2023 Associate Benefits Book

Summary Plan Descriptions

What's inside

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Pharmacy benefit
Dental plan
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Life insurance
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...and much more

Effective **January 1, 2023**
Walmart 401(k) Plan effective **February 1, 2023**
Associate Stock Purchase Plan effective **April 1, 2023**

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Welcome to your 2023 Associate Benefits Book

This is where you'll find the Summary Plan Descriptions (SPDs) for the Associates' Health and Welfare Plan (the Plan) and the Walmart 401(k) Plan.

The prospectus for the Associate Stock Purchase Plan is here, too.

Check out the table of contents for a complete list of what you'll find in this book. It's a great resource to help you understand your benefits.

Lots of information. So easy to find.

When you download the 2023 *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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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. See page 288 in the **Legal information** chapter for more details.

Eligibility, enrollment, and effective dates

RESOURCES		
Find What You Need	**Online**	**Other Resources**
• Enroll in Walmart benefits • Notify People Services within 60 days of an election change event	Go to **One.Walmart.com/Enroll**	Call People Services at **800-421-1362**
Notify People Services if you have questions about the payroll deductions for your benefits		Call People Services at **800-421-1362**
Pay premiums for benefits while on a leave of absence		See the **Keeping your premiums current** section in this chapter for detailed information. Failure to pay your premiums to keep coverage current 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 going to **One.Walmart.com/Enroll** and choosing "make a payment" or by calling **800-421-1362** and saying "make a payment." You may also send a check or money order payable to the Associates' Health and Welfare Trust to: **Walmart People Services** **P.O. Box 1039** **Department 3001** **Lowell, Arkansas 72745** To ensure timely posting of your payment, be sure to include your WIN (Walmart ID) number and work location on the check.

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

- Your job classification (or changes to your job classification) determines when your initial enrollment period begins. If you are an hourly Hawaii associate, see the chapter titled **Eligibility, enrollment, and effective dates for associates in Hawaii**.
- You can enroll for benefits during your initial enrollment period as a newly eligible associate, during Annual Enrollment, or when you have an election change event.
- You must enroll before your effective date. See the **Enrollment and effective dates by job classification** section of this chapter for details.
- Medical, dental, vision, critical illness, accident, accidental death and dismemberment (AD&D), short-term disability enhanced, long-term disability, and truck driver long-term disability benefits cannot be changed, added, or dropped outside an initial enrollment period, Annual Enrollment, or after you have an election change event.
- If you do not enroll in long-term disability or truck driver long-term disability benefits 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 have to provide Proof of Good Health.
- You may enroll in, drop, or change optional life insurance benefits at any time, but if you increase your coverage or enroll after your initial enrollment period, you will have to provide Proof of Good Health.

The Associates' Health and Welfare Plan

Walmart Inc. (the company) sponsors the Associates' Health and Welfare Plan (the Plan), which is a comprehensive employee benefit plan that offers medical, dental, vision, Resources for Living (employee assistance and wellness), disability, life insurance, business travel accident insurance, accident insurance, accidental death and dismemberment insurance and critical illness insurance benefits to eligible associates and their eligible family members. Eligibility for these benefits is described in this chapter, and the terms and conditions of the specific benefits offered under the Plan are described in the applicable chapters of this 2023 *Associate Benefits Book*. You are enrolled automatically for certain benefits under the Plan on your date of hire or a later date. For other benefits, however, you must enroll to have coverage. Refer to the **Associate eligibility** section in this chapter for details about your eligibility, the **Dependent eligibility** section in this chapter for information about dependent eligibility, including which family members may be enrolled for coverage, and the **Enrollment and effective dates by job classification** section in this chapter for details about initial enrollment periods and when coverage is effective, for all benefits available under the Plan.

Eligibility for benefits and the terms and conditions of each benefit are described in the Plan document and this 2023 *Associate Benefits Book*. To the extent that any information provided to you through other sources, whether oral or written, conflicts with the Plan document and this 2023 *Associate Benefits Book*, the terms in the 2023 *Associate Benefits Book* will control. In the event of any conflict between the terms of the Plan document and this 2023 *Associate Benefits Book*, the terms of the Plan document will control. If you wish to review the Plan document, please refer to the **Legal information** chapter of this *Associate Benefits Book*, which discusses your right to review the Plan Document.

Chapter overview

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

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

1	**YOUR EMPLOYMENT CLASSIFICATION** Your employment classification in the company's payroll system has an impact on your benefits. See page 7.
2	**BECOMING ELIGIBLE FOR BENEFITS** • When will you become eligible? Management and full-time hourly associates, see page 8; part-time hourly associates, see pages 7 & 9. • Who can you cover? See page 18. • When should you enroll? See page 24. • When is your coverage effective? See page 24.
3	**PAYING FOR YOUR BENEFITS** How do you pay for benefits? See page 33. When do you have to make special arrangements to pay for your benefits? See page 35.
4	**EVENTS THAT CAN AFFECT YOUR COVERAGE** What might impact your benefits? • If you go on a leave of absence or become disabled—see page 35. • A life event like a change in your family status—see page 38. • An employment event like a change in your job status—see page 39. • Special circumstances like a legal order or eligibility for a special enrollment period—see page 39.

Associate eligibility

The benefits you are eligible to enroll in and when you are eligible to enroll in them depend on a number of factors, which may include your job classification in the company payroll system, your date of hire, and average weekly hours. In addition, for some benefits, you may be required to meet an eligibility waiting period or provide Proof of Good Health before benefits you enrolled in become effective. See the **Enrollment and effective dates by job classification** section in this chapter for a list of the benefits you are eligible for and any waiting period or Proof of Good Health requirements that may apply. Some benefits may have waiting periods that apply to specific types of coverage. A discussion of those waiting periods is included in the respective benefit chapters in this *Associate Benefits Book*.

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

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

FULL-TIME HOURLY ASSOCIATE ELIGIBILITY

To be eligible to enroll in benefits as a full-time hourly associate, you must be classified in the company's payroll system as a full-time hourly associate. This includes pharmacists (except California pharmacists), full-time field supply chain associates, and field supervisor positions in stores and clubs, but excludes Vision Center managers. California pharmacists are eligible for benefits under the same terms as management associates. If you are a Vision Center manager, see below.

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

FULL-TIME HOURLY VISION CENTER MANAGER ELIGIBILITY

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

PART-TIME HOURLY ASSOCIATE ELIGIBILITY

To be eligible to enroll in benefits as a part-time hourly associate, you must be classified in the company's payroll system as a part-time hourly associate. If you are a part-time truck driver, see below.

In addition to being classified in the company's payroll system as a part-time hourly associate, to be eligible to enroll in medical benefits, you must work an average of at least 30 hours per week, with the following exceptions:

- Part-time hourly pharmacists hired prior to February 1, 2012, do not need to work a minimum number of hours per week.
- Part-time hourly pharmacists hired on or after February 1, 2012, must work an average of at least 24 hours per week.
- Part-time hourly associates in the field supply chain must work an average of at least 24 hours per week.
- Part-time hourly nurse practitioners must work an average of at least 24 hours per week.
- Part-time hourly associates in Hawaii are subject to different eligibility rules for medical and short-term disability benefits. Refer to the chapter titled **Eligibility, enrollment, and effective dates for associates in Hawaii** for details.

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

TEMPORARY ASSOCIATE ELIGIBILITY

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

In addition to being classified in the company's payroll system as a temporary associate, to be eligible to enroll in medical benefits, you must work an average of at least 30 hours per week, with the following exceptions:

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

If you are a temporary associate, the hours you work will be reviewed to determine your eligibility for medical benefits.

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

PART-TIME TRUCK DRIVER ELIGIBILITY

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

MANAGEMENT ASSOCIATE ELIGIBILITY

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

ASSOCIATES WHO ARE NOT ELIGIBLE

Unless stated otherwise, you are not eligible for the Plan if you fall in any of the following categories, even if you are reclassified by a court, the IRS, or the Department of Labor as a common-law employee of the company or any participating affiliate:

- A leased employee
- A nonresident alien (except that for purposes of optional associate life insurance, optional dependent life insurance, accidental death and disability insurance, and business travel accident insurance, nonresident aliens classified as full-time in the U.S. payroll system will be eligible; and nonresident aliens covered under a specific insurance policy for expatriates or third-country nationals who are employed by the company will be eligible, subject to the terms of those policies)
- An independent contractor
- A consultant
- An associate residing outside the United States
- An individual 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 plan options, including HMO and the PPO Plan options), or
- An associate covered by a collective bargaining agreement, to the extent that the agreement does not provide for participation in a benefit offered under the Plan.

ELIGIBILITY INFORMATION FOR ADDITIONAL ASSOCIATE CATEGORIES

Associates who enroll in medical benefits through an HMO or PPO Plan option: HMO and PPO Plan medical options are available for some work locations. The policies and enrollment materials for HMO and PPO Plan options may describe different eligibility requirements and waiting periods than those described in this chapter. If there is any difference between an HMO or the PPO Plan option's eligibility terms and the eligibility terms applicable to medical coverage under the Plan as described in this chapter, eligibility terms in this chapter will control.

In addition, some HMOs require participants to agree to arbitration terms, where permitted by law, before coverage under the HMO will become effective. If an HMO is available in your area and you enroll, your agreement must be received by the HMO within 60 days of your initial enrollment, or your HMO coverage will not take effect. If the HMO does not receive your agreement within 60 days, you will not have medical coverage under the Associates' Medical Plan (AMP) and will not be able to enroll again until the next Annual Enrollment or until you have a valid election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.

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

Localized associates: If you have been approved by the company as having localized status, you and your dependents residing in the United States are eligible for the same benefits under the Plan as associates who are United States citizens residing and working in the United States. Obtaining a Social Security number is not required to enroll in benefits under the Plan. Any applicable waiting period is waived. You are not eligible for expatriate coverage under the Plan. If you are a localized associate and an eligible dependent resides outside the United States, medical claims will be processed as network claims regardless of the provider's network status and paid at the applicable copay or coinsurance rate for network charges, subject to applicable limitations and exclusions under the Plan. In that case, you or your enrolled dependents must file a claim for reimbursement under the Plan's claims procedures.

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

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

- **During your first 52 weeks of employment:** Hours are measured every 60-days during your first 52 weeks of employment to determine eligibility for medical and other voluntary benefits coverage during the first 52 weeks. See **Your 60-day eligibility checks during your first 52 weeks of employment** in this section.
- **At 52 weeks of employment:** Hours worked over your entire first 52 consecutive weeks of employment are measured one time, at the end of the 52 weeks, to determine eligibility for medical benefits. See **Your one-time eligibility check at 52 weeks of employment** in this section.
- **After one year of employment:** Hours worked during a 12-month period are measured each year to determine eligibility for medical benefits in the next calendar year. See **Your annual eligibility check** in this section.

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

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

YOUR 60-DAY ELIGIBILITY CHECKS DURING YOUR FIRST 52 WEEKS OF EMPLOYMENT

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

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

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

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

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

EXAMPLE: If your date of hire is April 16, 2023, your hours worked from that day through June 13, 2023 will be measured on your 60th day of employment, which is June 14, to determine whether you have worked the required number of hours during that 59-day measurement period. If you work the required number of hours during this first measurement period and you do not have a break in employment of more than 30 days, you will be eligible to enroll in benefits that are available to part-time and temporary associates. If you are eligible, your benefits will be effective on the first day of the month in which your 89th day of employment occurs, assuming you enroll before the end of your initial enrollment period. Because your 89th day of employment would be July 13, your benefits will be effective on July 1, assuming you enroll before the end of your initial enrollment

period. Your hours will not be measured again during your first 52 weeks of employment, even if you do not enroll during your initial enrollment period. The next time your eligibility for medical benefits will be checked is the annual eligibility check described in **Your annual eligibility check** in this section.

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

EXAMPLE: If your date of hire is April 16, 2023, your hours worked from that day through June 13, 2023, will be measured on your 60th day of employment, June 14. If you do not work the required number of hours over this 59-day measurement period, the next measurement period will be the 60-day period that runs from June 14 through August 12. The hours you work over this 60-day measurement period will be measured on August 13. If you work the required number of hours during this second measurement period and you do not have a break in employment of more than 30 days, you will be eligible to enroll in benefits, which would be effective on the first day of the month that contains the 89th day of employment, counted from the first day of the second measurement period, assuming you enroll before the end of your initial enrollment period. Because the 89th day of employment, beginning with June 14, occurs on September 10, your benefits would be effective on September 1, 2023, assuming you enroll before the end of your initial enrollment period. Your hours will not be measured again during your first 52 weeks of employment, even if you do not enroll during your initial enrollment period. The next time your eligibility for medical benefits will be checked is the annual eligibility check described in **Your annual eligibility check** in this section.

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

If you become eligible for benefits during your first 52 weeks of employment as the result of working the required number of hours in a 60-day measurement period, your eligibility for medical benefits continues through the end of the second calendar year following your date of hire (your "medical coverage eligibility period"), assuming you remain a part-time hourly or temporary associate. In the example above, the medical coverage eligibility period would continue through the end of the 2025 calendar year, which is the end of the second calendar year following your date of hire. Your eligibility for the other voluntary benefits described in the **Enrollment and effective dates by job classification** section will continue as long as you remain a part-time hourly or temporary associate, subject to applicable Plan terms. However, if you do not enroll in medical benefits when first eligible and prior to the end of the initial enrollment period, you will not be permitted to enroll in medical benefits during the remainder of your medical coverage eligibility period except during an Annual Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section later in this chapter. Likewise, if you do not enroll in most voluntary benefits (other than optional life insurance) during your initial enrollment period, you will also not be permitted to enroll except during an Annual Enrollment period, or if you have an election change event. Once eligible for voluntary benefits, you may enroll in optional life insurance at any time. The next time your eligibility for medical benefits will be checked is the annual eligibility check described in **Your annual eligibility check** in this section.

EXAMPLE: In the example above, your medical benefits would continue through the end of 2025, unless you drop coverage during the 2023 Annual Enrollment period (for the 2024 calendar year), or the 2024 Annual Enrollment period (for the 2025 calendar year), or if you have an election change event. If you do not elect medical coverage during your initial enrollment period, your eligibility for medical benefits will still continue through 2025. However, you will not be permitted to change coverage except during an Annual Enrollment period, or if you have an election change event. Your eligibility for the other voluntary benefits will continue as long as you remain a part-time hourly or temporary associate, subject to applicable Plan terms. However, if you do not enroll in most voluntary benefits during your initial enrollment period, you will also not be permitted to enroll except during an Annual Enrollment period, or if you have an election change event. Once eligible for voluntary benefits, you may enroll in optional life insurance at any time.

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

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

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

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

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

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

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

YOUR ONE-TIME ELIGIBILITY CHECK AT 52 WEEKS OF EMPLOYMENT

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

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

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

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

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

EXAMPLE: If your date of hire is April 16, 2022, your hours worked from that day through April 15, 2023 will be measured to determine whether you have worked the required number of hours during the initial measurement period. If you work the required number of hours during this initial measurement period and you do not have a break in employment of 13 weeks or more, you will be eligible to enroll in medical benefits. You will also be eligible to enroll in other voluntary benefits that are available to part-time and temporary associates, subject to applicable Plan terms. In this example, all benefits you enroll in would be effective on June 1, 2023, which is the first day of the second calendar month following your one-year anniversary date, April 16, 2023.

If you do not work the required number of hours during your initial measurement period to be eligible for medical benefits, your eligibility for medical benefits will be checked again at the annual eligibility check that follows your initial measurement period, as described in **Your annual eligibility check** in this section. If you had not passed the one-time check at 52 weeks of employment in the example above, your first annual eligibility check for medical benefits would be in the fall of 2023 for 2024 medical coverage. You may still be eligible for other voluntary benefits that are available to part-time and temporary associates, regardless of whether you work the required number of hours to be eligible for medical benefits, subject to applicable Plan terms. See the **Enrollment and effective dates by job classification** section in this chapter for other benefits you may be eligible for.

If you become eligible for benefits as a result of the one-time check at 52 weeks of employment, your eligibility for medical benefits continues through the end of the second calendar year following your date of hire, regardless of whether you actually enroll in medical coverage (your "medical coverage eligibility period"), subject to any applicable Plan terms and assuming you remain a part-time hourly or temporary associate. In the example above, the medical coverage eligibility period would continue through the end of the 2024 calendar year. Your eligibility for the other voluntary benefits described in the **Enrollment and effective dates by job classification** section later in this chapter will continue as long as you remain a part-time hourly or temporary associate, subject to applicable Plan terms. However, if you do not enroll in medical benefits when first eligible and prior to the end of your initial enrollment period, you will not be permitted to enroll in medical benefits during the remainder of your medical coverage eligibility period except during an Annual

Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section later in this chapter. Likewise, if you do not enroll in most voluntary benefits (other than optional life insurance) during your initial enrollment period, you will also not be permitted to enroll except during an Annual Enrollment period, or if you have an election change event. Once eligible for voluntary benefits, you may enroll in optional life insurance at any time. Your eligibility for medical benefits will not be checked again until the annual check that occurs in the final year of your medical coverage eligibility period, as described in **Your annual eligibility check** in this section.

If you take time off during the initial measurement period

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

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

If you leave the company and are rehired

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

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

(Continued on the next page)

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

If you return as a part-time or temporary associate 13 weeks or more from your termination date, you will be treated as a new associate and will be subject to the 60-day eligibility checks described in **Your 60-day eligibility checks during your first 52 weeks of employment** in this section, subject to otherwise applicable Plan terms.

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

YOUR ANNUAL ELIGIBILITY CHECK

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

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

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

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

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

If you do work the required number of hours during your annual measurement period without a break in employment of 13 weeks or more, you will be eligible to enroll in medical benefits at Annual Enrollment. If eligible, your benefits will be effective on January 1 of the following calendar year. If you do become eligible for benefits as a result of the annual check, your eligibility for medical benefits continues through December 31 of the year in which it is effective, regardless of whether you actually enroll in medical benefits, subject to any applicable Plan terms and assuming you remain a part-time hourly or temporary associate. However, if you do not enroll in medical benefits during the Annual Enrollment period, you will not be permitted to enroll in medical benefits during the next calendar year unless you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section later in this chapter. Your eligibility for medical benefits will not be checked again until the next annual eligibility check, provided you remain a part-time hourly or temporary associate.

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

If you are enrolled in medical benefits in the current calendar year but did not work the required number of hours to be eligible for medical benefits in the following calendar year, you will not be eligible for medical benefits for the following year unless your job classification changes and you meet the eligibility requirements based on your new classification. However, you will have the option under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue your medical coverage when the current calendar year ends. (See the **COBRA** chapter for more information.)

You may also be eligible for other voluntary benefits, regardless of whether you work the required number of hours to be eligible for medical benefits, subject to applicable Plan terms. See the **Enrollment and effective dates by job classification** section for other benefits you may be eligible for.

If you take time off during the annual measurement period

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

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

If you leave the company and are rehired

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

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

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

If you return as a part-time or temporary associate 13 weeks or more from your termination date, you will be treated as a new associate and will be subject to the 60 day eligibility checks described in the **Your 60-day eligibility checks during your first 52 weeks of employment** section, subject to otherwise applicable Plan terms.

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

Dependent eligibility

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

EMPLOYMENT CLASSIFICATION	ELIGIBLE DEPENDENTS (AS DEFINED BELOW)
• Management • Full-time hourly	**Can elect to cover:** • Spouse/partner • Dependent child(ren)
• Part-time hourly • Temporary • Part-time truck driver	**Can elect to cover:** • Dependent child(ren) But *not* spouse/partner

DEFINITIONS: ELIGIBLE DEPENDENTS* **Dependents not described in this chart are not eligible dependents.**	
SPOUSE/PARTNER Part-time hourly and temporary associates may not cover a spouse/partner	• Your spouse, as long as you are not legally separated • Your domestic partner (or "partner"), as long as you and your domestic partner: – Are in an exclusive and committed relationship similar to marriage and have been for at least 12 months – Are not married to each other or anyone else – Meet the age for marriage in 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.

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

If an individual is your eligible dependent and ceases to satisfy the definition of eligible dependent, that individual will no longer be eligible for coverage under the Plan and you are required to report the change in status. See **When your dependent becomes ineligible** later in this chapter for information. If you fail to report the change, you may be subject to the loss of benefits and/or termination of employment.

If a court order requires you to provide medical, dental, and/or vision coverage for your child, the child must be an eligible dependent as defined above. For more information on how the Plan handles a medical child support order, see **Medical child support orders** later in this chapter.

If you are enrolled for medical coverage in a local plan option, HMO option, or the PPO Plan option, note that these options do not offer out-of-network coverage and do not offer nationwide provider networks. If you have an eligible dependent living outside your medical plan option's service area, you may still enroll your eligible dependents, but they will not have access to network providers in the geographic area in which they live and may have access only to emergency coverage. If you are unsure whether your eligible dependent lives outside your AMP option's service area, call your health care advisor at the number on your plan ID card.

IF YOUR CHILD IS INCAPABLE OF SELF-SUPPORT

If your child is enrolled in 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 election change event. For information regarding an election change event, refer to the **Permitted election changes outside Annual Enrollment** 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 federal 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*
- Joint utility bill*
- Will and/or life insurance policy which designates the other as the primary beneficiary

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

Children: Copy of the following documents, as applicable:

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

- **Child of your domestic partner/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.
- **Child you are ordered by a court or agency to cover:** Signed qualified medical child support order. See **Medical child support orders** later in this chapter.

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

Dependents who are not eligible

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

- Residing outside the U.S. (not applicable to optional dependent life insurance, AD&D, critical illness, and accident insurance, and not applicable if your dependent is attending college full-time outside the U.S.)
- Covered under an expatriate plan
- Not an eligible dependent as defined under **Dependent eligibility** earlier in this chapter
- A Walmart associate already enrolled in coverage under the Plan (not applicable to optional dependent life insurance, AD&D, critical illness, and accident insurance)
- A dependent of another Walmart associate and already enrolled in coverage under the Plan (not applicable to optional dependent life insurance, AD&D, critical illness, and accident insurance)
- Enrolled in Medicare Part D (applicable only to eligibility for AMP options, including HMO and the PPO Plan options)
- On active duty in the armed forces of any country (applies only to optional life insurance or accidental death and dismemberment insurance).

When your dependent becomes ineligible

If your dependent is enrolled in coverage under the Plan and becomes ineligible for coverage, you must notify People Services at **800-421-1362** within 60 days from the date your dependent becomes ineligible. If your dependent is enrolled in medical, dental, or vision coverage and you notify People Services within this time frame, the Plan will send an election notice, allowing your dependent to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage. Your dependent's election to enroll in COBRA coverage must be received within 60 days from the date your dependent loses coverage or the date of the election notice, if later. See the **COBRA** chapter for more information.

Failure to notify the Plan by calling People Services at **800-421-1362** when your dependent becomes ineligible for coverage may be considered an intentional misrepresentation of material facts, which may result in your coverage being canceled. If your dependent becomes ineligible for coverage and you fail to notify the Plan by calling People Services, you may be responsible for any charges mistakenly paid by the Plan after the date that your dependent became ineligible.

When you enroll for benefits

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

You must enroll for benefits during your "initial enrollment period." Your "initial enrollment period" is the first time you are eligible to enroll. The timing of your initial enrollment period varies by job classification and may change if your job classification changes, provided you have not already had an "initial enrollment period" while you were in the 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 experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter:

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

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

Proof of Good Health. 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 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.

Late enrollees. If you do not enroll in the long-term disability plan, truck driver 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 also 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 TIER

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

Under the medical, dental, and vision plans, and critical illness and accident insurance, you may elect one of the following coverage tiers:

- Associate only
- Associate + spouse/partner (except for part-time hourly associates, temporary associates, and part-time truck drivers)
- Associate + child(ren), or
- Associate + family (except for part-time hourly associates, temporary associates, and part-time truck drivers).

CONFIRMING YOUR ENROLLMENT

Once you enroll in 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 People Services at **800-421-1362**.

YOUR PLAN ID CARD

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

If you enroll in any of the medical coverage options under the AMP or the PPO Plan (if applicable) and you also enroll in the Associates' Dental Plan (the "dental plan") and/or the Associates' Vision Plan (the "vision plan"), your plan ID card will also serve as your dental ID card and/or your vision ID card.

If you enroll in an HMO and you also enroll in the dental plan and/or the vision plan, you will receive separate ID cards for the dental and/or vision plan.

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

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

When coverage is effective

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

Medical, dental, vision, critical illness, accident, accidental death and dismemberment ("AD&D"), Resources for Living, company-paid life and business travel accident. If you are not at work on the day your coverage would otherwise become effective (including for a leave of absence) for medical, dental, vision, critical illness insurance, accident

insurance, 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 on this page, as long as you are enrolled for the benefit and applicable premiums are current. No enrollment or premiums are required for Resources for Living, business travel accident insurance, short-term disability basic, or company-paid life insurance.

Optional associate life and optional dependent life. If you are not at work for any reason (including for a leave of absence) other than scheduled paid time off (PTO) on the day your coverage would otherwise become effective for optional associate life insurance or optional dependent life insurance, your coverage will be effective on the first day you are "actively at work," as defined on this page, as long as you are enrolled for the benefit and applicable premiums are current. If your spouse/partner or dependent child is confined for medical treatment (at home or elsewhere), coverage will not be effective until they obtain a final medical release from that confinement.

Disability. If you are an hourly associate and have not worked hours during the pay period in which your coverage would otherwise become effective or are a management associate and do not have earned wages in the same pay period in which your coverage otherwise becomes effective, for full-time hourly short-term disability basic or enhanced (as applicable), salaried and truck driver short-term disability, full-time hourly and salaried long-term disability (LTD) basic or enhanced (as applicable), or truck driver LTD insurance (as applicable), your coverage will be effective on the first day of the pay period you are considered "actively at work," as defined below, al long as you are enrolled for the benefit and applicable premiums are current.

"ACTIVE WORK" OR "ACTIVELY AT WORK"

Medical, dental, vision, critical illness, accident, accidental death and dismemberment ("AD&D"), Resources for Living. For medical, dental, vision, critical illness insurance, accident insurance, 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 is effective (for example, due to illness).

Life and business travel accident. 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.

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

AUTOMATIC REENROLLMENT

If you are currently enrolled in benefits and are eligible for those same benefits during the following calendar year, but do not make an affirmative election related to those benefits during 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 People Services at **800-421-1362** for information.

If you do not make an affirmative election during Annual Enrollment and are enrolled automatically in coverage as described above, you may not change this coverage except during Annual Enrollment, unless you experience an election change event.

If you do not make an affirmative election during Annual Enrollment, as described above, you will be deemed to have consented to automatic reenrollment, and your payroll deductions will be adjusted accordingly.

If you leave the company and are rehired

MANAGEMENT, FULL-TIME HOURLY, AND TRUCK DRIVER ASSOCIATES

If you terminate employment after meeting applicable eligibility requirements for benefits, and you return to the company as a management, full-time hourly, or truck driver associate, your eligibility for benefits will be determined in accordance with the rules in the chart below:

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

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

PART-TIME HOURLY AND TEMPORARY ASSOCIATES

See the **Part-time hourly and temporary associates: eligibility checks for medical 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.

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

Enrollment and effective dates by job classification

FULL-TIME HOURLY ASSOCIATES
Includes pharmacists (except California pharmacists*), full-time field supply chain, field supervisor positions in stores and clubs; excludes Vision Center managers

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

(Continued on the next page)

FULL-TIME HOURLY ASSOCIATES (CONTINUED)
Includes pharmacists (except California pharmacists*), full-time field supply chain, field supervisor positions in stores and clubs; excludes Vision Center managers

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
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** You must enroll in coverage between the date of your first biweekly pay 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, provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status. • 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, provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status. **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; provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status. If you are required to provide Proof of Good Health, payroll deductions of your premiums will not begin until your coverage is effective, as described above.
• Short-term disability basic plan – Basic coverage (not available to associates who work in California, Hawaii, New Jersey, and Rhode Island; different coverage is available in New York) – Maternity benefits *See the* **Full-time hourly short-term disability** *chapter for general information about state benefits.*	You are enrolled automatically on the 12-month anniversary of your date of hire, and your coverage is effective on that date.

(Continued on the next page)

FULL-TIME HOURLY ASSOCIATES (CONTINUED)
Includes pharmacists (except California pharmacists*), full-time field supply chain, field supervisor positions in stores and clubs; excludes Vision Center managers

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
• Short-term disability enhanced plan (not available to associates who work in California, Hawaii, New Jersey, and Rhode Island; New York short-term disability enhanced plan is available in New York) *See the* **Full-time hourly short-term disability** *chapter for general information about state benefits.*	**Initial enrollment period:** You must enroll in coverage between the date of your first biweekly pay and the day *prior* to the first day of the calendar month during which your 89th day of continuous full-time employment falls. **When coverage is effective:** • **If you enroll in coverage during your initial enrollment period:** Coverage is effective on the 12-month anniversary of your date of hire. • **If you enroll in coverage after your initial enrollment period:** Coverage is effective 12 months after the date you enroll in coverage at Annual Enrollment or, in the case of an election change event, 12 months after the date of the event. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until Annual Enrollment for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
• Long-term disability (LTD) plan (including enhanced benefits)	**Initial enrollment period:** You must enroll in coverage between the date of your first biweekly pay 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 an election change event and are approved, your coverage is effective on the later of 1) the first day of the pay period following the date Lincoln approves your coverage, or 2) the 12-month anniversary of your date of hire. – If you enroll in coverage during Annual Enrollment and are approved, your coverage will be effective the later of 1) January 1 of the following year 2) if approved on or after January 1, the first day of the pay period following the date Lincoln approves your coverage, or 3) the 12-month anniversary of your date of hire. – If you are not approved, you may be eligible to enroll during the next Annual Enrollment or after an election change event but will be subject to the same Proof of Good Health requirements. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until Annual Enrollment for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.

*If you are classified as a "California pharmacist" in payroll systems, see the chart for management associates.

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

NOTE: Some benefits require you to meet the definition of active work. See the **"Active work" or "actively at work"** section in this chapter for information.

FULL-TIME HOURLY VISION CENTER MANAGERS
NOTE: *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 • HMO plans • Dental – Enrollment is for two full calendar years • Vision • Critical illness insurance • Accident insurance • AD&D	**Initial enrollment period:** You must enroll in coverage between the date of your first biweekly pay and the day *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, unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
• Resources for Living • Company-paid life insurance • Business travel accident insurance	You are enrolled automatically on your date of hire and your coverage is effective on that date.	
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** You must enroll in coverage between the date of your first biweekly pay and the day *prior* to the 60th day of employment, measured from your date of hire. **When coverage is effective:*** **If you enroll during your initial enrollment period:** • If you enroll for the guaranteed issue amount, coverage is effective on the date you enroll, provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status. • 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, provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status. **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; provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status. If you are required to provide Proof of Good Health, payroll deductions of your premiums will not begin until your coverage is effective, as described above.	
• Short-term disability basic plan – Basic coverage (not available to associates who work in California, Hawaii, New Jersey, and Rhode Island; different coverage is available in New York) – Maternity benefits *See the **Full-time hourly short-term disability** chapter for general information about state benefits.*	You are enrolled automatically on your date of hire, and your coverage is effective on that date.	

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FULL-TIME HOURLY VISION CENTER MANAGERS (CONTINUED)
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
• Short-term disability enhanced plan (not available to associates who work in California, Hawaii, New Jersey, and Rhode Island; New York short-term disability enhanced plan is available in New York) *See the* **Full-time hourly short-term disability** *chapter for general information about state benefits.*	**Initial enrollment period:** You must enroll in coverage between the date of your first biweekly pay and the day *prior* to the 60th day of employment, measured from your date of hire. **When coverage is effective:** • **If you enroll during your initial enrollment period:** Coverage is effective your date of hire. • **If you enroll in coverage after your initial enrollment period:** Coverage is effective 12 months after the date you enroll in coverage at Annual Enrollment or, in the case of an election change event, 12 months after the date of the event. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until Annual Enrollment for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
• Long-term disability (LTD) plan (including enhanced benefits)	**Initial enrollment period:** You must enroll in coverage between the date of your first biweekly paycheck and the day *prior* to the 60th day following your date of hire. **When coverage is effective:** • **If you enroll in coverage during your initial enrollment period:** Coverage is effective on your date of hire. • **If you enroll in coverage after your initial enrollment period:** 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 an election 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 the later of 1) January 1 of the following year, or 2) if approved on or after January 1, the first day of the pay period following the date Lincoln approves your coverage. – If you are not approved, you may be eligible to enroll during the next Annual Enrollment or after an election change event but will be subject to the same Proof of Good Health requirements. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until Annual Enrollment for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.

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

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* • HMO plans • Dental – Enrollment is for two full calendar years • Vision • Critical illness insurance • Accident insurance • AD&D	**Initial enrollment period:** **If you are eligible for benefits during the first 52 weeks of employment as a result of working the required number of hours in a 60-day measurement cycle:** You must enroll in coverage between the date you are first notified that you have met the eligibility requirements and the day *prior* to the 60th day following notification. See the section titled **Part-time hourly and temporary associates: eligibility checks for medical benefits**.* **If you are eligible for medical coverage as a result of the annual eligibility check that occurs at 52 weeks of employment:** You must enroll in medical 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.* **Regardless of whether you are eligible for medical coverage as a result of the eligibility checks described above:** You are still eligible to enroll in all benefits listed, except medical coverage, after 52 weeks of employment. You must enroll in coverage between the date following your 52-week anniversary and the day *prior* to the 60th day following the date of your 52-week anniversary.* **When coverage is effective:** **If you are eligible during the first 52 weeks of employment as a result of working the required number of hours in a 60-day measurement cycle:** Your coverage is effective on the first day of the month in which your 89th day of employment occurs, counting from the date on which the successful 60-day measurement cycle began. See the section titled **Part-time hourly and temporary associates: eligibility checks for medical benefits**. **If you are eligible as a result of the annual eligibility check that occurs at 52 weeks of employment (for medical)* or on your 52-week anniversary (for all other benefits):** Your coverage is effective on 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 unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter. *To be eligible for medical coverage, part-time hourly and temporary associates must work the required number of hours and pass one of the eligibility checks described under **Part-time hourly and temporary associates: eligibility checks for medical benefits** earlier in this chapter. Part-time hourly pharmacists hired before February 1, 2012, are exempt from this requirement.
• Resources for Living • Business travel accident insurance	You are enrolled automatically on your date of hire, and your coverage is effective on that date.

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PART-TIME HOURLY AND TEMPORARY ASSOCIATES (CONTINUED)
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
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** **If you are eligible during the first 52 weeks of employment as a result of working the required number of hours in a 60-day measurement cycle:** You must enroll in optional associate or optional dependent life insurance coverage between the date you are first notified that you have met the eligibility requirements and the day *prior* to the 60th day following notification. **If you are eligible on your 52-week anniversary:** 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:**** For purposes of determining the effective date of your optional life insurance, you will need to refer to the discussion of eligibility for medical coverage. If you become eligible for medical coverage before your first 52-week anniversary because you worked the required number of hours in a 60-day measurement period, the effective date of your medical coverage is the "applicable date" for determining the effective date for optional life insurance. If you did not become eligible for medical coverage before your 52-week anniversary and instead become eligible on your 52-week anniversary, the "applicable date" for determining the effective date for optional life insurance is the first day of the second calendar month following your 52-week anniversary. **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 "applicable date," provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status. • If you enroll for more than the guaranteed issue amount, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam at your own expense. If approved, your coverage is effective on the later of 1) the date Prudential approves your coverage, or 2) the "applicable date," provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status. **If you enroll after your initial enrollment period:** Once eligible, 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 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, provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status. If you are required to provide Proof of Good Health, payroll deductions of your premiums will not begin until your coverage is effective, as described above.

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

Part-time hourly and temporary associates may only cover their eligible dependent children and may not cover their spouse/partners. Disability coverage and company-paid life insurance are not available to part-time hourly and temporary associates.

NOTE: Some benefits require you to meet the definition of active work. See the **"Active work" or "actively at work"** section in this chapter for information.

PART-TIME TRUCK DRIVERS
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 • HMO plans • Dental – Enrollment is for two full calendar years • Vision • Critical illness insurance • Accident insurance • AD&D	**Initial enrollment period:** You must enroll in coverage between the date of your first biweekly pay and the day *prior* to your coverage effective date. **When coverage is effective:** Your coverage is effective the first day of the calendar month during which your 89th day of continuous 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 unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
• Resources for Living • Business travel accident insurance	You are enrolled automatically on your date of hire and your coverage is effective on that date.	
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** You must enroll in coverage between the date of your first biweekly pay 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 employment falls, provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status. • If you enroll for more than the guaranteed issue amount, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam 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 employment falls, provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status. **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 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, provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status. If you are required to provide Proof of Good Health, payroll deductions of your premiums will not begin until your coverage is effective, as described above.	

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

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

Part-time truck drivers may only cover their eligible dependent children and may not cover their spouses/partners. Disability coverage and company-paid life insurance are not available to part-time truck drivers.

NOTE: Some benefits require you to meet the definition of active work. See the **"Active work" or "actively at work"** section in this chapter for information.

MANAGEMENT ASSOCIATES
Includes management trainees, California pharmacists,* and full-time truck drivers

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.*

<table>
<tr><th>Plan</th><th colspan="2">Enrollment periods and coverage effective dates</th></tr>
<tr><td>• Medical
• HMO plans
• Dental
– Enrollment is for two full calendar years
• Vision
• Critical illness insurance
• Accident insurance
• AD&D</td><td>Initial enrollment period:
You must enroll in coverage between the date of your first biweekly pay 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.</td><td>If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until Annual Enrollment for the next calendar year unless you experience an election change event, as described in the Permitted election changes outside Annual Enrollment section of this chapter.</td></tr>
<tr><td>• Resources for Living
• Company-paid life insurance
• Business travel accident insurance
• Short-term disability plan**</td><td colspan="2">You are enrolled automatically on your date of hire and your coverage is effective on that date.</td></tr>
<tr><td>• Optional associate life insurance
• Optional dependent life insurance</td><td colspan="2">Initial enrollment period:
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 during your initial enrollment period:
• If you enroll for the guaranteed issue amount, coverage is effective on the date you enroll, provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status.
• 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, provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status.

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, provided you are not on a leave of absence on the date coverage would otherwise be effective. If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status.

If you are required to provide Proof of Good Health, payroll deductions of your premiums will not begin until your coverage is effective, as described above.</td></tr>
</table>

(Continued on the next page)

MANAGEMENT ASSOCIATES (CONTINUED)
Includes management trainees, California pharmacists,* and full-time truck drivers

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
• Long-term disability (LTD) plan (including enhanced benefits) • Truck driver LTD plan (including enhanced benefits)	**Initial enrollment period:** You must enroll in coverage between the date of your first biweekly pay 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 on 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 an election 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 the later of 1) January 1 of the following year, or 2) if approved on or after January 1 of the current year, the first day of the pay period following the date Lincoln approves your coverage. – If you are not approved, you may be eligible to enroll during the next Annual Enrollment or after an election change event but will be subject to the same Proof of Good Health requirements. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until Annual Enrollment for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.

*Pharmacists who work in California and have the designation of "California pharmacist" in payroll systems are eligible for the benefits listed here for management associates.

**The salaried and truck driver short-term disability plans are not covered by ERISA and are not part of the Associates' Health and Welfare Plan.

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

NOTE: Some benefits require you to meet the definition of active work. See **"Active work" or "actively at work"** in this chapter for information.

Paying for your benefits

You are required to pay premiums for any benefit that you choose to enroll in (e.g., medical, dental, vision, optional life, etc.) for benefit coverage to remain in effect. You are not required to pay premiums for any benefit that you are automatically enrolled in (i.e., Resources for Living, basic short-term disability for hourly associates, short-term disability for salaried associates, short-term disability for truck drivers, company-paid life insurance coverage, and business travel accident insurance).

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

TOBACCO RATES

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

- You and/or a covered spouse/partner do not use tobacco products, 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, 2023. Alternatively, if you call Walmart's Quit Tobacco program at **855-955-1905**, the program will work with you (and, if you wish, your doctor) to find a program that is right for you.

Not using tobacco products means that you have not used any type of tobacco product in the last 30 days, and you agree not to use any tobacco products in 2023. "Tobacco products" include cigarettes, cigars, pipes, snuff, chewing tobacco, and e-cigarettes or any such nicotine-delivery devices.

IMPORTANT

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

You will be asked to attest to your 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. 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.

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 Code of Conduct which can be found on **One.Walmart.com**. If we receive a report of abuse, we will conduct an ethics investigation.

The company offers the Quit Tobacco program at no cost to all associates. For information, see **Quit Tobacco program** in **The medical plan** chapter.

HOW YOUR PREMIUMS ARE PAID

As a general rule, premiums are deducted from your biweekly pay. Your payroll deductions for benefits in any pay period are paying for the benefits coverage provided to you during that pay period. With biweekly pay, your deductions pay for coverage for the two weeks in that pay period. For example, if a pay period runs from April 1 through April 14, the payroll deductions for benefits taken from the pay received with respect to that two-week period are paying for your benefits coverage through April 14.

Premiums are not deducted from your pay until your elected coverage becomes effective.

The first biweekly pay after your coverage effective date will generally reflect deductions for each day you had coverage during that pay period. If a pay period spans two calendar years, your deductions will reflect the amount for the prior year through December 31 and the new amount for the new year, prorated for the number of days covered from January 1 until the end of the pay period.

Be sure to check your statement of earnings and deductions on your paystub to verify that the proper deductions are being taken. You can view your paystub the Monday before payday by going to Online Paystub on **One.Walmart.com**. If you believe the coverage or deductions are not correct on your paystub, call People Services immediately at **800-421-1362**. Requests for a review of 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.

TAXATION

Some types of coverage are paid for with pretax dollars. This means premiums are deducted from your biweekly pay before federal and, in most cases, state taxes are withheld. Because Social Security taxes are not withheld on any pretax dollars you spend for benefits, amounts you pay for benefits with pretax dollars are not counted as wages for Social Security purposes. As a result, your future Social Security benefits may be reduced somewhat. Other types of coverage are paid for with after-tax dollars, meaning premiums are paid from amounts that have already been taxed.

With some exceptions discussed below, premiums for the following types of coverage are paid on a pretax basis:

- Medical
- Dental
- Vision
- Critical illness insurance
- Accident insurance
- Accidental death and dismemberment (AD&D)

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

Premiums for the following types of coverage are paid on an after-tax basis:

- All types of disability coverage
- Optional associate and dependent life-insurance

There are some instances where premiums that are typically paid on a pretax basis are paid with after-tax dollars, including:

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

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 (including the HRA) 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 biweekly pay 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 elected by you but you are not receiving biweekly pay 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.

Keeping your premiums current

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

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

If any premiums remain past due for more than 30 days, coverage will be canceled effective back to the date for which premiums are current. 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 unless you experience a valid election change event, and provided you remain eligible. However, you may reenroll in optional life insurance at any time, provided you remain eligible. Reenrollment may require Proof of Good Health. See the **Permitted election changes outside Annual Enrollment** section of this chapter.
- If you are on a leave of absence and return to active work within one year of the first day of the leave, you will be enrolled for the same coverage (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 new associate and will be required to meet any applicable eligibility requirements before you may enroll in coverage.

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

PAYING PREMIUMS WHEN ON AN UNPAID LEAVE OR WHEN PREMIUMS ARE PAST DUE

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

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

PAYING PREMIUMS WHEN ON PAID LEAVE

As discussed above, if you receive biweekly pay from the company (i.e., any pay processed through the company payroll system), any premiums you currently owe (including past-due premiums) will be deducted from that biweekly pay to the extent permitted by law. This includes pay for wages, disability benefits, and other paid leave processed through the company payroll system, incentive payments, paid time off, etc.

While you are on a Family Medical Leave Act (FMLA) leave, personal leave, or military leave, you may retain most voluntary benefits you were enrolled in on the day immediately preceding the first day of the leave. This includes medical, dental, vision, critical illness insurance, accident insurance, optional associate life, optional dependent life, and AD&D. You will also retain Resources for Living, but no premiums are required for that benefit. Coverage for these voluntary benefits is generally maintained on the same terms and conditions as if you had continued to work during the leave. (Contact a member of your management team or Sedgwick for additional information about FMLA, personal, or military leave, or refer to the company's Leave of Absence Policy on **One.Walmart.com** for specific information. You may also contact your personnel representative if you have questions about the FMLA, personal, or military leave policy. Decisions about leaves of absence are made by the company, not the Plan.)

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

If you drop your coverage during your FMLA, personal, or military leave and return to work, you may contact People Services at **800-421-1362** within 60 days of returning to work to reinstate your coverage.

If you maintain any benefit coverage while on leave, there may be times when you receive paid leave or ongoing biweekly pay from the company for all or some of the time. This is the case if you are on a paid leave program (e.g., paid parental leave) or are receiving disability benefits because you are disabled within the meaning of a disability plan.

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

There may be times when you see disability premiums deducted from pay that would otherwise not be subject to disability premiums. For example, if you receive disability benefits processed through the Walmart payroll system when premiums (including disability premiums) from a prior payroll period remain past due, those past due premiums may be deducted from the disability benefits, notwithstanding the fact that no current disability premiums are due with respect to those current disability benefits.

If you are receiving any pay processed through the company payroll system—including disability benefits or other paid benefits under a company leave program—premiums that are currently owed (either past due or related to the current pay period) will be deducted to the extent permissible. If you are receiving payments from any other source (e.g., long-term disability benefits paid by Lincoln or short-term disability benefits that are not processed through the Walmart payroll system), no premiums will be deducted from those payments.

When you are on any leave of absence—for any reason—it is your responsibility to make sure that all premiums are paid on time so your benefits coverage remains active.

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

TO MAINTAIN COVERAGE UNDER THESE BENEFITS	
• Medical • Dental • Vision • Critical illness insurance • Accident insurance	• Optional associate life • Optional dependent life • AD&D • Short-term disability (other than for disability payments) • Long-term disability (other than for disability payments)
WHILE YOU ARE RECEIVING...	
Short-term disability benefits under the full-time hourly short-term disability plan (except for associates who work in CA, HI, NJ, NY, and RI)	Short-term disability benefits are processed through the company payroll system. You may also receive biweekly pay for paid time off, incentives, etc., which is also processed through the company payroll system. • Any past-due premiums (including past-due premiums for disability coverage) will be deducted from short-term disability payments and other pay you receive. • Any premiums due for the current pay period will be deducted from short-term disability payments and other pay you receive, except that no premiums will be due with respect to any disability payments. • You must make arrangements to pay any premiums still due or risk cancellation of your coverage.
Short-term disability benefits under the full-time hourly short-term disability plan (associates who work in CA, HI, NJ, NY, or RI)	Short-term disability benefits are not processed through the company payroll system.* However, you may receive biweekly pay for paid time off, incentives, etc., which is processed through the company payroll system. • Any past-due premiums (including past-due premiums for disability coverage) will not be deducted from short-term disability payments but will be deducted from other pay you receive. • Any premiums due for the current pay period will not be deducted from short-term disability payments but will be deducted from other pay you receive, except that no premiums will be due with respect to any disability payments. • You must make arrangements to pay any premiums still due or risk cancellation of your coverage. *In some states, your maternity benefit may be supplemented by payments processed through the company payroll system. In that case, any past-due premiums and current (non-disability) premiums would be deducted from those payments.
Long term disability benefits under the: • Full-time hourly and salaried long-term disability plan • Truck driver long-term disability plan	Long-term disability benefits under this plan are not processed through the company payroll system. However, you may receive biweekly pay for paid time off, incentives, etc., which is processed through the company payroll system. • Any past-due premiums (including past-due premiums for disability coverage) will not be deducted from long-term disability payments but will be deducted from other pay you receive. • Any premiums due for the current pay period will not be deducted from long-term disability payments but will be deducted from other pay you receive, except that no premiums will be due with respect to any disability payments. • You must make arrangements to pay any premiums still due or risk cancellation of your coverage.
Short-term disability benefits under the salaried short-term disability plan or truck driver short-term disability plan	Short-term disability benefits are processed through the company payroll system. You may also receive biweekly pay for paid time off, incentives, etc., which is also processed through the company payroll system. • Any past-due premiums (including past-due premiums for disability coverage) will be deducted from short-term disability payments and other pay you receive. • Any premiums due for the current pay period will be deducted from short-term disability payments and other pay you receive, except that no premiums will be due with respect to any disability payments. • You must make arrangements to pay any premiums still due or risk cancellation of your coverage.
Paid leave (non-disability) under a company paid leave program	Paid leave is processed through the company payroll system. You may also receive biweekly pay (e.g., incentives), etc., which is also processed through the company payroll system. • Any past-due premiums will be deducted from any payments you receive. • Any premiums due for the current pay period will be deducted, except that no premiums will be due with respect to any paid leave benefits. • You must make arrangements to pay any premiums still due or risk cancellation of your coverage.

Permitted election changes outside Annual Enrollment

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

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

Federal tax law generally requires that your pretax benefit choices remain in effect for the entire calendar year for which the choice was made, except in the case of life events or certain other events described in federal regulations. In this *Associate Benefits Book*, we use the term "election change events" to mean the full range of circumstances described in federal regulations that allow you to change your pretax elections. This does not apply to pretax contributions to a health savings account, which can be changed at any time.

You may make certain coverage changes if you experience an election change event. An election change event, for purposes of this *Associate Benefits Book*, is a life event or other event listed in federal regulations that allows you to make changes to your coverage outside of annual or initial enrollment. Any change you make in response to a life event must be directly related to the impact of the event on your benefits and affect your eligibility. In other words, there must be a logical relationship between the life event and the change you request, and the life event that occurs must also make an individual eligible or ineligible for coverage. This is referred to in federal regulations as "the consistency rule." For example, if you (the associate) and your spouse divorce, your spouse loses eligibility for benefits under the Plan on the date of the divorce 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 life event would not be permitted.

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

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

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

LIFE EVENTS

- Events that change your marital status:
  - Marriage
  - Death of your spouse
  - Divorce (including the end of a common-law marriage in states where a divorce decree is required to end a recognized common-law marriage)
  - Annulment, 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 or legal guardianship of a dependent
  - Loss of legal custody or legal guardianship of a dependent for whom you have previously been awarded legal custody or guardianship by a judge
  - Your paternity test result
  - A dependent loses eligibility, such as at the end of the month in which the dependent reaches age 26, 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 (such as if a new HMO, local plan, or PPO Plan option is offered), you will have 60 calendar days from your transfer to submit a request to change your coverage. If you transfer work locations where your medical coverage is affected and do not submit a request, you will automatically be enrolled in a predetermined plan.

GAIN OF COVERAGE

- Gain of coverage under any other employer plan.
- If you are a part-time hourly or temporary associate and your hours are reduced such that you work an average of less than 30 hours per week (regardless of whether the reduction in hours affects your eligibility for medical coverage) and you intend to enroll in another plan that provides minimum essential coverage that is effective no later than the first day of the second month following the month that your medical coverage under the Plan would end, you may drop medical coverage (including an HMO or PPO Plan option).
- 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 medical coverage (including an HMO or PPO Plan option), accident insurance, or critical illness insurance coverage except during Annual Enrollment.
- If you are eligible for a Special Enrollment Period to enroll in a qualified health plan through a Health Insurance Marketplace, or you seek to enroll in a qualified health plan through a Marketplace during the Marketplace's annual enrollment, as described in **Changes in your coverage following an election change event**, you can drop medical coverage (including an HMO or PPO Plan option) in accordance with rules set forth by the Department of Health and Human Services. You and any dependent who cease coverage under the Plan must provide evidence of your enrollment rights and state that you intend to enroll in a qualified health plan through a Marketplace effective no later than the day immediately following the last day of your medical coverage (including an HMO or PPO Plan option).

LOSS OF COVERAGE

- Loss of coverage under any other employer plan.
- Reduction of coverage under this Plan.
- Significant loss of coverage, such as if an HMO plan in your area discontinues service. The Plan determines when a significant loss of coverage has occurred.
- If you or your eligible dependents lose coverage under a governmental plan, including Medicaid or a state children's health insurance plan, an educational institution's plan, or a tribal government plan, you can add medical coverage (including an HMO or PPO Plan option), accident insurance, or critical illness insurance within 60 days of the loss of coverage. (This does not apply to loss of coverage under a Health Insurance Marketplace plan, although loss of coverage under a Health Insurance Marketplace plan may result in a HIPAA special enrollment right if you originally declined coverage under the AMP because you had coverage through a Health Insurance Marketplace plan.)
- You may add medical, dental, or vision coverage for you and/or your eligible dependents if:
  - You originally declined coverage because you and/or your dependents had COBRA coverage and that COBRA coverage has ended (nonpayment of 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 medical child support order—see **Medical child support orders** later in this chapter) requires you to provide medical, dental, and/or vision coverage for your eligible dependent child, you may add coverage for your eligible dependent child (and yourself, if you are not already covered). If the order requires your spouse, former spouse, or other person to provide medical, dental, and/or vision coverage for your dependent child, and that other coverage is in fact provided, you may drop coverage for the dependent child.

MEDICARE OR MEDICAID ENTITLEMENT

If you or your eligible dependents are enrolled in medical coverage (including an HMO or PPO Plan option), accident insurance, or critical illness insurance, you can drop that coverage if you or your dependents become entitled to Medicare or Medicaid benefits or coverage under a state children's health insurance plan. If you or your eligible dependents become eligible for assistance under Medicaid or a state children's health insurance plan to help you pay for Plan coverage, you must request coverage under the Plan within 60 days of becoming eligible for assistance.

For information about circumstances in which you may change your benefits, contact People Services at **800-421-1362**.

CHANGES IN YOUR COVERAGE FOLLOWING AN ELECTION CHANGE EVENT

When you experience an election change event, you must request your change within 60 days from the date of the event.

Unless otherwise provided in the Plan, if you add a spouse or partner or other eligible dependent due to a life event, each person must individually meet any applicable benefit waiting period (for example, for transplant coverage or weight loss surgery) and will be subject to applicable Plan limitations. If you change medical plans due to an election change event, your annual deductible and out-of-pocket maximum will be reset,* and you will be responsible for meeting the new deductible and out-of-pocket maximum in their entirety. If you change from the Contribution Plan to another plan, your HRA balance under the Contribution Plan will be forfeited. See **The medical plan** chapter for information.

If you are covered as a dependent and move to coverage as an associate during the Plan year, you will not receive credit under the AMP for expenses incurred prior to the date of the change.* However, if you are covered as a dependent and you experience a qualifying event that affects your status as a dependent and makes you eligible for your own continuation coverage under COBRA, you will receive credit toward your deductibles and out-of-pocket maximum under the AMP for expenses incurred as a covered dependent. You will also receive credit toward any waiting periods.

The Plan reserves the right to request additional necessary documentation to show proof of an election change event.

*If you or an eligible dependent were enrolled in the Associates' Medical Plan (AMP) and had accrued amounts toward, or had reached, the maximum lifetime benefit applicable to fertility benefits under the Centers of Excellence family-building program, no portion of the maximum lifetime benefit will reset for any reason.

HIPAA SPECIAL ENROLLMENT FOR MEDICAL COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you also may have a right to a special enrollment in medical coverage under the Plan if you lose other coverage or acquire a dependent. These events (some of which are also life events) include:

- If you decline enrollment for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself, and if you choose, your dependents in this Plan if you or your dependents lose eligibility for that coverage (or if the employer stops contributing toward your or your dependents' other coverage). You must request enrollment within 60 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Such coverage will be effective upon the date you enroll in the Plan.
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your eligible dependents. You must request enrollment within 60 days. Such coverage will be effective the date of the event.
- If you or a dependent is no longer eligible for coverage under Medicaid or a state children's health plan, or you or a dependent becomes eligible for assistance for Plan coverage under Medicaid or a state children's health plan, you must request enrollment within 60 days of the prior coverage terminating or your becoming eligible for assistance. Such coverage will be effective upon the date you enroll in the Plan.

To request special enrollment or obtain more information, refer to the information earlier in this chapter regarding election change events or contact People Services at **800-421-1362**.

HOW TO CHANGE YOUR ELECTIONS DUE TO AN ELECTION CHANGE EVENT

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

- Adoption
- Birth
- Commencement of domestic partnership
- Commencement of legal relationship with a person other than your spouse or domestic partner
- Death of spouse/partner
- Divorce or legal separation
- Gain or loss of legal custody or legal guardianship

- Gain or loss of coverage by you, your dependent(s), or your eligible spouse/partner
- Going on leave of absence
- Marriage
- Returning from leave of absence
- Special enrollment period
- Termination of domestic partnership, or
- Termination of legal relationship with a person other than a spouse or domestic partner.

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

If your election change event is the birth of a dependent, the Plan will accept provider billing charges related to the birth as notice that the newborn is to be added as a dependent under your coverage, so long as the charges are submitted within 60 days of the birth.

If you are adding a dependent as a result of marriage, commencement of a domestic partnership, or commencement of a legal relationship with a person other than a spouse or domestic partner, but the individual to be added as a dependent dies before you have provided notice of the election change event, the individual will not be added to your coverage as a dependent.

If you add coverage as a result of an election change event, that coverage will be effective on the date of the event. If you drop coverage as the result of an election change event, that coverage will continue through the date of the event. If any change is the result of being on an unpaid leave of absence, the change is effective as of the effective date of your leave of absence. This does not apply to optional associate life insurance, optional dependent life insurance, short-term disability enhanced plan coverage, long-term disability (including enhanced benefits), or truck driver long-term disability (including enhanced benefits); see the **Enrollment and effective dates by job classification** charts in this chapter for information about effective dates.

If your election change results in an increase in your coverage costs, such as if you change from associate-only coverage to associate + dependent coverage, the increased premiums will be deducted from your pay after you notify People Services of your election change event and will be retroactive to the effective date of your new coverage. These retroactive deductions are made on an after-tax basis.

If you do not notify People Services or go online and make a change within 60 days of the election change event, you cannot add or drop coverage until the next Annual Enrollment or until you experience a different election change event. However, as described earlier in this **Permitted election changes outside Annual Enrollment** section, any change you make in connection with an election change event must be directly related to the impact of the event on your benefits. Also, if the election change event is due to your dependent losing eligibility, your dependent will lose the right to elect COBRA coverage for medical, dental, and/or vision benefits if you do not notify People Services of the event within 60 days. Similarly, if the election change event is due to your divorce, the termination of a domestic partnership, or the termination of a legal relationship with a person other than your spouse or domestic partner, your former spouse/partner will lose the right to elect COBRA coverage for medical, dental, and/or vision benefits if People Services is not notified of the event within 60 days. See the **COBRA** chapter for more information.

If your job classification changes

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

If your job classification changes from management or full-time hourly associate to part-time or temporary associate or part-time truck driver, your spouse/partner will no longer be eligible for medical, dental, vision, dependent life insurance, AD&D, critical illness, or accident coverage. You will no longer be eligible for company-paid life or disability coverage. If this change results in you or your spouse/partner or other dependent losing coverage, see the **COBRA** chapter to learn how you and/or your eligible dependents may be able to continue medical, dental, and vision coverage.

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 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 coverage under the Plan as a part-time hourly or temporary associate immediately prior to your transition **OR** You gained eligibility for benefits by passing any of your 60-day eligibility checks described earlier in this chapter in the section titled **Your 60-day eligibility checks during your first 52 weeks of employment**	**You have 60 days to enroll or make changes from the first day of the pay period in which your transition occurs.** • If you are currently enrolled in **medical, dental, vision, AD&D, critical illness,** or **accident insurance**, 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, dental, vision, AD&D, critical illness, and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next Annual Enrollment or until you experience a valid election change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types 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, dental, vision, AD&D, critical illness, and/or accident insurance coverage 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.

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION (CONTINUED)	
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 coverage under the Plan as a part-time hourly or temporary associate immediately prior to your transition **OR** You gained eligibility for benefits by passing any of your 60-day eligibility checks described earlier in this chapter in the section titled **Your 60-day eligibility checks during your first 52 weeks of employment** (Continued)	• You are eligible to enroll in **optional dependent life insurance** for your spouse/partner: – 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 provide Proof of Good Health for your spouse/partner, who may be required to undergo a medical exam at their 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 enrolled automatically in the **short-term disability basic plan** effective the later of 1) the first day of the pay period in which your transition occurs, or 2) the 12-month anniversary of your date of hire unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. • You are eligible to enroll in the **short-term disability enhanced plan** unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans (associates in New York can enroll in the NY short-term disability enhanced 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 on 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 enroll within 60 days from the first day of the pay period in which your transition occurs and you have not been employed for more than 52 weeks on that date, 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 short-term disability enhanced plan after your initial enrollment period. • You are eligible to enroll in the **full-time hourly and salaried 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 on 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 enroll within 60 days from the first day of the pay period in which your transition occurs and you have not been employed for more than 52 weeks on that date, 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 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 within 60 days from the first day of the pay period in which your transition occurs by calling People Services, 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 enroll. 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 biweekly pay 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 coverage under the Plan as a part-time hourly or temporary associate immediately prior to your transition	**You have 60 days to enroll or make changes from the first day of the pay period in which your transition occurs.** • You are eligible to enroll in **medical coverage**. See **The medical plan** chapter 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 **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in medical coverage after your initial enrollment period. • If you are currently enrolled in **dental, vision, AD&D, critical illness,** or **accident insurance**, 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 dental, vision, AD&D, critical illness, and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next Annual Enrollment or until you experience a valid election change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types 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 dental, vision, AD&D, critical illness, and/or accident insurance coverage 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 dependent life insurance** for your spouse/partner: – 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, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health for your spouse/partner, who may be required to undergo a medical exam at their 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 enrolled automatically in the **full-time hourly short-term disability basic plan** effective the first day of the pay period in which your transition occurs unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans.

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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 coverage under the Plan as a part-time hourly or temporary associate immediately prior to your transition (Continued)	• You are eligible to enroll in the **full-time hourly short-term disability enhanced plan**, unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans (associates in New York can enroll in the NY short-term disability enhanced 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 short-term disability enhanced plan after your initial enrollment period. • You are eligible to enroll in the **full-time hourly and salaried 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 within 60 days from the first day of the pay period in which your transition occurs by calling People Services, 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 enroll. 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 biweekly pay 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 reached the first day of the month in which your 89th day of continuous employment occurs but have been continuously employed for less than 52 weeks **AND** You did not gain eligibility for benefits by passing any of your 60-day eligibility checks described earlier in this chapter in the section titled **Your 60-day eligibility checks during your first 52 weeks of employment**	**You have 60 days to enroll or make changes from the first day of the pay period in which your transition occurs.** • You are eligible to enroll in **medical, dental, vision, AD&D, critical illness,** and **accident 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, vision, AD&D, critical illness, and/or accident insurance coverage 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 **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 your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for you and 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 enrolled automatically in the **full-time hourly short-term disability basic plan** effective on the 12-month anniversary of your date of hire unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. • You are eligible to enroll in the **full-time hourly short-term disability enhanced plan** unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans (associates in New York can enroll in the NY short-term disability enhanced 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 12-month anniversary of the date of your transition. – 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 short-term disability enhanced plan after your initial enrollment period. • You are eligible to enroll in **full-time hourly and salaried long-term disability (LTD) 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 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 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 within 60 days from the first day of the pay period in which your transition occurs by calling People Services, 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 enroll. 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 biweekly pay 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 reached the first day of the month in which your 89th day of continuous employment occurs but have been continuously employed for less than 52 weeks **AND** You gained eligibility for benefits by passing any of your 60-day eligibility checks described earlier in this chapter in the section titled **Your 60-day eligibility checks during your first 52 weeks of employment**	**You have 60 days to enroll or make changes from the first day of the pay period in which your transition occurs.** • If you are currently enrolled in **medical, dental, vision, AD&D, critical illness,** or **accident insurance**,* 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, dental, vision, AD&D, critical illness, and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next Annual Enrollment or until you experience a valid election change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types 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, dental, vision, AD&D, critical illness, and/or accident insurance coverage 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 dependent life insurance** for your spouse/partner: – 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, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health for your spouse/partner, who may be required to undergo a medical exam at their 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 dependent life insurance after your initial enrollment period. • You are enrolled automatically in the **full-time hourly short-term disability basic plan** effective on the 12-month anniversary of your date of hire unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. • You are eligible to enroll in the **full-time hourly short-term disability enhanced plan** unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans (associates in New York can enroll in the NY short-term disability enhanced 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 12-month anniversary of the date of your transition. – 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 short-term disability enhanced plan after your initial enrollment period.

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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 reached the first day of the month in which your 89th day of continuous employment occurs but have been continuously employed for less than 52 weeks **AND** You gained eligibility for benefits by passing any of your 60-day eligibility checks described earlier in this chapter in the section titled **Your 60-day eligibility checks during your first 52 weeks of employment** (Continued)	• You are eligible to enroll in **full-time hourly and salaried long-term disability (LTD) 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 later of 1) the 12-month anniversary of your date of hire, or 2) the 12-month anniversary of the date of your transition. – 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 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 within 60 days from the first day of the pay period in which your transition occurs by calling People Services, 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 enroll. 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 biweekly pay on an after-tax basis retroactively to your effective date.
You have not reached the first day of the month in which your 89th day of continuous employment occurs **AND** You did not gain eligibility for benefits by passing your 60-day eligibility check described earlier in this chapter in the section titled **Your 60-day eligibility checks during your first 52 weeks of employment**	**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, vision, AD&D, critical illness,** and **accident 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 calendar month during which your 89th day of continuous full-time employment falls 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, vision, AD&D, critical illness, and/or accident insurance coverage after your initial enrollment period. • You are enrolled automatically in **company-paid life insurance** on the first day of the calendar month during which your 89th day of continuous employment falls. • 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 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 provide Proof of Good Health for you and 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 enrolled automatically in the **full-time hourly short-term disability basic plan** effective on the 12-month anniversary of your date of hire unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans.

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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 not reached the first day of the month in which your 89th day of continuous employment occurs **AND** You did not gain eligibility for benefits by passing your 60-day eligibility check described earlier in this chapter in the section titled **Your 60-day eligibility checks during your first 52 weeks of employment** (Continued)	• You are eligible to enroll in the **full-time hourly short-term disability enhanced plan**, unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans (associates in New York can enroll in the NY short-term disability enhanced 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 short-term disability enhanced plan after your initial enrollment period. • You are eligible to enroll in **full-time hourly and salaried long-term disability (LTD) 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 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 after your initial enrollment period. *Your coverage is effective as follows: • If you enroll online or by calling People Services 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 calling People Services 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 biweekly pay on an after-tax basis retroactively to your effective date.
You have not reached the first day of the month in which your 89th day of continuous employment occurs **AND** You gained eligibility for benefits by passing your 60-day eligibility checks described earlier in this chapter in the section titled **Your 60-day eligibility checks during your first 52 weeks of employment**	**You have 60 days to enroll or make changes from the first day of the pay period in which your transition occurs.** • If you are currently enrolled in **medical, dental, vision, AD&D, critical illness,** or **accident insurance**, 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, dental, vision, AD&D, critical illness, and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next Annual Enrollment or until you experience a valid election change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types 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, dental, vision, AD&D, critical illness, and/or accident insurance coverage after your initial enrollment period. • You are enrolled automatically in **company-paid life insurance** on the first day of the calendar month during which your 89th day of continuous full-time employment falls.

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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 not reached the first day of the month in which your 89th day of continuous employment occurs **AND** You gained eligibility for benefits by passing your 60-day eligibility checks described earlier in this chapter in the section titled **Your 60-day eligibility checks during your first 52 weeks of employment** (Continued)	• 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 the later of 1) the first day of the calendar month during which your 89th day of continuous full-time 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 provide Proof of Good Health for you and 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 full-time 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 enrolled automatically in the **full-time hourly short-term disability basic plan** effective on the 12-month anniversary of your date of hire unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. • You are eligible to enroll in the **full-time hourly short-term disability enhanced plan** unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans (associates in New York can enroll in the NY short-term disability enhanced 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 short-term disability enhanced plan after your initial enrollment period. • You are eligible to enroll in **full-time hourly and salaried long-term disability (LTD) 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 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 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 within 60 days from the first day of the pay period in which your transition occurs by calling People Services, 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 enroll. 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 biweekly pay 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 coverage under the Plan as a part-time hourly or temporary associate immediately prior to your transition **OR** You have been continuously employed for less than 52 weeks and you gained eligibility for benefits by passing any of your 60-day eligibility checks described earlier in this chapter in the section titled **Your 60-day eligibility checks during your first 52 weeks of employment**	**You have 60 days to enroll or make changes from the first day of the pay period in which your transition occurs.** • If you are currently enrolled in **medical, dental, vision, AD&D, critical illness,** or **accident insurance**, 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, dental, vision, AD&D, critical illness, and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next Annual Enrollment or until you experience a valid election change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types 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, dental, vision, AD&D, critical illness, and/or accident insurance coverage 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. • The maximum amount of **optional associate life insurance** coverage you can select increases from $200,000 to $1,000,000, and you are eligible to enroll in **optional dependent life insurance** for your spouse/partner: – If you enroll your spouse/partner 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 your spouse/partner for more than the guaranteed issue amount (or increase your coverage), coverage is subject to Prudential's approval. You and/or your spouse/partner will each 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. – 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 enrolled automatically in the **salaried short-term disability plan** or **truck driver short-term disability plan**, as appropriate, effective on the first day of the pay period in which your transition occurs. • You are eligible to enroll in the **full-time hourly and salaried long-term disability (LTD) plan** or **truck driver LTD plan**, as appropriate, 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 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 within 60 days from the first day of the pay period in which your transition occurs by calling People Services, 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 enroll. 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 biweekly pay 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 coverage under the Plan as a part-time hourly or temporary associate immediately prior to your transition **OR** You have been continuously employed for less than 52 weeks and you did not gain eligibility for benefits by passing any of your 60-day eligibility checks described earlier in this chapter in the section titled **Your 60-day eligibility checks during your first 52 weeks of employment**	**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, vision, AD&D, critical illness,** and **accident 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 **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, dental, vision, AD&D, critical illness, and/or accident insurance coverage 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. • The maximum amount of **optional associate life insurance** coverage you can select increases from $200,000 to $1,000,000, and you are eligible to enroll in **optional dependent life insurance** for your spouse/partner: – If you enroll your spouse/partner 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 your spouse/partner for more than the guaranteed issue amount (or increase your coverage), coverage is subject to Prudential's approval. You and/or your spouse/partner will each 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. – 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 enrolled automatically in the **salaried short-term disability plan** or **truck driver short-term disability plan**, as appropriate, effective on the first day of the pay period in which your transition occurs. • You are eligible to enroll in the **full-time hourly and salaried long-term disability (LTD) plan** or **truck driver LTD plan**, as appropriate, 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 within 60 days from the first day of the pay period in which your transition occurs by calling People Services, 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 enroll. 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 biweekly pay 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 reached the first day of the month in which your 89th day of continuous employment occurs	• 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. • If you enrolled in the **full-time hourly short-term disability plan** or the **full-time hourly short-term disability enhanced plan**, your coverage will be canceled effective the day prior to the first day of the pay period in which your transition occurs. • You are enrolled automatically in the **salaried short-term disability plan** or the **truck driver short-term disability plan**, as appropriate, effective on the first day of the pay period in which your transition occurs. • Your **long-term disability** coverage will change as follows: – If you elected the **full-time hourly and salaried 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 **full-time hourly and salaried 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 not reached the first day of the month in which your 89th day of continuous employment occurs	**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, vision, AD&D, critical illness,** and **accident 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 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 **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 your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for you and 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 enrolled automatically in the **salaried short-term disability plan** or **truck driver short-term disability plan**, as appropriate, effective on the first day of the pay period in which your transition occurs. • You are eligible to enroll in the **full-time hourly and salaried long-term disability (LTD) plan** or **truck driver LTD plan**, as appropriate, 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 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 within 60 days from the first day of the pay period in which your transition occurs by calling People Services, 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 enroll. 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 biweekly pay on an after-tax basis retroactively to your effective date.

FULL-TIME HOURLY VISION CENTER MANAGERS TRANSFERRING TO MANAGEMENT	
	Coverage effective dates and details
	• Your eligibility for coverage under the **full-time hourly short-term disability basic plan** and the **short-term disability enhanced plan** will be terminated effective the day prior to the first day of the pay period in which your transition occurs. • You are enrolled automatically in the **salaried short-term disability plan** the first day of the pay period in which your transition occurs.

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, vision, AD&D, critical illness,** and **accident 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 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 you and 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 no longer enrolled in the **salaried short-term disability plan** or the **truck driver short-term disability plan**, as applicable, effective the day prior to the first day of the pay period in which your transition occurs. • You are enrolled automatically in **full-time hourly short-term disability enhanced plan** unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. (Associates in New York are enrolled automatically in the NY short-term disability enhanced plan.) See the **Full-time hourly short-term disability** chapter for more information. You can change this election within 60 days from the first day of the pay period in which your transition occurs. – If you do not change the election 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 change your election (i.e., you cancel enrollment in **full-time hourly short-term disability enhanced coverage**) 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 short-term disability enhanced plan after your initial enrollment period. You are enrolled automatically in the **full-time hourly short-term disability basic plan** effective on the first day of the pay period in which your transition occurs unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans.

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MANAGEMENT ASSOCIATES TRANSFERRING TO FULL-TIME HOURLY (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
Within 60 days of your date of hire and before you have enrolled for benefits (Continued)	• You are eligible to enroll in **full-time hourly and salaried long-term disability (LTD) 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 you enroll, 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 within 60 days from the first day of the pay period in which your transition occurs by calling People Services, 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 enroll. 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 biweekly pay 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 over $200,000 are reduced to $200,000. • Your enrollment in the **salaried short-term disability plan** or the **truck driver short-term disability plan**, as appropriate, is canceled effective the day prior to the first day of the pay period in which your transition occurs. • You are enrolled automatically in the **full-time hourly short-term disability enhanced plan** unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. (Associates in New York are enrolled automatically in the NY short-term disability enhanced plan.) See the **Full-time hourly short-term disability** chapter for more information. You can change this election within 60 days from the first day of the pay period in which your transition occurs. – If you do not change the election 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 change your election (i.e., you cancel enrollment in **short-term disability enhanced coverage**) 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 short-term disability enhanced plan after your initial enrollment period. You are enrolled automatically in the **full-time hourly short-term disability basic plan** effective on the first day of the pay period in which your transition occurs unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans.

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MANAGEMENT ASSOCIATES TRANSFERRING TO FULL-TIME HOURLY (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
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 over $200,000 are reduced to $200,000. • Your enrollment in the **salaried short-term disability plan** or the **truck driver short-term disability plan**, as appropriate, is canceled effective the day prior to the first day of the pay period in which your transition occurs. • You are enrolled automatically in the **full-time hourly short-term disability enhanced plan** unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. (Associates in New York are enrolled automatically in the NY short-term disability enhanced plan.) See the **Full-time hourly short-term disability** chapter for more information. You can change this election within 60 days from the first day of the pay period in which your transition occurs. – If you do not change the election 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 change your election (i.e., you cancel enrollment in **full-time hourly short-term disability enhanced coverage**) 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 short-term disability enhanced plan after your initial enrollment period. You are enrolled automatically in the **full-time hourly short-term disability basic plan** effective on the first day of the pay period in which your transition occurs unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans.

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, dental, vision, AD&D, critical illness,** or **accident insurance coverage**, your coverage type is automatically adjusted to associate-only or associate + child(ren) (depending on whether you have covered dependents), effective the first day of the pay period after your transition occurs. Associate + spouse/partner and associate + family coverage are not available to part-time hourly or temporary associates. • Your enrollment in **company-paid life insurance** 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 company-paid life insurance to an individual policy. • 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 following the pay period in which your transition occurs. You may be able to convert your spouse/partner life insurance to an individual policy. • Your enrollment in the **full-time hourly short-term disability basic plan** and **short-term disability enhanced plan** (if you enrolled) is canceled effective the day prior to the first day of the pay period in which your transition occurs. • If you elected the **full-time hourly long-term disability plan**, your enrollment is canceled effective the day prior to the first day of the pay period following the pay period in which your transition occurs.

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FULL-TIME HOURLY ASSOCIATES TRANSFERRING TO PART-TIME HOURLY OR TEMPORARY (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
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, dental, vision, AD&D, critical illness,** and **accident coverage** for you and your children. You are eligible to enroll in associate-only or associate + child(ren) coverage types. 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 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 full-time employment falls or the date you enroll.* • You are eligible to enroll in **optional associate life insurance** and **optional dependent life insurance** for your children: – 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 and you enroll for the guaranteed amount, 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 calendar month during which your 89th day of continuous full-time employment falls and you enroll for the guaranteed amount, your coverage is effective the date you enroll. – 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 full-time employment falls and you enroll for more than the guaranteed amount, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam at your own expense. If approved, your coverage is effective on the later of the first day of the calendar month during which your 89th day of continuous employment falls or the date Prudential approves your coverage. – 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 calendar month during which your 89th day of continuous employment falls and you enroll for more than the guaranteed amount, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam 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 **Part-time hourly and temporary 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. • 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. • Your enrollment in the **full-time hourly short-term disability basic plan** and **short-term disability enhanced plan** (if you enrolled) is canceled effective the day prior to the first day of the pay period following the pay period in which your transition occurs. • If you elected the **full-time hourly and salaried long-term disability plan**, 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 calling People Services 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 calling People Services 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, dental, vision, AD&D, critical illness,** and **accident coverage** for you and your children. You are eligible to enroll in associate-only or associate + child(ren) coverage types. 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 the 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. • You are eligible to enroll in **optional associate life insurance** and **optional dependent life insurance** for your children: – 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 and you enroll for the guaranteed amount, 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 calendar month during which your 89th day of continuous employment falls and you enroll for the guaranteed amount, your coverage is effective the date you enroll. – 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 and you enroll for more than the guaranteed amount, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam at your own expense. If approved, your coverage is effective on the later of the first day of the calendar month during which your 89th day of continuous employment falls or the date Prudential approves your coverage. – 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 calendar month during which your 89th day of continuous employment falls and you enroll for more than the guaranteed amount, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam 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 **Part-time hourly and temporary 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. • Your enrollment in the **salaried short-term disability plan** or the **truck driver short-term disability plan**, as appropriate, is canceled effective the day prior to the first day of the pay period in which your transition occurs.
	*Your coverage is effective either the first day of the pay period in which your transition occurs or the date you enroll, 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 within 60 days from the first day of the pay period in which your transition occurs by calling People Services, 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 enroll. 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 biweekly pay on an after-tax basis retroactively to your effective date.

(Continued on the next page)

MANAGEMENT ASSOCIATES TRANSFERRING TO PART-TIME HOURLY OR TEMPORARY (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
You are within 60 days of your date of hire and you have enrolled for benefits	**You have 60 days to enroll from the date your transition in status occurs.** • If you are enrolled in **medical, dental, vision, AD&D, critical illness,** or **accident insurance coverage**, your coverage type is automatically adjusted to associate-only or associate + child(ren) (depending on whether you have covered dependents), effective the first day of the pay period after your transition occurs. Associate + spouse/partner and associate + family coverage are not available to part-time hourly or temporary associates. • Your enrollment in **company-paid life insurance** 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 company-paid life insurance to an individual policy. • **Optional associate life insurance** coverage amounts over $200,000 are reduced to $200,000. • 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. You may be able to convert your spouse/partner life insurance to an individual policy. • Your enrollment in the **salaried short-term disability plan** or the **truck driver short-term disability plan**, as appropriate, is canceled effective the day prior to the first day of the pay period following the pay period in which the transition occurs. • If you elected the **full-time hourly and salaried long-term disability (LTD) plan** or the **truck driver LTD plan**, as appropriate, your enrollment is canceled effective the day prior to the first day of the pay period following the pay period in which the transition occurs.
More than 60 days have passed since your date of hire	**You have 60 days to enroll from the date your transition in status occurs.** • If you are enrolled in **medical, dental, vision, AD&D, critical illness,** or **accident insurance coverage**, your coverage type is automatically adjusted to associate-only or associate + child(ren) (depending on whether you have covered dependents), effective the first day of the pay period after your transition occurs. Associate + spouse/partner and associate + family coverage are not available to part-time hourly or temporary associates. • Your enrollment in **company-paid life insurance** 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 company-paid life insurance to individual policies. • **Optional associate life insurance** coverage amounts over $200,000 are reduced to $200,000. • 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. You may be able to convert your spouse/partner life insurance to individual policies. • Your enrollment in the **salaried short-term disability plan** or the **truck driver short-term disability plan**, as appropriate, is canceled effective the day prior to the first day of the pay period following the pay period in which your transition occurs. • If you elected the **full-time hourly and salaried long-term disability (LTD) plan** or the **truck driver LTD plan**, as appropriate, your enrollment is canceled effective the day prior to the first day of the pay period following the pay period in which your transition occurs.

Medical child support orders

If you are eligible for coverage under the Plan, you may be required to provide coverage for your child pursuant to a properly completed National Medical Support Notice (NMSN) or a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court or administrative agency order requiring an associate or other parent or guardian to provide health care coverage for eligible dependents after a divorce or child custody proceeding. Federal law requires the Plan to provide medical, dental and/or vision benefits to any eligible dependent of a Plan participant required by a qualified court order or enforcement agency notice meeting the qualifications of a QMCSO. A NMSN is a standardized medical support notice that is used by state child support enforcement agencies to require children to be enrolled in an employer's group plan. A properly completed NMSN is considered a QMCSO and must be honored by all employers' group health plans.

You can obtain the written procedures for determining whether an order meets the federal requirements, free of charge, by contacting Medical Support Services at **877-930-5607**.

Once the Plan determines an order to be a QMCSO, coverage begins the first day of the pay period in which the Plan receives the order, unless another date is specified in the order. If you are eligible for the medical, dental, and/or vision plan and did not elect coverage before the order was received, you will be enrolled in the default Premier Plan with associate + child(ren) coverage at the tobacco rate, unless the QMCSO specifies otherwise. If you are in the state of Hawaii, the default plan is Health Plan Hawaii (HMSA). If you are in a location where the PPO Plan is offered, the default plan is the Saver Plan.

If you were enrolled in coverage before the order was received, your child will be added under your existing coverage, with the following exceptions:

- If you are enrolled in an HMO plan or one of the local plans, your coverage will change to the Premier Plan, under which the child would have coverage regardless of where he or she lives.
- If you are enrolled in the PPO Plan, your coverage will change to the Saver Plan, under which the child would have coverage regardless of where he or she lives.
- If you are in the state of Hawaii, your coverage will change to HMSA.

You have 60 days to call People Services at **800-421-1362** to select an alternative medical plan.

When the Plan receives a QMCSO, it will apply the following rules:

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

When the third-party administrator enforces coverage for a court-ordered dependent, information regarding the dependent is shared only with the legal custodian. If you have questions, contact Medical Support Services at **877-930-5607**.

DROPPING OR CHANGING QMCSO COVERAGE

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

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

  EXAMPLE: You are enrolled in medical coverage prior to the issuance of a QMCSO. A QMCSO is issued for your child. Pursuant to the terms of the QMCSO, you and your child are enrolled in medical coverage. Due to a change in circumstance, the QMCSO is terminated prospectively. The day after the QMCSO is terminated, you request to drop coverage for you and your child. The Plan permits you to drop the coverage for your child who was the

subject of the QMCSO as of the date the QMCSO is terminated. However, you may only drop your associate coverage at Annual Enrollment, unless another election change event occurs.

- The QMCSO is rescinded by a court or administrative agency order (such as if an agency determines the order is invalid).

  EXAMPLE: You had no medical coverage prior to a court issuing a QMCSO, which requires you to cover yourself and a child. Pursuant to the QMCSO, you enroll in medical coverage under the Plan for you and your child. Six months later, the court determines that it had issued the QMCSO in error and issues a "rescind order" that retroactively withdraws the QMCSO. The Plan allows you to return to "no coverage" effective as of the first date of your and your child's enrollment and refunds any associate premiums. You will be required to pay the cost of benefits the Plan paid on your behalf during the period for which coverage is rescinded and premiums refunded. Call the third-party administrator on the back of your Plan ID care for more information about this process.
- 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 by court or administrative agency order, the enforcement of the order will end on the date specified in the order or the first day of the pay period in which the Plan receives the order, whichever is later. Although the order automatically ends, coverage for the child will not. You will receive a termination notification letter from Medical Support Services that your order has terminated, and you will have 60 days from your notification date to call People Services to drop the child's coverage.

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

If the order to rescind coverage is received, coverage will be retroactively withdrawn and you will be returned to the coverage status you had before the QMCSO was enforced, to the extent permitted by law.

When your Plan coverage ends

Coverage under the Associates' Health and Welfare Plan for you and your dependents ends on the earliest of the following:

- At termination of your employment
- On the last day of coverage for which 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
- Upon an act of fraud or a misstatement of a material fact, or
- When you voluntarily drop coverage.

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

- **After an election change event:** coverage will continue through the date of the event. See **Permitted election changes outside Annual Enrollment** in this chapter for information.
- **At Annual Enrollment:** coverage continues through December 31 of the current year.

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

Eligibility, enrollment, and effective dates for associates in Hawaii

Eligibility, enrollment, and effective dates for associates in Hawaii

Because you work in Hawaii, there are some special rules about medical and short-term disability benefits. Those differences are described in this chapter. The rest of the information in this 2023 *Associate Benefits Book* applies to you.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Health Plan Hawaii (HMSA)	Go to **hmsa.com**	**808-948-6372**
Kaiser Foundation Health Plan	Go to **kaiserpermanente.org**	**800-966-5955**
Enroll in Walmart benefits	Go to **One.Walmart.com/Enroll**	Call People Services at **800-421-1362**
Eligibility questions under the legally mandated Hawaii Temporary Disability Insurance program	Go to **One.Walmart.com/LOA > mySedgwick**	Call Sedgwick at **800-492-5678**
Notify People Services within 60 days of an election change event	Go to **One.Walmart.com**	Call People Services at **800-421-1362**

What you need to know as a Hawaii associate

- Associates in Hawaii have two medical coverage options: Health Plan Hawaii (HMSA) and the Kaiser Foundation Health Plan. For information about these medical options, go to **One.Walmart.com**, or refer to the contact information for each option in the chart above.
- Because Hawaii has a legally mandated disability plan, full-time hourly associates are generally not eligible to participate in a Walmart short-term disability plan. However, you may still be eligible for the maternity benefit under the Walmart short-term disability basic plan. See the **Full-time hourly short-term disability** chapter for details.
- Initial eligibility periods for coverage vary for Hawaii associates based on their employment status, as described in this chapter.

Eligibility waiting periods for medical coverage

MANAGEMENT ASSOCIATES

If you are a management associate in Hawaii, the eligibility terms described in the **Eligibility, enrollment, and effective dates** chapter apply to you; management associates and management trainees in Hawaii are eligible for medical coverage on their date of hire. For details on eligibility and enrollment in all of the benefits available under the Associates' Health and Welfare Plan, refer to the chart for management associates in the Enrollment and effective dates by job classification section of the **Eligibility, enrollment, and effective dates** chapter.

FULL-TIME HOURLY, PART-TIME HOURLY AND TEMPORARY ASSOCIATES

If you are a full-time hourly associate (including full-time hourly pharmacists and field supervisor positions in stores and clubs) or a part-time hourly and temporary associate in Hawaii, your eligibility for medical coverage is subject to special rules applicable to Hawaii associates. For benefits other than medical and disability, eligibility terms are described in the **Eligibility, enrollment, and effective dates** chapter. Eligibility for other benefits is also described in charts under **Enrollment and effective dates for Hawaii associates** later in this chapter. For details refer to the appropriate chart.

Medical coverage options for Hawaii associates

Associates in Hawaii have two coverage options:

- Health Plan Hawaii (HMSA), and
- Kaiser Foundation Health Plan.

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

Paying premiums during a leave of absence for Hawaii associates

Because the associate portion of your medical premium is wage-based, no premium is due from you if you are not receiving wages during an approved leave of absence. The only premium due for medical coverage while you are on an approved leave of absence with no wages is the dependent portion of your premium. All other benefit options require payment during an approved leave of absence as described in the **Eligibility, enrollment, and effective dates** chapter.

Under Hawaii law, Walmart must contribute at least 50% of the premium for your (associate only) medical coverage, but not for dependent coverage. Associates are required to pay the rest of the biweekly cost of the premium, but only up to 1.5% of their wages or 50% of the biweekly cost of the premium, whichever is less. For example: if your biweekly wages are $1,000 and you qualify for tobacco-free rates, you are not required to pay more than $15 biweekly for coverage (assuming that the entire premium is at least $30 biweekly).

Enrollment and effective dates for Hawaii associates

FULL-TIME HOURLY ASSOCIATES
Includes full-time hourly pharmacists and field supervisor positions in stores and clubs

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.*

<table>
<tr><th>Plan</th><th colspan="2">Enrollment Periods and Effective Dates</th></tr>
<tr><td rowspan="2">Medical</td><td colspan="2">Initial enrollment period:
You must enroll in coverage between the date of your first paycheck and the day prior to your effective date.</td></tr>
<tr><td>When coverage is effective:
Your coverage is effective the earlier of:
• The first day of the pay period following a period of working at least 20 hours per week for four consecutive weeks, or
• The first day of the calendar month during which your 89th day of continuous full-time employment falls.</td><td rowspan="3">If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until Annual Enrollment for the next calendar year unless you experience an election change event, as described in the Permitted election changes outside Annual Enrollment section of the Eligibility, enrollment, and effective dates chapter.</td></tr>
<tr><td>Dental (enrollment is for two full calendar years)
Vision
Critical illness insurance
Accident insurance
AD&D</td><td>Initial enrollment period:
You must enroll in coverage between the date of your first paycheck and the day prior to your coverage effective date.</td></tr>
<tr><td colspan="2">When coverage is effective:
Your coverage is effective the first day of the calendar month during which your 89th day of continuous full-time employment falls.</td></tr>
</table>

(Continued on the next page)

FULL-TIME HOURLY ASSOCIATES (CONTINUED)
Includes full-time hourly pharmacists and field supervisor positions in stores and clubs

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 Effective Dates
Company-paid life insurance	You are automatically enrolled 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	You are automatically enrolled on your date of hire.
Hawaii Temporary Disability Insurance* (legally mandated plan) Walmart short-term disability basic plan • Basic coverage (not available to associates who work in Hawaii) • Maternity benefits (available to associates who work in Hawaii) *See the **Full-time hourly short-term disability** chapter for general information about state benefits	For Hawaii Temporary Disability Insurance, see the **Resources** chart at the beginning of this chapter for contact information on eligibility and effective dates. For maternity benefits under the short-term disability basic plan, you are enrolled automatically on the 12-month anniversary of your date of hire, and your coverage is effective on that date, subject to actively-at-work requirements described in the **Eligibility, enrollment, and effective dates** chapter.
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 your coverage effective date. **When coverage is effective:** **If you enroll during your initial enrollment period:** • The guaranteed issue amount 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. • When you enroll for more than the guaranteed issue amount, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam 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 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 LTD enhanced plan	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the day *prior* to 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 during Annual Enrollment and are approved, your coverage will be effective the later of 1) January 1 of the following year, 2) if approved on or after January 1, the first day of the pay period following the date Lincoln approves your coverage, or 3) the 12-month anniversary of your date of hire. – If you are not approved, you may be eligible to enroll during the next Annual Enrollment or after an election change event but will be subject to the same Proof of Good Health requirements.

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.*

<table>
<tr><th>Plan</th><th colspan="2">Enrollment Periods and Effective Dates</th></tr>
<tr><td>Medical*</td><td colspan="2">Initial enrollment period:
You must enroll in coverage between the date of your first paycheck and the day prior to your effective date.</td></tr>
<tr><td>*Part-time hourly and temporary associates in Hawaii are not subject to the requirements described under Part-time hourly and temporary associates: eligibility checks for medical benefits in the Eligibility, enrollment, and effective dates chapter.</td><td>When coverage is effective:
Your coverage is effective the earlier of:
• The first day of the pay period following a period of working at least 20 hours per week for four consecutive weeks, or
• The first day of the calendar month during which your 89th day of continuous employment falls.</td><td rowspan="3">If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until Annual Enrollment for the next calendar year unless you experience an election change event, as described in the Permitted election changes outside Annual Enrollment section of the Eligibility, enrollment, and effective dates chapter.</td></tr>
<tr><td>Dental (enrollment is for two full calendar years)
Vision
Critical illness insurance</td><td>Initial enrollment period:
You must enroll in coverage between the date of your first paycheck and the day prior to your coverage effective date.</td></tr>
<tr><td>Accident insurance
AD&D</td><td colspan="2">When coverage is effective:
Your coverage is effective the first day of the calendar month during which your 89th day of continuous employment falls.</td></tr>
<tr><td>Resources for Living
Business travel accident insurance</td><td colspan="2">You are automatically enrolled on your date of hire.</td></tr>
<tr><td>Hawaii Temporary Disability Insurance (legally mandated plan)</td><td colspan="2">For Hawaii Temporary Disability Insurance, see the Resources chart at the beginning of this chapter for contact information on eligibility and effective dates.</td></tr>
<tr><td>Optional associate life insurance
Optional dependent life insurance</td><td colspan="2">Initial enrollment period:
You must enroll in coverage between the date of your first paycheck and the day prior to your coverage effective date.
When coverage is effective:
If you enroll during your initial enrollment period:
• The guaranteed issue amount is effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous employment falls.
• When you enroll for more than the guaranteed issue amount, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam 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 employment falls.
If you enroll after your initial enrollment period: You may enroll in, increase, or drop coverage 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 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.</td></tr>
</table>

NOTE: Part-time hourly and temporary associates may only cover their eligible dependent children and may not cover their spouses/partners. Company-paid life insurance is not available to part-time hourly and temporary associates.

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

The medical plan

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

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

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

The medical plan

RESOURCES			
Find What You Need	**Online**	**By Phone: Health Care Advisor**	**Other Resources**
Aetna (Premier, Contribution, Saver, and Banner Local Plan)	Go to **One.Walmart.com** or **aetna.com**	**855-548-2387** **800-525-6257 (Chicago metro & south FL)** **833-554-1544 (AZ, TN, MN, CO)** **800-626-9170 (GA, OH)**	**Aetna** **151 Farmington Avenue** **Hartford, Connecticut 06156**
BlueAdvantage Administrators of Arkansas (Premier, Contribution, and Saver Plan)	Go to **One.Walmart.com** or **blueadvantagearkansas.com**	**866-823-3790**	**BlueAdvantage Administrators of Arkansas** **P.O. Box 1460** **Little Rock, Arkansas 72203-1460**
UMR (Premier, Contribution, and Saver Plan)	Go to **One.Walmart.com** or **UMR.com**	**855-870-9177**	**UMR** **P.O. Box 30541** **Salt Lake City, Utah 84130-0541**
Included Health • Personal Healthcare Assistant for participants in Illinois, Indiana, Missouri, North Carolina, South Carolina, and Virginia		**855-377-2200** Personal Healthcare Assistant	
HealthSCOPE Benefits (cancer, transplant, and other travel programs, and Mercy Arkansas Local Plan)		**800-804-1272**	
Contigo Health (heart, spine, hip and knee replacement, and weight loss surgery programs)		**877-230-7037**	
Request a paper copy of this 2023 *Associate Benefits Book*		Call People Services at **800-421-1362**	

- This chapter generally describes the medical benefits offered under the self-insured AMP options. See the section titled **The Associates' Medical Plan (AMP)** for information about what it means for an option to be self-insured.
- In some locations, the AMP also offers health maintenance organization (HMO) and PPO Plan options. Though offered under the AMP, HMO and PPO Plan options are fully insured and administered separately by the insurer. Terms of coverage for these options are not described in this chapter. If a fully insured option is available at your work location, coverage details are described in materials online at **One.Walmart.com** or provided separately by the HMO or PPO insurer. However, the eligibility terms in the **Eligibility, enrollment, and effective dates** chapter override any inconsistent terms in any HMO and PPO documents.
- Some HMOs require participants to accept an arbitration agreement before coverage under the HMO can become effective. If the arbitration agreement is not received by the HMO within 60 days of your enrollment, your HMO coverage will not take effect and you will not have medical coverage under the AMP unless you experience a valid election change event as described in the **Eligibility, enrollment, and effective dates** chapter.
- Some programs described in this chapter also are available to participants enrolled in the fully insured PPO Plan option. For details, see the **Helping you manage your health** section in this chapter.

The Associates' Medical Plan (AMP)

The information in this chapter generally applies to you if you enroll in the Premier, Contribution, or Saver Plan option, or the Banner or Mercy Arkansas Local Plan option. These options are referred to, for purposes of this chapter, as "AMP options."

The AMP provides medical benefits for you and your eligible family members through various AMP options. The AMP options discussed in this chapter are self-insured, which means that benefits provided under the options are not insured by an insurance company. In other words, an insurance company is not paying benefits out of its own assets. Instead, you and other associates enrolled in the AMP options make contributions (often referred to as "premiums") through payroll deductions to cover a portion of the cost of benefits, and the rest of the cost is paid from company assets or through a trust funded by the company.

While every AMP option generally provides benefits for the same covered services, a specific option may have alternative designs in different locations. The information in this chapter will explain each self-insured AMP option, including alternative designs, and what you can do to make the most of the benefits offered to you.

Associates who enroll in medical coverage through an HMO or PPO Plan option: HMO and PPO Plan options are available for some work locations. The policies and enrollment materials for HMO and PPO Plan options may describe different eligibility requirements and waiting periods than those described in the **Eligibility, enrollment, and effective dates** chapter. If there is any difference between an HMO or the PPO Plan option's eligibility terms and the eligibility terms of the Associates' Medical Plan (AMP) as described in the **Eligibility, enrollment, and effective dates** chapter, eligibility terms in the **Eligibility, enrollment, and effective dates** chapter will control. However, policy terms related to covered benefits under these options are described in materials provided separately by the HMO or PPO insurer or available at **One.Walmart.com**.

Enrollment

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

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

WHEN AND HOW TO ENROLL

Don't confuse the **enrollment period** with the **effective date** of your coverage. The enrollment period is the time period during which you are required to make your benefit elections. Your coverage effective date is when those elections take effect. Your specific enrollment period and effective date will vary depending on a number of factors. Refer to the **Eligibility, enrollment, and effective dates** chapter for more information. Be sure to enroll by the enrollment deadline that will be stated in the enrollment materials that you receive. The AMP is not permitted to make exceptions to let individual associates enroll after the enrollment period ends so you must enroll by the deadline, or you will have to wait until the next Annual Enrollment unless you experience an election change event. See the **Eligibility, enrollment, and effective dates** chapter for details.

The online benefits enrollment tool can be accessed through **One.Walmart.com**.

CHOOSING A COVERAGE TIER

When you enroll in the AMP, you will select your coverage tier, including any eligible family members you wish to cover. Coverage tiers are:

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

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

COST OF COVERAGE

The contributions, or "premiums" you pay for medical coverage will vary, depending on the AMP option you choose, the coverage tier you choose, and whether you are eligible for tobacco-free rates.

Role of third-party administrator (TPA)

The AMP provides medical benefits only for certain services, which are generally referred to as "covered services." Expenses for "covered services" are "eligible medical expenses." The AMP administrator has delegated the fiduciary authority to make claims and appeals decisions, including prior authorization determinations where applicable, to several third-party administrators ("TPAs"). Your specific TPA will depend on the AMP option you choose and your work location, and in some cases, the type of services you receive. The TPA that generally administers the AMP option you elect is identified on your plan ID card.

However, for certain covered services, like those available through the Centers of Excellence program or the travel benefit for complex care, a different TPA will administer the benefits. See the chart below. The TPA will use its internal policies and procedures to make claims and appeals decisions on behalf of the AMP.

Note that your TPA may also be an insurance company that issues health insurance policies. This does not mean your medical benefits under the AMP are insured. These insurers may also serve as TPAs for self-funded plans. In this case, the administrator of the AMP has delegated responsibility for determining claims for benefits under the AMP to the applicable TPA, which may consult health care professionals to assist in making claims determinations.

THIRD-PARTY ADMINISTRATORS (TPAS) DELEGATED BY PLAN ADMINISTRATOR	
Premier, Contribution, and Saver Plan options and family-building benefits under the Centers of Excellence program	Aetna Life Insurance Company (Aetna)* BlueAdvantage Administrators of Arkansas (BlueAdvantage)* UMR
Banner Local Plan option	Aetna
Mercy Arkansas Local Plan option	HealthSCOPE Benefits
Centers of Excellence program: Cancer medical record review, outpatient kidney dialysis or ESRD medical record review, transplant services, and related travel benefits (including for family building) Also: breast pump preventive care benefit and doula program	HealthSCOPE Benefits
Centers of Excellence program: Heart surgery, spine surgery, hip and knee replacement, and weight loss surgery, and related travel benefits under the Centers of Excellence program	Contigo Health

*For AMP participants in Alabama, Alaska, Arizona, Colorado, Illinois, Indiana, Iowa, Kentucky, Minnesota, Missouri, North Carolina, South Carolina, Tennessee, Virginia, West Virginia, or Wisconsin, preauthorization requests ("pre-service claims") may be decided by Included Health or a third party on behalf of Included Health.

In addition to determining your claims for benefits, the TPA for your AMP option also provides access to its provider network. A provider network is a group of providers who have each contracted with the TPA and have agreed to accept a negotiated amount for covered services they provide. That means the total amount of the eligible medical expenses paid by you and the AMP for covered services will not be more than the negotiated amount. **Network providers are not permitted to bill you for any amount over that negotiated amount for covered services under the AMP.**

AMP options available to you

Generally, the specific AMP options available to you will depend on your work or assigned-facility location ("work location"). If you are a remote worker or are receiving continuation coverage under COBRA, you will be assigned to the facility closest to your address of record. If you are a truck driver, your plan option may be determined by your home address on record rather than work location. The specific AMP options available to you will be listed in your enrollment materials and when you enter the online enrollment system, only those options will be available for you to choose. Over the next few pages, you will find charts of the various options that may be available at your work location. Each chart provides a summary of coverage for each AMP option. Immediately following the charts is information to help you evaluate the option that is right for you.

PREMIER, CONTRIBUTION, SAVER PLAN OPTIONS

The three main options available to most associates nationwide are the Premier, Contribution, and Saver Plan options. The chart titled **Premier, Contribution, Saver Plan options—Nationwide** compares these options side by side and provides coverage information for each option. Depending on your work location, every one of these options may not be available in your specific location. In some locations, there may be agreements between the AMP (or a TPA) and providers that include financial incentives to providers to manage care.

The Premier, Contribution, and Saver Plan options may vary slightly in the actual design in some locations. To make it easier for you to evaluate the specific AMP options available to you, immediately following the **Premier, Contribution, Saver Plan options—Nationwide** chart, you will see five charts with those same AMP options but identified by geographical areas in which those options are available. Whether you will be offered one of the location-specific Premier, Contribution, or Saver Plan options depends on your work location.

If your work location is in one of the following areas, the AMP options offered to you will include one or more of the location-specific Premier, Contribution, and Saver Plan option designs:

LOCATION-SPECIFIC PREMIER, CONTRIBUTION, AND SAVER PLAN OPTIONS

Region	Counties
Northwest Arkansas	Benton, Madison, and Washington
Florida	**Central (including Orlando and Tampa):** Brevard, Citrus, Hernando, Hillsborough, Lake, Manatee, Marion, Orange, Osceola, Pasco, Pinellas, Polk, Sarasota, Seminole, Sumter, and Volusia
	Northeast: Alachua, Baker, Bradford, Clay, Duval, Flagler, Nassau, Putnam, and St. Johns
	South (including Ft. Lauderdale, Miami, Naples, and Port St. Lucie): Broward, Charlotte, Collier, DeSoto, Glades, Hardee, Hendry, Highlands, Indian River, Lee, Martin, Miami-Dade, Monroe, Okeechobee, Palm Beach, and St. Lucie
Illinois/Indiana (Chicago metro)	**Illinois:** Cook, DeKalb, DuPage, Grundy, Kane, Kendall, Lake, McHenry, and Will
	Indiana: Lake and Porter
Oklahoma	**Oklahoma City:** Canadian, Cleveland, Lincoln, Logan, McClain, and Oklahoma
	Tulsa: Creek, Osage, Rogers, Tulsa, and Wagoner
Texas	**Austin:** Bastrop, Caldwell, Hays, Travis, and Williamson
	Dallas/Fort Worth ("DFW"): Collin, Dallas, Denton, Ellis, Henderson (northwestern), Hunt, Johnson, Kaufman, Parker, Rockwall, Tarrant, and Wise
	Houston: Austin, Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery, and Waller
	San Antonio: Atascosa, Bexar, Comal, Guadalupe, Kendall, Medina, and Wilson

The charts applicable to these locations are:

- **Premier, Contribution, Saver Plan options—northwest Arkansas (select counties)**
- **Premier, Contribution, Saver Plan options—central, northeast, and south Florida (select counties)**
- **Premier, Contribution, Saver Plan options—Chicago metro (select counties)**
- **Premier, Contribution, Saver Plan options—Oklahoma (select counties)**
- **Premier, Contribution, Saver Plan options—Texas (select counties)**

Unless otherwise indicated throughout this chapter, references to a "Premier," "Contribution," or "Saver" Plan option will be a reference to the option, generally, regardless of whether the option is available nationwide or only in certain areas, unless otherwise specified.

For example:

"Premier Plan option" is a reference to the Premier Plan option, generally, whether available nationwide or in a specific area.

"Contribution Plan option/northwest Arkansas" is a reference to the Contribution Plan option available to associates with work locations in the Arkansas counties specified on the previous page.

"Saver Plan option/nationwide" is a reference to the Saver Plan option available to associates with work locations that are not in any of the counties specified on the previous page.

"Saver Plan option/central, northeast, and south Florida" is a reference to the Saver Plan option available to associates with work locations in the Florida counties specified on the previous page.

"Premier Plan option/Chicago metro" is a reference to the Premier Plan option available to associates with work locations in the Chicago metro counties specified on the previous page.

"Premier Plan option/Oklahoma" is a reference to the Premier Plan option available to associates with work locations in the Oklahoma counties specified on the previous page.

"Premier Plan option/Texas" is a reference to the Premier Plan option available to associates with work locations in the Texas counties specified on the previous page.

LOCAL PLAN OPTIONS

If available at your work location, the AMP options available to you may also include "local plans," which provide access to groups of providers in a specific area. Agreements between the AMP and these providers may include financial incentives to manage care. With limited exceptions, in the designated area where a local plan option is available, it will generally replace the Contribution Plan option as a coverage option if your work location is in that area. In other words, if a local plan is available in an area that includes your work location, the AMP options available to you will likely be the Premier, Saver, or the available local plan option, but not the Contribution Plan option, with limited exceptions.

Local plan options are available in designated areas, as listed here:

Banner Local Plan

- Phoenix, Arizona metropolitan area

Mercy Arkansas Local Plan

- Portions of northwest Arkansas and McDonald County, Missouri

For details about coverage under the local plan options, see the chart titled **Local plan options—Banner and Mercy Arkansas**.

PREMIER, CONTRIBUTION, SAVER PLAN OPTIONS—NATIONWIDE

Refer to the charts on the following pages if your work location is in the following areas:

- Northwest Arkansas (select counties)
- Central, northeast, and south Florida (select counties)
- Chicago metro (select counties)
- Oklahoma (select counties)
- Texas (select counties)

	Premier Plan	Contribution Plan	Saver Plan
Annual deductible (Individual/Family) • Network • Out-of-network	 $2,750/$5,500 $5,500/$11,000	 $1,750/$3,500 $3,500/$7,000	 $3,000/$6,000 $6,000/$12,000
Walmart-provided funds (Individual/Family)	N/A	$250/$500 *Maximum annual company contribution to HRA*	$350/$700 *Maximum annual company matching contribution to HSA*
Annual out-of-pocket maximum (Individual/Family) • Network • Out-of-network	 $6,850/$13,700 None	 $6,850/$13,700 None	 $6,650/$13,300 None
Eligible preventive care • Network • Non-network	 100% (no deductible) 50% (no deductible)	 100% (no deductible) 50% (no deductible)	 100% (no deductible) 50% (no deductible)
Doctor visits (provider's office or telehealth) *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** • Network • Non-network **Specialist** • Network • Non-network	 100% after $35 copay 50% after deductible 100% after $75 copay 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible
Telehealth video visits through Doctor On Demand by Included Health	$0 copay	$0 copay	$0 copay after deductible
Urgent care* • Network • Non-network	 100% after $75 copay 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Diagnostic tests *Nonpreventive tests ordered or performed outside a doctor's office* • Network • Non-network	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Advanced imaging MRI and CT scans • *Alternate network* • Network • Non-network	 75% after deductible 50% after deductible 50% after deductible	 75% after deductible 50% after deductible 50% after deductible	 75% after deductible 50% after deductible 50% after deductible
Hospitalization* Inpatient & outpatient care *Including non-office provider visits and surgical services* • Network • Non-network	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Mental health **Inpatient & outpatient (facility)** • Network • Non-network **Outpatient (provider's office or telehealth)** • Network • Non-network	 75% after deductible 50% after deductible 100% after $35 copay 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible
Emergency services*	100% after deductible and $300 copay	100% after deductible and $300 copay	100% after deductible and $300 copay
Pharmacy	See **The pharmacy benefit** chapter		
Centers of Excellence	See the **Centers of Excellence** section of this chapter		
Walmart Health	See the **Walmart Health** section of this chapter		

**For full details about surprise billing and cost sharing for urgent care, hospitalization, and emergency services, see later in chapter. May not apply to urgent care facilities in your state.*

PREMIER, CONTRIBUTION, SAVER PLAN OPTIONS—NORTHWEST ARKANSAS

Select counties—see Location-specific Premier, Contribution, and Saver Plan Options chart

	Premier Plan	Contribution Plan	Saver Plan
Annual deductible (Individual/Family) • Network (Network benefits only)	$2,750/$5,500	$1,750/$3,500	$3,000/$6,000
Walmart-provided funds (Individual/Family)	N/A	$250/$500 *Maximum annual company contribution to HRA*	$350/$700 *Maximum annual company matching contribution to HSA*
Annual out-of-pocket maximum (Individual/Family) • Network (Network benefits only)	$6,850/$13,700	$6,850/$13,700	$6,650/$13,300
Eligible preventive care • Network • Non-network	100% (no deductible) No coverage	100% (no deductible) No coverage	100% (no deductible) No coverage
Doctor visits (provider's office or telehealth) *Including routine same-day diagnostic tests performed in doctor's office*			
Primary care • Network • Non-network	100% after $35 copay No coverage	75% after deductible No coverage	75% after deductible No coverage
Specialist • Network • Non-network	100% after $75 copay No coverage	75% after deductible No coverage	75% after deductible No coverage
Telehealth video visits through Doctor On Demand by Included Health	$0 copay	$0 copay	$0 copay after deductible
Urgent care* • Network • Non-network	100% after $75 copay No coverage	75% after deductible No coverage	75% after deductible No coverage
Diagnostic tests *Nonpreventive tests ordered or performed outside a doctor's office* • Network • Non-network	75% after deductible No coverage	75% after deductible No coverage	75% after deductible No coverage
Advanced imaging MRI and CT scans • *Alternate network* • Network • Non-network	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Hospitalization* Inpatient & outpatient care *Including non-office provider visits and surgical services* • Network • Non-network	75% after deductible No coverage	75% after deductible No coverage	75% after deductible No coverage
Mental health **Inpatient & outpatient (facility)** • Network • Non-network	75% after deductible No coverage	75% after deductible No coverage	75% after deductible No coverage
Outpatient (provider's office or telehealth) • Network • Non-network	100% after $35 copay No coverage	75% after deductible No coverage	75% after deductible No coverage
Emergency services*	100% after deductible and $300 copay	100% after deductible and $300 copay	100% after deductible and $300 copay
Pharmacy	See **The pharmacy benefit** chapter		
Centers of Excellence	See the **Centers of Excellence** section of this chapter		
Walmart Health	See the **Walmart Health** section of this chapter		

**For full details about surprise billing and cost sharing for urgent care, hospitalization, and emergency services, see later in chapter. May not apply to urgent care facilities in your state.*

PREMIER, CONTRIBUTION, SAVER PLAN OPTIONS—CENTRAL, NORTHEAST, AND SOUTH FLORIDA

Select counties—see Location-specific Premier, Contribution, and Saver Plan Options chart

	Premier Plan	Contribution Plan *(Limited availability)*	Saver Plan
Annual deductible (Individual/Family) • Network *preferred* & *nonpreferred* • Out-of-network	 $2,750/$5,500 $5,500/$11,000	 $1,750/$3,500 $3,500/$7,000	 $3,000/$6,000 $6,000/$12,000
Walmart-provided funds (Individual/Family)	N/A	$250/$500 *Maximum annual company contribution to HRA*	$350/$700 *Maximum annual company matching contribution to HSA*
Annual out-of-pocket maximum (Individual/Family) • Network *preferred* & *nonpreferred* • Out-of-network	 $6,850/$13,700 None	 $6,850/$13,700 None	 $6,650/$13,300 None
Eligible preventive care • Network *preferred* • Network *nonpreferred* & non-network	 100% (no deductible) 50% (no deductible)	 100% (no deductible) 50% (no deductible)	 100% (no deductible) 50% (no deductible)
Doctor visits (provider's office or telehealth) *Including routine same-day diagnostic tests performed in doctor's office*			
Primary care • Network *preferred** • Network *nonpreferred* & non-network	 100% after $35 copay 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Specialist • Network *preferred** • Network *nonpreferred* & non-network	 100% after $75 copay 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Telehealth video visits through Doctor On Demand by Included Health	$0 copay	$0 copay	$0 copay after deductible
Urgent care** • Network *preferred* • Network *nonpreferred* & non-network	 100% after $75 copay 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Diagnostic tests *Nonpreventive tests ordered or performed outside a doctor's office* • Network • Non-network	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Advanced imaging MRI and CT scans • *Alternate network* • Network • Non-network	 75% after deductible 50% after deductible 50% after deductible	 75% after deductible 50% after deductible 50% after deductible	 75% after deductible 50% after deductible 50% after deductible
Hospitalization** Inpatient & outpatient care *Including non-office provider visits and surgical services* • Network • Non-network	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Mental health **Inpatient & outpatient (facility)** • Network • Non-network **Outpatient (provider's office or telehealth)** • Network • Non-network	 75% after deductible 50% after deductible 100% after $35 copay 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible
Emergency services**	100% after deductible and $300 copay	100% after deductible and $300 copay	100% after deductible and $300 copay
Pharmacy	See **The pharmacy benefit** chapter		
Centers of Excellence	See the **Centers of Excellence** section of this chapter		
Walmart Health	See the **Walmart Health** section of this chapter		

**Benefits for professional charges in a non-office setting are 75% for preferred and 50% for nonpreferred.*

***For full details about surprise billing and cost sharing for urgent care, hospitalization, and emergency services, see later in chapter. May not apply to urgent care facilities in your state.*

PREMIER, CONTRIBUTION, SAVER PLAN OPTIONS—CHICAGO METRO

Select counties—see Location-specific Premier, Contribution, and Saver Plan Options chart

	Premier Plan	Contribution Plan *(Limited availability)*	Saver Plan
Annual deductible (Individual/Family) • Network *preferred* & *nonpreferred* (Network benefits only)	$2,750/$5,500	$1,750/$3,500	$3,000/$6,000
Walmart-provided funds (Individual/Family)	N/A	$250/$500 *Maximum annual company contribution to HRA*	$350/$700 *Maximum annual company matching contribution to HSA*
Annual out-of-pocket maximum (Individual/Family) • Network *preferred* & *nonpreferred* (Network benefits only)	$6,850/$13,700	$6,850/$13,700	$6,650/$13,300
Eligible preventive care • Network *preferred* • Network *nonpreferred* • Non-network	100% (no deductible) 50% (no deductible) No coverage	100% (no deductible) 50% (no deductible) No coverage	100% (no deductible) 50% (no deductible) No coverage
Doctor visits (provider's office or telehealth) *Including routine same-day diagnostic tests performed in doctor's office*			
Primary care • Network *preferred** • Network *nonpreferred* • Non-network	100% after $35 copay 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Specialist • Network *preferred** • Network *nonpreferred* • Non-network	100% after $75 copay 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Telehealth video visits through Doctor On Demand by Included Health	$0 copay	$0 copay	$0 copay after deductible
Urgent care** • Network *preferred* • Network *nonpreferred* • Non-network	100% after $75 copay 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Diagnostic tests *Nonpreventive tests ordered or performed outside a doctor's office* • Network • Non-network	75% after deductible No coverage	75% after deductible No coverage	75% after deductible No coverage
Advanced imaging MRI and CT scans • *Alternate network* • Network • Non-network	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Hospitalization** Inpatient & outpatient care *Including non-office provider visits and surgical services* • Network • Non-network	75% after deductible No coverage	75% after deductible No coverage	75% after deductible No coverage
Mental health **Inpatient & outpatient (facility)** • Network • Non-network	75% after deductible No coverage	75% after deductible No coverage	75% after deductible No coverage
Outpatient (provider's office or telehealth) • Network • Non-network	100% after $35 copay No coverage	75% after deductible No coverage	75% after deductible No coverage
Emergency services**	100% after deductible and $300 copay	100% after deductible and $300 copay	100% after deductible and $300 copay
Pharmacy	See **The pharmacy benefit** chapter		
Centers of Excellence	See the **Centers of Excellence** section of this chapter		
Walmart Health	See the **Walmart Health** section of this chapter		

**Benefits for professional charges in a non-office setting are 75% for preferred and 50% for nonpreferred.*

***For full details about surprise billing and cost sharing for urgent care, hospitalization, and emergency services, see later in chapter. May not apply to urgent care facilities in your state.*

PREMIER, CONTRIBUTION, SAVER PLAN OPTIONS—OKLAHOMA

Select counties—see Location-specific Premier, Contribution, and Saver Plan Options chart

The Contribution Plan is available in limited locations in the Oklahoma City and Tulsa areas.

	Premier Plan	Contribution Plan *(Limited availability)*	Saver Plan
Annual deductible (Individual/Family) • Network *preferred* & *nonpreferred* (Network benefits only)	$2,750/$5,500	$1,750/$3,500	$3,000/$6,000
Walmart-provided funds (Individual/Family)	N/A	$250/$500 *Maximum annual company contribution to HRA*	$350/$700 *Maximum annual company matching contribution to HSA*
Annual out-of-pocket maximum (Individual/Family) • Network *preferred* & *nonpreferred* (Network benefits only)	$6,850/$13,700	$6,850/$13,700	$6,650/$13,300
Eligible preventive care • Network *preferred* • Network *nonpreferred* • Non-network	100% (no deductible) 50% (no deductible) No coverage	100% (no deductible) 50% (no deductible) No coverage	100% (no deductible) 50% (no deductible) No coverage
Doctor visits (provider's office or telehealth) *Including routine same-day diagnostic tests performed in doctor's office*			
Primary care • Network *preferred** • Network *nonpreferred* • Non-network	100% after $35 copay 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Specialist • Network *preferred** • Network *nonpreferred* • Non-network	100% after $75 copay 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Telehealth video visits through Doctor On Demand by Included Health	$0 copay	$0 copay	$0 copay after deductible
Urgent care** • Network *preferred* • Network *nonpreferred* • Non-network	100% after $75 copay 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Diagnostic tests *Nonpreventive tests ordered or performed outside a doctor's office* • Network • Non-network	75% after deductible No coverage	75% after deductible No coverage	75% after deductible No coverage
Advanced imaging MRI and CT scans • *Alternate network* • Network • Non-network	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Hospitalization** Inpatient & outpatient care *Including non-office provider visits and surgical services* • Network • Non-network	75% after deductible No coverage	75% after deductible No coverage	75% after deductible No coverage
Mental health **Inpatient & outpatient (facility)** • Network • Non-network	75% after deductible No coverage	75% after deductible No coverage	75% after deductible No coverage
Outpatient (provider's office or telehealth) • Network • Non-network	100% after $35 copay No coverage	75% after deductible No coverage	75% after deductible No coverage
Emergency services**	100% after deductible and $300 copay	100% after deductible and $300 copay	100% after deductible and $300 copay
Pharmacy	See **The pharmacy benefit** chapter		
Centers of Excellence	See the **Centers of Excellence** section of this chapter		
Walmart Health	See the **Walmart Health** section of this chapter		

** Benefits for professional charges in a non-office setting are 75% for preferred and 50% for nonpreferred.*

***For full details about surprise billing and cost sharing for urgent care, hospitalization, and emergency services, see later in chapter. May not apply to urgent care facilities in your state.*

PREMIER, CONTRIBUTION, SAVER PLAN OPTIONS—TEXAS

Select counties—see Location-specific Premier, Contribution, and Saver Plan Options chart

The Contribution Plan is available in limited locations in the Austin, Dallas/Fort Worth, Houston, and San Antonio areas.

	Premier Plan	Contribution Plan *(Limited availability)*	Saver Plan
Annual deductible (Individual/Family) • Network *preferred* & *nonpreferred* (Network benefits only)	$2,750/$5,500	$1,750/$3,500	$3,000/$6,000
Walmart-provided funds (Individual/Family)	N/A	$250/$500 *Maximum annual company contribution to HRA*	$350/$700 *Maximum annual company matching contribution to HSA*
Annual out-of-pocket maximum (Individual/Family) • Network *preferred* & *nonpreferred* (Network benefits only)	$6,850/$13,700	$6,850/$13,700	$6,650/$13,300
Eligible preventive care • Network *preferred* • Network *nonpreferred* • Non-network	100% (no deductible) 50% (no deductible) No coverage	100% (no deductible) 50% (no deductible) No coverage	100% (no deductible) 50% (no deductible) No coverage
Doctor visits (provider's office or telehealth) *Including routine same-day diagnostic tests performed in doctor's office*			
Primary care • Network *preferred** • Network *nonpreferred* • Non-network	100% after $35 copay 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Specialist • Network *preferred** • Network *nonpreferred* • Non-network	100% after $75 copay 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Telehealth video visits through Doctor On Demand by Included Health	$0 copay	$0 copay	$0 copay after deductible
Urgent care** • Network *preferred* • Network *nonpreferred* • Non-network	100% after $75 copay 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Diagnostic tests *Nonpreventive tests ordered or performed outside a doctor's office* • Network • Non-network	75% after deductible No coverage	75% after deductible No coverage	75% after deductible No coverage
Advanced imaging MRI and CT scans • *Alternate network* • Network • Non-network	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Hospitalization** Inpatient & outpatient care *Including non-office provider visits and surgical services* • Network • Non-network	75% after deductible No coverage	75% after deductible No coverage	75% after deductible No coverage
Mental health **Inpatient & outpatient (facility)** • Network • Non-network	75% after deductible No coverage	75% after deductible No coverage	75% after deductible No coverage
Outpatient (provider's office or telehealth) • Network • Non-network	100% after $35 copay No coverage	75% after deductible No coverage	75% after deductible No coverage
Emergency services**	100% after deductible and $300 copay	100% after deductible and $300 copay	100% after deductible and $300 copay
Pharmacy	See **The pharmacy benefit** chapter		
Centers of Excellence	See the **Centers of Excellence** section of this chapter		
Walmart Health	See the **Walmart Health** section of this chapter		

**Benefits for professional charges in a non-office setting are 75% for preferred and 50% for nonpreferred.*

***For full details about surprise billing and cost sharing for urgent care, hospitalization, and emergency services, see later in chapter. May not apply to urgent care facilities in your state.*

LOCAL PLAN OPTIONS—BANNER AND MERCY ARKANSAS		
	Banner	**Mercy Arkansas**
Annual deductible (Individual/Family) • Network (Network benefits only)	$3,000/$6,000	$1,750/$3,500
Walmart-provided funds (Individual/Family)	N/A	N/A
Annual out-of-pocket maximum (Individual/Family) • Network (Network benefits only)	$6,850/$13,700	$6,850/$13,700
Eligible preventive care • Network • Non-network	100% (no deductible) No coverage	100% (no deductible) No coverage
Doctor visits (provider's office or telehealth) *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** • Network • Non-network **Specialist** • Network • Non-network	 100% after $35 copay No coverage 100% after $75 copay No coverage	 100% after $35 copay No coverage 100% after $75 copay No coverage
Telehealth video visits through Doctor On Demand by Included Health	$0 copay	$0 copay
Urgent care* • Network • Non-network	100% after $75 copay No coverage	100% after $75 copay No coverage
Diagnostic tests *Nonpreventive tests ordered or performed outside a doctor's office* • Network • Non-network	 75% after deductible No coverage	 75% after deductible No coverage
Hospitalization* Inpatient & outpatient care *Including non-office provider visits and surgical services* • Network • Non-network	 75% after deductible No coverage	 75% after deductible No coverage
Mental health **Inpatient & outpatient (facility)** • Network • Non-network **Outpatient (provider's office or telehealth)** • Network • Non-network	 75% after deductible No coverage 100% after $35 copay No coverage	 75% after deductible No coverage 100% after $35 copay No coverage
Emergency services*	100% after deductible and $300 copay	100% after deductible and $300 copay
Pharmacy	See **The pharmacy benefit** chapter	
Centers of Excellence	See the **Centers of Excellence** section of this chapter	
Walmart Care Clinic and Walmart Health	See the **Walmart Health** section of this chapter	

NOTE: The Mercy Arkansas Local Plan offers limited coverage for chiropractic care office visits. There is a maximum of 10 visits per calendar year.

**For full details about surprise billing and cost sharing for urgent care, hospitalization, and emergency services, see later in chapter. May not apply to urgent care facilities in your state.*

Evaluating your options

WALMART-PROVIDED FUNDS

Contribution Plan option—health reimbursement account

The Contribution Plan option includes a health reimbursement account ("HRA"). Each year, the company allocates money to the HRA for you and any covered dependents to use toward your share of the cost of eligible medical expenses, including those that apply toward your annual deductible(s) and out-of-pocket maximum. You may not contribute your own money to the HRA. Amounts contributed by the company are made available only for the purposes stated below and will be forfeited if you are no longer enrolled in the Contribution Plan option. The annual amount allocated to the HRA within the Contribution Plan option depends on whether you are enrolled in associate-only coverage (in which case you will be allocated the "individual" amount) or a level of coverage that includes eligible dependents (in which case you will be allocated the "family" amount).

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

Only amounts designated as "rollover funds" may be used to pay for covered services rendered in a previous year. For example, if you were enrolled in the Contribution Plan option in 2022 and 2023, any HRA funds allocated in 2023 could be used only for eligible medical expenses for services received in 2023 but not those received prior to 2023 (such as an expense incurred in 2022 but not processed until 2023). However, any "rollover funds"—HRA funds that roll over from 2022 to 2023—may be used for any eligible medical expense for services received while enrolled in the Contribution Plan.

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

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

Saver Plan option—health savings account

The Saver Plan option gives you the opportunity to contribute to a health savings account ("HSA") through payroll deductions on a pretax basis. The company matches your payroll deductions into your HSA, dollar-for-dollar up to $350 if you have associate-only coverage or $700 if you have elected anything other than associate-only coverage. Combined contributions to your HSA (your own and the company's) cannot exceed the 2023 annual IRS limit of $3,850 for associate-only coverage or $7,750 for all other coverage tiers, plus a $1,000 catch-up contribution if you turn 55 by the end of the 2023 calendar year.

You can choose to use money in your HSA to pay eligible medical expenses that are subject to the annual deductible(s), or you can pay them out of your own pocket and save your HSA money for future expenses. See the **Health savings account (HSA)** chapter for additional information.

COST SHARING

The charts on the prior pages explain how the cost of covered services is shared between you and the AMP. The portion of eligible medical expenses you are responsible for paying is referred to as "cost sharing," which generally includes the deductible, copayment (or copay), and coinsurance amounts that are listed in the coverage summary charts. Cost sharing does not include any other expenses, such as amounts for services that are not covered services or amounts that you pay to a non-network provider that are in excess of the maximum allowable charge.

Annual deductible

Your deductible is the amount of eligible medical expenses you pay each year for most covered services, including prescription drugs, before the AMP begins to share in the cost of covered services. For example, if you have a $1,750 annual network deductible, you will generally need to pay the first $1,750 of your total eligible medical expenses for network covered services before the AMP pays any benefit. The AMP will pay eligible preventive care services and some

covered services in the Premier Plan and local plan options that are subject to a copay (e.g., doctor office visits) before you meet the applicable annual deductible(s).

Some AMP options have a separate network annual deductible (for eligible medical expenses paid to network providers) and an out-of-network annual deductible (for eligible medical expenses paid to non-network providers). In those cases, your share of eligible medical expenses that applies to the network annual deductible also applies toward the out-of-network annual deductible, and vice versa. If the AMP option you choose has a network and out-of-network deductible, the AMP will begin paying a portion of the cost of covered services from a network provider after you have met the network annual deductible, but the AMP will generally not pay any portion of the cost of covered services from a non-network provider until the out-of-network deductible has been met. If an AMP option does not cover out-of-network services, you will only have a network annual deductible. In this case, amounts paid for out-of-network services are not eligible medical expenses and will not count toward your network annual deductible.

All AMP options have an "individual" deductible amount and a "family" deductible amount. The "individual" amount is your applicable annual deductible if you have elected associate-only coverage. The "family" amount is your applicable annual deductible if you have elected any other level of coverage that includes eligible dependents. If you elect coverage for eligible dependents, the deductible(s) can be met by any combination of you and your covered dependents, but no AMP benefits are payable, except for services not subject to a deductible, for either you or your covered dependents until the entire applicable (network or out-of-network) annual deductible is met.

If you are enrolled in the Contribution Plan option: You can meet your annual deductible with your company-provided HRA funds allocated in the current year and any rollover HRA funds you may have from a previous year. When you have used all your HRA funds, you must use your own funds to meet the remainder of your annual deductible.

If you are enrolled in the Saver Plan option: You generally must pay full cost for covered services and prescription drugs until you meet your network annual deductible. There are exceptions (some preventive and over-the-counter drugs and preventive services), which are discussed below and in **The pharmacy benefit** chapter.

The following expenses, if applicable to a specific option, **do not count** toward the network or out-of-network annual deductible(s).

- Copays for pharmacy, in-person or telehealth doctor visits, urgent care, Walmart Health, or covered services for a non-emergency medical condition in an emergency department
- Coinsurance for pharmacy and for hip or knee replacement services outside the Centers of Excellence program without an exception
- Discounts, coupons, pharmacy discount programs or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug charges paid directly to pharmacies on your behalf through discount programs/coupons)
- Amounts in excess of the maximum allowable charge that you pay to non-network providers, including but not limited to amounts paid for services for a non-emergency medical condition in an emergency department, amounts paid to a provider subject to notice and consent requirements who has obtained your consent to bill you for amounts in excess of the maximum allowable charge, and amounts you pay to a non-network provider of air ambulance services for services that would not be covered by the AMP if provided by a network provider of air ambulance services
- Charges for services (other than copays, discussed above) provided at any non-network Walmart Health (however, amounts for covered diagnostic tests performed outside the non-network Walmart Health will be subject to otherwise applicable AMP terms, including other exclusions in this list)
- Charges for services not covered by the AMP, including amounts paid for out-of-network services if you are in an AMP option that does not cover out-of-network services
- Charges for services not covered under the Centers of Excellence program for family-building services such as those incurred after you have met your maximum lifetime benefit amount
- Charges paid 100% by the AMP, such as charges for preventive services (including preventive drugs) and certain Centers of Excellence services
- Charges for non-network preventive services, and
- Premiums.

Copayments

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

NOTE: The AMP benefit for non-office provider visits (e.g., inpatient visit or surgical services) is 75%, after deductible, for network providers (or for Premier, Contribution, Saver Plan options in select counties in central, northeast and south Florida, Chicago metro, Oklahoma and Texas; 75%, after deductible, for *preferred* providers; and 50%, after deductible, for *nonpreferred* providers (if applicable).

Coinsurance

For most covered services not subject to a copayment, you will be required to share the cost of eligible medical expenses with the AMP after you meet your applicable annual deductible. The portion you pay is called "coinsurance."

The charts that contain the coverage summaries show the benefit (expressed as a percentage of eligible medical expenses) the AMP will pay for covered services, which varies depending on the status of the provider. You will be responsible for paying the remaining portion of the eligible medical expenses, which is also expressed as a percentage. For example, if the AMP pays a benefit of 75% of eligible medical expenses (after your deductible has been met), your coinsurance amount will be 25% of eligible medical expenses. Your coinsurance for specific AMP options may be different from the coinsurance for other AMP options.

- **Premier, Contribution, and Saver Plan options/nationwide:** These AMP options will generally pay a greater portion of the cost of covered services received from a network provider than those received from a non-network provider. That means your coinsurance will be a smaller portion of the cost of covered services if those services are received from a network provider rather than from a non-network provider. And, when you receive services from a non-network provider, you will generally be responsible for the cost of services in excess of the AMP's maximum allowable charge except in the case of covered services for an emergency medical condition in an emergency department or certain services provided by a non-network provider in a network facility that has not obtained your consent to bill you. See the **Provider networks** section for other exceptions. Find network providers in the provider directory: **IncludedHealth.com/Walmart**.
- **Premier, Contribution, and Saver Plan options/central, northeast, and south Florida:** For some covered services, the AMP benefit under these options may depend not only on whether the provider is a network provider, but on whether the provider is a *preferred* network provider or a *nonpreferred* network provider. *Preferred* providers and *nonpreferred* providers are both network providers. However, under these options, the AMP will generally pay a greater portion of the cost of covered services received from a *preferred* provider than those received from a *nonpreferred* provider. That means your coinsurance will be a smaller portion of the cost of covered services if those services are received from a *preferred* provider rather than a *nonpreferred* provider. However, any coinsurance you pay for covered services will be applied to the deductible and out-of-pocket maximum regardless of whether you receive services from a *preferred provider* or *nonpreferred* provider. The AMP also pays a portion of the cost of covered services received from a non-network provider under these options, but it will generally be a smaller portion than the AMP pays for covered services received from a *preferred* network provider. And, when you receive services from a non-network provider, you will generally be responsible for the cost of services in excess of the AMP's maximum allowable charge except in the case of covered services for an emergency medical condition in an emergency department or certain services provided by a non-network provider in a network facility that has not obtained your consent to bill you. See the **Provider networks** section for other exceptions. Find *preferred* providers in the provider directory: **IncludedHealth.com/Walmart**.
- **Premier, Contribution, and Saver Plan options/Chicago metro, Oklahoma, and Texas:** The AMP benefit for some covered services under these options may depend not only on whether the provider is a network provider, but on whether the provider is a *preferred* network provider or a *nonpreferred* network provider. *Preferred* providers and *nonpreferred* providers are both network providers. However, under these options, the AMP will generally pay a greater portion of the cost of covered services received from a *preferred* provider than those received from a *nonpreferred* provider. That means your coinsurance will be a smaller portion of the cost of covered services if those services are received from a *preferred* provider rather than a *nonpreferred* provider. However, any coinsurance you pay for covered services will be applied to the deductible and annual out-of-pocket maximum, regardless of whether you receive services from a *preferred* provider or *nonpreferred* provider. The AMP does not provide coverage for services received from a non-network provider under these options. That means you will be responsible for paying the entire cost of services received from a non-network provider. There is an exception for covered services for an emergency medical condition in an emergency department or certain services provided by a non-network provider in a network facility that has not obtained your consent to bill you. See the **Provider networks** section for other exceptions. Find *preferred* providers in the provider directory: **IncludedHealth.com/Walmart**.
- **Premier, Contribution, and Saver Plan options/northwest Arkansas:** The AMP does not provide coverage for services received from a non-network provider under these options. That means you will be responsible for paying the entire cost of services received from a non-network provider. There is an exception for covered services for an emergency medical condition in an emergency department or certain services provided by a non-network provider in a network facility that has not obtained your consent to bill you. See the **Provider networks** section for other exceptions. Find network providers in the provider directory: **IncludedHealth.com/Walmart**.
- **Local plan options:** The AMP does not provide coverage for services received from a non-network provider under these options. That means you will be responsible for paying the entire cost of services received from a non-network provider. There is an exception for

covered services for an emergency medical condition in an emergency department or certain services provided by a non-network provider in a network facility that has not obtained your consent to bill you. See the **Provider networks** section for other exceptions. Find network providers in the provider directory: **IncludedHealth.com/Walmart**.

For all AMP options other than the local plan options, if your covered services include an MRI or CT scan, the AMP will generally pay a greater portion of the cost of covered services received from an *alternate network* provider than those received from a network provider. If no *alternate network* provider is available in your area, the AMP will pay the alternate network benefit amount if you use a network provider. See **Advanced imaging network** in the **Provider networks** section for more information.

The portion that you and the AMP each pay is not calculated based on the provider's billed charges. It is calculated as a percentage of the maximum amount the AMP will allow for a covered service, also referred to as the "maximum allowable charge," or "MAC." Generally, if your AMP option includes out-of-network coverage and you receive services from a non-network provider (other than covered services for a non-emergency medical condition in an emergency department and certain covered services from a non-network provider at a network facility that has not obtained your consent to bill you), you will be responsible for paying not only cost-sharing amounts but also any amounts in excess of the maximum allowable charge. Network providers will not bill you for covered services in excess of the maximum allowable charge. See the **What is covered by the AMP** section later in this chapter for more information about how the maximum allowable charge is calculated.

Annual out-of-pocket maximum

The annual out-of-pocket maximum amount is the most you could pay during the calendar year for your share of the costs of covered services provided by network providers. There is no out-of-pocket maximum for services received from non-network providers. After you meet the annual out-of-pocket maximum, the AMP generally pays 100% of the maximum allowable charge. However, not every expense you pay for health care will go toward the out-of-pocket maximum. The following are not applied to your out-of-pocket maximum: premiums, amounts billed by a non-network provider that are above the maximum allowable charge (if your AMP option provides out-of-network coverage), or amounts for services that the AMP does not cover. The out-of-pocket maximum only applies to covered services received from a network provider, including when covered services are received from *nonpreferred* providers, *preferred* providers, and *alternate network* providers (for advanced imaging services). In some cases, coinsurance for covered services received from a network provider will not count toward your out-of-pocket maximum, including coinsurance for hip or knee replacement services outside the Centers of Excellence program without a network exception, coinsurance for advanced imaging services received from a network provider when an *alternate network* provider is available, or coinsurance for services received from a network provider when a Blue Select network provider is available (in applicable locations). See the **Provider networks** section and **Centers of Excellence** section for more details.

The AMP option you choose has an individual out-of-pocket maximum and a family out-of-pocket maximum. Regardless of the coverage tier you choose, you and each of your covered family members are subject to the individual out-of-pocket maximum. Once you or any of your covered family members have incurred charges for network covered services up to that amount, that individual's eligible medical expenses are paid at 100% for the rest of the calendar year. The family out-of-pocket maximum is a combination of all family members' eligible medical expenses for covered services received from network providers. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible medical expenses for covered services from a network provider are paid at 100% for the rest of the calendar year for each member of your family, even if each individual has not met the individual out-of-pocket maximum.

The following expenses, if applicable to a specific AMP option, **do count** toward the annual out-of-pocket maximum:

- Amounts paid toward your annual network and out-of-network deductible
- Copays for in-person or telehealth doctor visits, urgent care, non-network Walmart Health, or covered services that are emergency services for an emergency medical condition in an emergency department
- Coinsurance for services provided by a network provider or by a non-network provider that the AMP pays as in-network
- Pharmacy copays/coinsurance.

The following expenses, if applicable to a specific AMP option, **do not count** toward the annual out-of-pocket maximum:

- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services
- Coinsurance when receiving hip or knee replacement services outside of the Centers of Excellence program without an exception from network providers, when receiving advanced imaging services from a network

provider when an *alternate network* provider is available, or when receiving services from a network provider when a Blue Select network provider is available (in applicable locations). See the **Provider networks** section and **Centers of Excellence** section for more details.

- Charges for non-network preventive services
- Coinsurance when using non-network providers
- Amounts in excess of the maximum allowable charge that you pay to non-network providers, including but not limited to amounts paid for services for a non-emergency medical condition in an emergency department, amounts paid to a provider subject to notice and consent requirements who has obtained your consent to bill you for amounts in excess of the maximum allowable charge, and amounts you pay to a non-network provider of air ambulance services for services that would not be not covered by the AMP if provided by a network provider of air ambulance services
- Copays and charges for services provided at any non-network Walmart Health (however, amounts for covered diagnostic tests performed outside Walmart Health will be subject to otherwise applicable AMP terms, including other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription)
- Charges for services not covered by the AMP, including amounts paid for out-of-network services if you are in an AMP option that does not cover out-of-network services
- Charges for services not covered under the Centers of Excellence program for family-building services such as those incurred after you have met your maximum lifetime benefit amount, and
- Premiums.

Provider networks

The AMP contracts with your TPA or directly with providers to provide a network of health care providers from whom you can receive covered services under the AMP at discounted prices. See the **TPA networks** section on the following page. Although the company and the AMP seek to utilize providers and provider networks that provide quality care, neither the company nor the AMP make any representations regarding the quality of services you will receive from any provider. The AMP does not furnish hospital or medical services and is not liable for any act or omission of any provider or agent of such provider, including failure or refusal to render services. All medical decisions are between you and your provider.

A network provider is, generally, a provider who has agreed to accept a contracted amount as full payment for covered services. Each AMP option has a specific group of providers who have agreed with the TPAs to accept a contracted price—that is generally your network. However, the AMP also has networks that are specific to covered services offered by the AMP, such as those under the Centers of Excellence program or advanced imaging services (MRI and CT scans), with their own rules. In addition, some AMP options have *preferred* and *nonpreferred* network providers. Both are network providers, but the AMP pays a greater portion of the cost of covered services received from a *preferred* network provider. Network providers may not bill you for amounts in excess of the contracted price for the service.

A non-network provider is one who has not agreed to accept a contracted amount as full payment for covered services. With some exceptions, non-network providers are permitted to bill you for amounts in excess of the amount paid by the AMP. This is why you can generally expect to pay more when you see a non-network provider.

Generally, when the AMP pays an amount for covered services, neither the AMP's portion nor your portion (your coinsurance) is based on the amount billed by the provider, but rather on the "maximum allowable charge." The maximum allowable charge is the maximum charge for covered services that the AMP will pay in whole or part, subject to copayments, deductibles, and coinsurance amounts. The maximum allowable charge for network providers and non-network providers is determined in a different way. For network providers, the maximum allowable charge is the amount network providers have agreed to accept as full payment for covered services.

The maximum allowable charge for non-network providers is generally determined by the AMP. With some exceptions, non-network providers can bill you for amounts in excess of the maximum allowable charge determined by the AMP. See **Maximum allowable charge** in the **What is covered by the AMP** section later in this chapter for detailed information about how the AMP determines the maximum allowable charge for non-network providers.

The AMP, its TPAs, and network providers may agree to certain incentive arrangements (which may pay bonuses or withhold provider payments) designed to reward high-quality and cost-effective treatments. For example, the Mercy Arkansas Local Plan contract includes such an arrangement. Contact your TPA for information regarding these arrangements.

The sections that follow discuss the various networks used by the AMP.

TPA NETWORKS

Depending on your work location and choice of AMP option, your benefits under the AMP are administered by one of the following third-party administrators:

- Aetna
- BlueAdvantage Administrators of Arkansas
  - If your work location is in the District of Columbia, Florida, Georgia, Maryland, Minnesota, Missouri (Kansas City area), New Hampshire, New Jersey, Oklahoma, Pennsylvania, Tennessee, northern Virginia, or Wisconsin, see important information below in the section titled **Blue Select networks through BlueAdvantage Administrators of Arkansas**.
- HealthSCOPE Benefits
- UMR

If your provider leaves the network prior to your receiving services, and you then choose to receive services from that provider, services provided by that provider are generally treated as out-of-network services. If your AMP option provides out-of-network coverage and you receive services from a non-network provider, you will generally be responsible for the cost of services in excess of the AMP's maximum allowable charge. If your AMP option does not provide out-of-network coverage, you will generally be responsible for the entire amount charged by the non-network provider. In certain circumstances, you may be eligible for continued coverage, called "continuity of care." See important information about continuity of care services described in the section titled **When network benefits are paid for out-of-network services** on the following page.

Find network providers at **IncludedHealth.com/Walmart**.

BLUE SELECT NETWORKS THROUGH BLUEADVANTAGE ADMINISTRATORS OF ARKANSAS

If you are enrolled in the Premier, Contribution, or Saver Plan option and BlueAdvantage Administrators of Arkansas is your TPA, you may have more narrow networks—called Blue Select networks—if your work location is in a particular service area. In these locations, you must use a provider in the Blue Select network for network terms—i.e., network annual deductibles and network coinsurance—to apply. If your work location is in one of the areas below, services provided by providers who are not in the Blue Select networks will be treated as out-of-network services. Coinsurance paid for eligible services from a network provider when a Blue Select network provider is available will not apply to your out-of-pocket maximum. You can find providers who are in your Blue Select network, listed below, by accessing the Provider Directory at **IncludedHealth.com/Walmart**. Your plan ID card will also identify your specific network.

If your work location is not in one of the areas listed below but you receive services in one of these areas (e.g., you are traveling in one of these areas), you may use any network provider, including those not in the Blue Select networks.

If BlueAdvantage Administrators of Arkansas is your third-party administrator, you must access the Blue Select network for services to be treated as in-network if your work location is in one of the following areas:

- Florida: NetworkBlue
- Georgia: Blue Open Access POS
- Maryland, Northern Virginia, District of Columbia: BlueChoice Advantage Open Access
- Minnesota: High Value Network
- Missouri (Kansas City): Preferred-Care Blue
- New Hampshire: BlueChoice Open Access POS
- New Jersey: Horizon Managed Care Network
- Oklahoma: BluePreferred
- Pennsylvania: Community Blue Network
- Tennessee: Network S
- Wisconsin: Blue Preferred POS

For information about the Blue Select networks, call your health care advisor at the number on your plan ID card.

CENTERS OF EXCELLENCE NETWORK

In some cases, the AMP will not pay all or any benefit for services received from a network provider. See the **Centers of Excellence** section for information about network requirements when covered services include the following:

- Surgeries for certain heart conditions (age 18 and up)
- Medical record e-review by a Centers of Excellence facility for cardiac valve repair or replacement surgery (all ages) to determine if on-site cardiac valve surgery is recommended
- Medical record review by Mayo Clinic for certain types of cancer (all ages) to determine if an on-site evaluation is recommended; eligible types of cancer are breast, colorectal, lung, prostate, and blood (including myeloma, lymphoma, and leukemia)
- Medical record review by Mayo Clinic for outpatient kidney dialysis or end-stage renal disease (ESRD) (all ages) to determine if an on-site evaluation for kidney transplant evaluation is recommended
- Family-building treatment (age 18 and up) at Kindbody Signature Clinics, including but not limited to in vitro fertilization (IVF) and intrauterine insemination (IUI)
- Surgeries for certain spine conditions (age 18 and up, except for certain spine conditions, such as scoliosis)
- Hip or knee replacement surgery

- Liver, kidney, heart (including durable ventricular assist devices [VADs] and total artificial hearts), lung (including lung volume reduction surgery [LVRS]), pancreas, simultaneous kidney/pancreas, multiple organ, and bone marrow/stem cell transplants (including CAR T-cell treatment), and
- Weight loss surgeries, including gastric bypass, gastric sleeve, and duodenal switch (age 18 and up).

ADVANCED IMAGING NETWORK

If you participate in the Premier, Contribution, or Saver Plan options (but not a local plan option), an alternate network of providers for advanced imaging services (MRI and CT scans) may be available to you. The AMP benefit for advanced imaging services will depend on whether the provider is an *alternate network* provider, a network provider, or a non-network provider. The AMP will generally pay a greater portion of the cost of covered services received from an *alternate network* provider than those received from a network provider when an *alternate network* provider is available. The AMP will also pay a portion of the cost of covered services received from a non-network provider if your AMP option covers out-of-network services. However, the benefit paid by the AMP will generally be a smaller portion of the cost of covered services than the AMP pays for covered services received from an *alternate network* provider (or a network provider, if no *alternate network* provider is available). And, when you receive services from a non-network provider, you will be responsible for the cost of services in excess of the AMP's maximum allowable charge. If your AMP option does not cover out-of-network services, you will be responsible for the entire amount billed by the non-network provider. See **Provider networks** earlier in this chapter for a discussion of the difference between a network provider and a non-network provider.

Whether the coinsurance you pay for eligible medical expenses counts toward your out-of-pocket maximum depends on whether the provider is an *alternate network* provider, a network provider, or a non-network provider:

- If your provider is an *alternate network* provider, coinsurance will count toward your annual out-of-pocket maximum.
- If an *alternate network* provider is not available in your area and you receive covered services from a network provider, the AMP will pay the *alternate network* benefit amount, and coinsurance will count toward your annual out-of-pocket maximum.
- If an *alternate network* provider is available and you receive covered services from another provider, regardless of whether the provider is a network provider or non-network provider, coinsurance will not count toward your annual out-of-pocket maximum.

Preauthorization is required for advanced imaging services—see the **Preauthorization** section later in this chapter. Your health care advisor will assist you with any questions and can be reached at the number on your plan ID card.

WHEN NETWORK BENEFITS ARE PAID FOR OUT-OF-NETWORK SERVICES

In some cases, covered services you receive from a non-network provider may be treated as covered services received from a network provider. In these cases, the AMP will pay the in-network benefit rate, based on the maximum allowable charge used for non-network providers (rather than a contracted amount used for network providers), generally subject to other applicable AMP terms. Except as provided below, you will still be responsible for any amounts in excess of the maximum allowable charge. For emergency services and certain services received in a network facility from a non-network provider, such as anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, you will not be responsible for amounts in excess of the maximum allowable charge. If you receive other services at these network facilities, non-network providers cannot balance bill you for those amounts unless you give written consent. In most other cases, you will still be responsible for any amounts in excess of the maximum allowable charge. In some cases, you may have to pay for treatment when you receive it and file a claim for reimbursement.

Eligible medical expenses for covered services received from a non-network provider will be paid as if they were covered services received from a network provider in the following circumstances:

- If your dependent child under age 19 requires treatment at a Children's Miracle Network hospital.
- If there are no network providers with the relevant specialty within 30 miles of your home (not applicable to local plan options, Centers of Excellence services, or the services related to the travel benefit for complex care).
- Services for treatment received while on vacation or business travel in the U.S., where such treatment either could not have reasonably been foreseen prior to the travel or the course of treatment began prior to the travel and for medical reasons must be continued during such travel.
- If continuity of care protections, as described here, apply:
  - You are undergoing a course of treatment for a serious and complex condition, undergoing a course of institutional or inpatient care, scheduled to undergo nonelective surgery, or determined to be terminally ill. In these cases, covered services from a non-network provider are treated as covered services from a network provider until the effective date of the next Annual Enrollment, or 90 days after you are notified that the provider is no longer a network provider, whichever is

later; provided the course of treatment began when the provider was a network provider and there is no interruption of the doctor/patient relationship (for example, if you change TPAs during the year because of a change in work location and are in the middle of a course of treatment). Your non-network provider will not be permitted to bill you for the difference between the maximum allowable charge and the billed amount for covered services received during the 90-day period after you are notified that the provider is no longer in the network, or when you are no longer receiving treatment as a continuing care patient, if earlier.

- You are pregnant and undergoing a course of treatment for the pregnancy. In that case, covered services from a non-network provider are treated as covered services from a network provider for 90 days after you are notified that the provider is no longer a network provider or six weeks after delivery, whichever is later; provided services began when the provider was a network provider, and there is no interruption of the doctor/patient relationship. Your non-network provider will not be permitted to bill you for the difference between the maximum allowable charge and the billed amount for covered services received during the 90-day period after you are notified that the provider is no longer in the network, or when you are no longer receiving treatment as a continuing care patient, if earlier.
- You add coverage under the AMP and were utilizing an AMP non-network provider in a course of treatment begun prior to your effective date of coverage, where there is no interruption of the doctor/patient relationship. In that case, services from a non-network provider will be treated as services from a network provider until the next Annual Enrollment.

In the following additional instances, applicable law requires that a non-network provider will not be permitted to bill you for the difference between the provider's billed charges and the AMP's maximum allowable charge:

- If you receive emergency services from a non-network provider or a non-network emergency department
- If you receive covered services from a non-network provider at a network health care facility and have not given the non-network provider permission to bill you for the difference between the billed amount and the maximum allowable charge
- If you receive services from a non-network provider of air ambulance services that would be covered services under the AMP if provided by a network provider of air ambulance services

In addition, with respect to transport by ambulance (other than air ambulance), covered services received from a non-network provider may be treated as covered services received from a network provider. In that case, the portion of eligible medical expenses paid by the AMP is based on up to 200% of the maximum allowable charge if you are directly admitted to the hospital from an emergency department, or you pass away prior to hospital admission. You will still be responsible for any amounts in excess of 200% of the maximum allowable charge, subject to all other applicable AMP terms. For information about air ambulance coverage, call your health care advisor at the number on your plan ID card.

With respect to transport by out-of-network air ambulance services, out-of-network covered services will be treated as network covered expenses. Your cost-sharing will be the same as for network air ambulance services, and the amount on which your cost-sharing percentage is calculated will be based on the billed amount or the amount calculated under the Employee Retirement Income Security Act of 1974 ("ERISA"), whichever is less. The amounts paid by the AMP for out-of-network air ambulance services will be the amount negotiated by the AMP or the amount determined by the independent dispute resolution process required under ERISA. Under applicable law, the non-network air ambulance provider will not be permitted to bill you for the difference between the billed charges and the amount paid by the AMP.

COVERAGE WHEN YOU TRAVEL TO A FOREIGN COUNTRY

If you travel abroad, follow these steps:

- Before you begin your travel, contact your TPA for details about medical coverage and emergency medical services when traveling abroad. Coverage outside the United States may vary.
- Always carry your plan ID card with you when you travel and present it when you receive medical services.

Emergency, preventive, and telehealth services

EMERGENCY SERVICES

Benefits for emergency services are an important part of your AMP coverage. When you seek treatment in an emergency department for services that are not "emergency services" for an "emergency medical condition,"

your out-of-pocket costs could be significant, especially if the facility or provider is not in your AMP option's network. **Please review this section carefully.**

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

The emergency department copay is $300 per visit, whether you visit a network facility or not (unless you are admitted to the hospital from the emergency department or you pass away prior to admission). This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible.

If services you receive in an emergency department are "emergency services," the AMP will pay the cost of covered services as in-network benefits, which is 100% after you have met your network deductible and paid the $300 copay, even if the emergency department or provider is a non-network provider or facility. The AMP payment to a non-network provider or facility will be based on the amount negotiated by the AMP or the amount determined by the independent dispute resolution process required under the Employee Retirement Income Security Act of 1974. The non-network provider or facility will not be permitted to bill you for the difference between the billed amount and the amount paid by the AMP.

If, after a retrospective review, when deciding your non-network provider or facility post-service claim, the TPA determines that a prudent layperson would not consider the medical condition to have been an emergency medical condition, services will be subject to all applicable AMP terms. If your AMP option has out-of-network coverage, the AMP will pay 50% of the maximum allowable charge for covered services after you have met your out-of-network deductible, and you will be responsible for paying the deductible, the copay of $300, the coinsurance, and amounts in excess of the maximum allowable charge for medical services provided in the emergency department of a non-network facility. If you are enrolled in the Premier, Contribution, or Saver Plan options in Chicago metro, Oklahoma, Texas, or northwest Arkansas, the AMP will pay 50% of the maximum allowable charge for covered services after you have met your network deductible, the copay of $300, the coinsurance, and amounts in excess of the maximum allowable charge. If you are in a local plan option, services received from a non-network provider or facility will not be paid by the AMP, and you will be responsible for the entire amount. You will be able to appeal the TPA's determination under the post-service claims procedures (including external review) described in the **Claims and appeals** chapter.

If the provider or facility is a network facility, the AMP will pay 100% of covered services after you have met your annual deductible, regardless of whether the third-party administrator determines that the visit is for an "emergency medical condition," subject to the $300 copay.

PREVENTIVE SERVICES

The AMP will pay all or a portion of the cost of covered preventive services before you meet your applicable deductible according to the following terms:

- If you are enrolled in one of the **Premier, Contribution,** or **Saver Plan options/nationwide**: the AMP will pay 100% of the cost of covered preventive services received from a network provider. If the provider is a non-network provider, the AMP will pay 50% of the cost of covered services, and amounts you pay will not apply to your deductible or out-of-pocket maximum.
- If you are enrolled in one of the **Premier, Contribution,** or **Saver Plan options in central, northeast, or south Florida; Chicago metro; or Oklahoma, or Texas**, the AMP will pay 100% of the cost of covered preventive services received from a *preferred* network provider. If the provider is a *nonpreferred* network provider (or a non-network provider in central, northeast, or south Florida), the AMP will pay 50% of the cost of covered preventive services. Amounts paid for covered preventive services from a *nonpreferred* network provider will count toward your network deductible and out-of-pocket maximum but amounts paid for preventive services from a non-network provider will not. Only central, northeast, and south Florida have out-of-network coverage.
- If you are enrolled in one of the **Premier, Contribution,** or **Saver Plan options/northwest Arkansas**: the AMP will pay 100% of the cost of covered preventive services received from a network provider. This AMP option does not provide out-of-network coverage.
- If you are enrolled in one of the **local plans**: the AMP will pay 100% of the cost of covered preventive services received from a network provider. This AMP option does not provide out-of-network coverage.

If your AMP option provides out-of-network coverage, and covered preventive services are provided by a non-network provider, you are also responsible for any amount above the maximum allowable charge.

Detailed information about what services are preventive services can be found in the **Preventive care program** section later in this chapter.

TELEHEALTH VIDEO VISITS THROUGH DOCTOR ON DEMAND BY INCLUDED HEALTH

You have access to Doctor On Demand by Included Health, a telehealth service offering video medical (including urgent care) and mental health visits. Doctor On Demand doctors can diagnose, treat, and write prescriptions for a wide range of non-emergency medical issues. The service is available in all 50 states, 24 hours a day, seven days a week by computer, tablet, or smartphone. You will need to download the Doctor On Demand app from the App Store or Google Play.

Doctor On Demand is available at no cost for most AMP options. If you are in the Saver Plan option, you must first meet your network deductible, after which Doctor On Demand visits are available at no cost to you. For information about services and technical requirements, visit Doctor On Demand online at **DoctorOnDemand.com/Walmart** or call **800-997-6196**.

Telehealth services outside of Doctor On Demand will be paid under the otherwise applicable AMP terms (for example, the same as outpatient doctor visits), as allowed by the AMP.

Centers of Excellence

The Centers of Excellence program works with specific facilities to provide covered services related to a range of conditions and illnesses. Through this program, you and your covered dependents have access to specialized providers and facilities selected for their expertise in certain complex procedures.

The AMP and each Centers of Excellence facility are considered an "Organized Health Care Arrangement" (OHCA) for purposes of the HIPAA privacy rules. This means that the AMP and each Centers of Excellence facility may share information for the purposes of determining eligibility for and administering the Centers of Excellence program, as permitted by HIPAA.

The Centers of Excellence program covers:

- Surgeries for certain heart conditions (age 18 and up)
- Medical record e-review by a Centers of Excellence facility for cardiac valve repair or replacement surgery (all ages) to determine if on-site cardiac valve surgery is recommended
- Medical record review by Mayo Clinic for certain types of cancer (all ages) to determine if an on-site evaluation is recommended; eligible types of cancer are breast, colorectal, lung, prostate, and blood (including myeloma, lymphoma, and leukemia)
- Medical record review by Mayo Clinic for outpatient kidney dialysis or end-stage renal disease (ESRD) (all ages) to determine if an on-site evaluation for kidney transplant evaluation is recommended
- Family-building treatment (age 18 and up) at Kindbody Signature Clinics, including but not limited to in vitro fertilization (IVF) and intrauterine insemination (IUI)
- Surgeries for certain spine conditions (age 18 and up, except for certain spine conditions, such as scoliosis)
- Hip or knee replacement surgery
- Liver, kidney, heart (including durable ventricular assist devices [VADs] and total artificial hearts), lung (including lung volume reduction surgery [LVRS]), pancreas, simultaneous kidney/pancreas, multiple organ, and bone marrow/stem cell transplants (including CAR T-cell treatment), and
- Weight loss surgeries, including gastric bypass, gastric sleeve, and duodenal switch (age 18 and up).

In performing evaluation services or in making determinations about Centers of Excellence care, the Centers of Excellence facility is not acting as agent for the AMP, but as your health care provider. If you receive services at a Centers of Excellence facility that is not part of the Centers of Excellence program, those services will be subject to terms and conditions described in this section and in the chart on the following page, in the **Outside of Centers of Excellence Program** column, even if they are received from a network provider. As shown in that chart, certain covered services received at a Centers of Excellence facility are covered at 100% before your annual deductible is met (excluding family-building and weight loss surgery). However, if you are enrolled in the Saver Plan, you must meet your annual network deductible before the AMP will pay any benefits.

The chart on the following page is a summary only. Read all of the information in this section to understand all Centers of Excellence program requirements and restrictions, including when exceptions may apply to permit you to receive covered services at a non-Centers of Excellence facility under regular AMP terms and conditions of coverage.

CENTERS OF EXCELLENCE			
	Centers of Excellence Program		Outside of Centers of Excellence Program
	Administrator[1]	Coverage	
Heart surgery Including cardiac valve repair/replacement Requires a cardiac valve eReview by Cleveland Clinic	**Contigo Health 877-230-7037**	100% No deductible[2]	Regular AMP terms and conditions apply
Cancer medical record review May include on-site evaluation and treatment, when recommended by Mayo Clinic Eligible cancer types: breast, colorectal, lung, prostate, blood (including myeloma, lymphoma, leukemia)	**HealthSCOPE Benefits 800-804-1289**		
Outpatient kidney dialysis or ESRD medical records review May include on-site kidney transplant evaluation, when recommended by Mayo Clinic	**HealthSCOPE Benefits 479-621-2830**		
Family-building treatment at Kindbody Signature Clinics Subject to $20,000 maximum lifetime benefit (medical and pharmacy expenses) per individual AMP participant	**Your medical plan administrator (see plan ID card)** **Travel by HealthSCOPE Benefits 800-804-1289**	75% After network deductible	No coverage
Hip and knee replacement	**Contigo Health 877-230-7037**	100% No deductible[2]	**Premier, Contribution, Saver Plan options in areas other than central, northeast, and south Florida; Chicago metro; select counties of Oklahoma and Texas; and northwest Arkansas:**[3] 50% after out-of-network deductible Coinsurance will not apply to out-of-pocket maximum
			Premier, Contribution, Saver Plan options in central, northeast, and south Florida; Chicago metro; select counties of Oklahoma and Texas; and northwest Arkansas:[3] 50% after network deductible if *preferred* network provider is used (in northwest Arkansas, a network provider) Coinsurance will not apply to out-of-network deductible, if applicable, or out-of-pocket maximum[4] No coverage[4] for *nonpreferred* network provider, where applicable, or non-network provider in northwest Arkansas
			Local plans: No coverage[4]
Spine surgery	**Contigo Health 877-230-7037**	100% No deductible[2]	No coverage[4]
Transplant Mayo Clinic only. Excludes cornea and intestinal transplant	**HealthSCOPE Benefits 479-621-2830**	100% No deductible[2]	No coverage[4]
Weight loss surgery Gastric bypass, gastric sleeve, and duodenal switch	**Contigo Health 877-230-7037**	75% After network deductible	No coverage

[1] If you are enrolled in a local plan, call your health care advisor to be directed to the appropriate administrator.
[2] Participants enrolled in the Saver Plan option must meet their network annual deductible before the AMP pays any benefits.
[3] See **AMP options available to you** earlier in this chapter for the specific counties included in these areas.
[4] Exceptions may apply. See the specific program details in this section.

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

GENERAL REQUIREMENTS TO PARTICIPATE IN THE CENTERS OF EXCELLENCE PROGRAM

To participate in the Centers of Excellence program:

- Services must be preauthorized by the applicable Centers of Excellence program administrator. The specific administrator from whom preauthorization must be obtained varies, depending on the service to be provided and your AMP option. See the **Centers of Excellence** chart on the previous page.
- Your preauthorization request will be a pre-service claim (or urgent claim, if applicable), as described in the **Claims and appeals** chapter. If your request for preauthorization of a Centers of Excellence service is denied, you have the right to appeal. See the **Claims and appeals** chapter for information.
- You acknowledge that the Centers of Excellence facility must receive necessary medical records prior to your acceptance into the Centers of Excellence program.
- For most covered services, you must be able to safely travel for medical care and must not require emergency care at the time of travel.
- The specific Centers of Excellence facility providing covered services under the Centers of Excellence program is determined by where you live and the indicated service.
- For most services offered under the Centers of Excellence program, you must supply contact information for a local physician who has agreed to manage your follow-up care after you return home from the Centers of Excellence facility.
- For most covered services, you must identify a designated caregiver who is willing and able to meet caregiver requirements, which will be explained to you by the Centers of Excellence program administrator.
- You acknowledge that you, your caregiver, and any visitors must abide by all rules and policies of the hotel, transport service, and Centers of Excellence facility, including those that apply to on-site conduct. Failure to do so may result in loss of eligibility for benefits under the Centers of Excellence program.
- Services performed at a Centers of Excellence facility that are outside the scope of services covered by the Centers of Excellence program are subject to regular AMP terms and conditions of coverage.
- For hip or knee replacement or spine surgery, you must certify that your injury (if applicable) will not result in litigation with a third party, is not subject to the AMP's subrogation and reimbursement rights as described in the **Claims and appeals** chapter, and is not a compensable injury, as defined by applicable workers' compensation law.
- If you are eligible for, or covered by, more than one medical plan, including Medicare (such as if you are enrolled in Medicare Part A but are not enrolled in Medicare Part B), the AMP must be the primary payer. If there is a possibility that any other medical plan is or could have been the primary payer under any circumstance (if you had enrolled in that plan), contact the Centers of Excellence program administrator listed in the chart on the previous page for more information about your eligibility for the Centers of Excellence program.

If the Centers of Excellence provider determines that you are not a medically appropriate candidate for Centers of Excellence services at that specific Centers of Excellence facility, the AMP may pay a benefit for covered services under otherwise applicable AMP terms, where you are determined to be medically eligible for such services.

If you receive services from a Centers of Excellence provider through the Centers of Excellence program, travel benefits may be provided for travel to a Centers of Excellence facility and may include airfare, mileage, lodging, and a daily expense allowance for food and other expenses, for both you and a caregiver. Travel benefits must be pre-approved and scheduled through the Centers of Excellence program administrator (for travel benefits). Some travel benefits are considered taxable earnings and will be reflected on the enrolled associate's Form W-2. Travel benefits are subject to applicable IRS and AMP limits.

IF YOU RECEIVE ELIGIBLE TREATMENT OUTSIDE THE CENTERS OF EXCELLENCE PROGRAM

If you receive services for a medical condition that would be covered services under the Centers of Excellence program, from: 1) a provider or facility that is not part of the Centers of Excellence program, or 2) a provider or facility that is otherwise a part of the Centers of Excellence program, but you do not work through the Centers of Excellence program administrator, you will be subject to terms summarized in the **Centers of Excellence** chart on the previous page, unless you have received an exception. In some cases, absent an exception, the AMP will not pay any benefit if otherwise eligible services are not provided through the Centers of Excellence program, even if the services were provided by a network provider. See the **Hip or knee replacement and spine surgery** and **Transplants** sections later in this chapter for important exceptions.

Under limited circumstances, the AMP provides out-of-network coverage for hip or knee replacement as described below in the **Hip or knee replacement and spine surgery** section and summarized in the **Centers of Excellence** chart on the previous page.

Services you receive prior to arrival at, or following discharge from, a Centers of Excellence facility, including services approved or recommended by the Centers of Excellence program provider, are subject to regular AMP terms and conditions of coverage. Services performed at a Centers of Excellence facility that are outside the scope of services covered under the Centers of Excellence program are subject to regular AMP terms and conditions of coverage.

HEART SURGERY AND VALVE REPAIR/REPLACEMENT E-REVIEW

Before receiving non-emergency services to repair or replace a cardiac valve, you may want to consider an eReview by Cleveland Clinic. Contact your health care advisor at the phone number on your plan ID card to start the eReview process. If you are eligible and choose to participate in the Centers of Excellence program for heart surgery, you will be connected with Contigo Health.

If you are eligible to participate in the Centers of Excellence program for heart surgery or valve repair/replacement eReview and you choose to do so, the AMP will pay 100% of the cost of covered services received through the Centers of Excellence program. Eligible medical expenses will be paid before you meet your deductible unless you are enrolled in the Saver Plan option. If you are enrolled in the Saver Plan option, you must meet your annual network deductible before the AMP pays any benefit.

If you choose not to participate in the Centers of Excellence program, the AMP will pay the cost of covered services after your deductible is met, subject to all other regular AMP terms and conditions of coverage.

CANCER MEDICAL RECORD REVIEW

The cancer medical record review includes a three-step process:

- **Review of medical records.** If you are eligible to participate in the Centers of Excellence program for a cancer medical record review, the program administrator will first send your medical records to Mayo Clinic to determine whether Mayo Clinic recommends that you travel to Mayo Clinic for an on-site evaluation. There is no guarantee that Mayo Clinic will recommend travel for an on-site evaluation.
- **Possible travel to Mayo Clinic for on-site evaluation.** If Mayo Clinic does recommend that you travel to Mayo Clinic for an on-site evaluation, and you choose to have that evaluation, there is no guarantee that Mayo Clinic will recommend further treatment at Mayo Clinic.
- **Possible treatment at Mayo Clinic.** Mayo Clinic may recommend treatment at Mayo Clinic, but there is no guarantee that they will do so.

Cancer types available for medical review are breast, lung, colorectal, prostate, and blood (including myeloma, lymphoma, and leukemia) cancers.

If you are eligible to participate in the Centers of Excellence program for cancer medical review and choose to do so, the AMP will pay 100% of the cost of covered services received from Mayo Clinic through the Centers of Excellence program. Eligible medical expenses will be paid before you meet your deductible unless you are enrolled in the Saver Plan option. If you are enrolled in the Saver Plan option, you must meet your annual network deductible before the AMP pays any benefit.

If you choose not to participate in the Centers of Excellence program, the AMP will pay the cost of covered services after your deductible is met, subject to all other regular AMP terms and conditions of coverage.

KIDNEY DIALYSIS OR ESRD MEDICAL RECORD REVIEW

If you have been diagnosed with end-stage renal disease (ESRD), are on kidney dialysis, or kidney dialysis has been recommended as a course of treatment, you may benefit from the Centers of Excellence program for kidney dialysis or ESRD medical record review by Mayo Clinic, which includes a three-step process:

- **Review of medical records.** If you are eligible to participate in the Centers of Excellence program for a kidney dialysis record review, the program administrator will first send your medical records to Mayo Clinic to determine whether Mayo Clinic recommends that you travel to Mayo Clinic for an on-site evaluation. There is no guarantee that Mayo Clinic will recommend travel for an on-site evaluation.
- **Possible travel to Mayo Clinic for on-site evaluation.** If Mayo Clinic does recommend that you travel to Mayo Clinic for an on-site evaluation, and you choose to have that evaluation, there is no guarantee that Mayo Clinic will recommend further treatment at Mayo Clinic.
- **Possible treatment at Mayo Clinic.** Mayo Clinic may recommend treatment at Mayo Clinic, but there is no guarantee that they will do so. If Mayo Clinic recommends a kidney transplant, coverage for a kidney transplant is only available under the Centers of Excellence program for transplants. See **Transplants** later in this section for additional information.

If you are eligible to participate in the Centers of Excellence program for kidney dialysis or ESRD medical record review and choose to do so, the AMP will pay 100% of the cost of covered services received from Mayo Clinic through the Centers of Excellence program. Eligible medical expenses will be paid before you meet your deductible, unless you are enrolled in the Saver Plan option. If you are enrolled in the Saver Plan option, you must meet your annual network deductible before the AMP pays any benefit.

If you are eligible to participate in the Centers of Excellence program for kidney dialysis or ESRD medical record review and choose not to do so, the AMP will pay the cost of covered services after your deductible is met, subject to all other regular AMP terms and conditions of coverage.

If a transplant is recommended, see the **Transplants** section later in this chapter for Centers of Excellence terms and conditions applicable to transplant services.

FAMILY BUILDING

The Centers of Excellence program for family-building services provides fertility treatment benefits, including in vitro fertilization (IVF), intrauterine insemination (IUI), and other approved medical and pharmacy services as described below, from Kindbody Signature Clinics. Program participants must be age 18 or over.

If you are eligible to participate in the Centers of Excellence program and choose to do so, the AMP will pay 75% of eligible medical expenses, including fertility medications, for covered services received from a Kindbody Signature Clinic through the Centers of Excellence program for family building, after your network deductible is met, up to a $20,000 maximum lifetime benefit. Covered services received through the Centers of Excellence program are subject to the AMP's regular terms and conditions of coverage, including the application of eligible medical expenses paid by you to your deductible and the application of coinsurance to your out-of-pocket maximum unless otherwise provided. See **Annual deductible** and **Annual out-of-pocket maximum** in the **Evaluating your options** section earlier in this chapter for exceptions.

The AMP will not allow any benefits after you have reached the $20,000 maximum lifetime benefit. The $20,000 maximum is per individual AMP participant. This maximum lifetime benefit amount will not be reset, even if you terminate employment and are rehired, regardless of when you terminate or are rehired. It will also not reset if you are currently an eligible dependent enrolled in the AMP and then become a Walmart associate who is directly eligible to enroll in medical coverage (or if you are currently a Walmart associate enrolled in the AMP and then become an eligible dependent under another associate's medical coverage). The $20,000 maximum lifetime benefit does not apply to services outside the Centers of Excellence program that may be covered under other AMP terms and conditions of coverage, independent of the Centers of Excellence program.

If you do not participate in the Centers of Excellence program, the AMP will not cover fertility treatment services received from a provider other than Kindbody or outside the Centers of Excellence program unless those services are otherwise covered services under other AMP terms and conditions of coverage.

Covered comprehensive fertility services include:

- In vitro fertilization (IVF)—fresh and frozen
- Intrauterine insemination (IUI)
- Frozen embryo transfers
- Frozen oocyte thaw and fertilization
- Preimplantation genetic testing (PGT-A; PGT-M, etc.)
- Donor eggs, embryos, and sperm (considered taxable)
- Cryopreservation (freezing) of oocyte (egg)/embryo/sperm (based on approved criteria managed by Kindbody, including but not limited to tissue storage following a cancer diagnosis, even if the patient is under the age of 18). Payment for storage of cryopreserved oocyte/embryo/sperm will be provided for one year. Payment for additional years of storage will be your responsibility.

Fertility medications will be filled through Kindbody's specialty pharmacy, Schraft's Pharmacy, and processed through AMP medical coverage, subject to AMP terms and conditions of coverage, including the $20,000 maximum lifetime benefit.

If you are interested in participating in the Centers of Excellence program for family building, you should contact the number on your plan ID card. You will begin with an initial consultation with a Kindbody Signature Clinic clinician, either virtually or in person, to begin the development of a personalized care plan. Kindbody provides a dedicated patient care navigator to provide program support to you and your family throughout the process.

HIP OR KNEE REPLACEMENT AND SPINE SURGERY

If you are eligible to participate in the Centers of Excellence program for hip or knee replacement and spine surgery, and choose to do so, the AMP will pay 100% of the cost of covered services received from the Centers of Excellence program provider and facility. Eligible medical expenses will be paid before you meet your deductible unless you are enrolled in the Saver Plan option. If you are enrolled in the Saver Plan option, you must meet your annual network deductible before the AMP pays any benefit.

If you are eligible to participate in the Centers of Excellence program for hip or knee replacement and choose not to do so, the AMP may pay a portion of the cost of covered services you receive outside the Centers of Excellence program unless you request and receive a network exception. See the **Centers of Excellence** chart earlier in this chapter and in the **Hip or knee replacement** section on the following page. If you request and receive a network exception, as discussed below, the AMP will pay the cost of covered services received outside the Centers of Excellence program for hip or knee replacement, subject to the AMP's regular terms and conditions of coverage.

If you are eligible to participate in the Centers of Excellence program for spine surgery and choose not to do so, the AMP will not pay the cost of any services received outside the Centers of Excellence program unless a network exception is requested and received.

A decision not to move forward with hip or knee replacement or spine surgery by the respective Centers of Excellence provider is not subject to review under this process if the Centers of Excellence provider decides not

to: 1) treat you based on your refusal to follow the terms and conditions of the Centers of Excellence Program, including the rules and policies listed elsewhere in this chapter, or 2) determines that the procedure is not appropriate because you refuse to comply with medical restrictions or requirements including but not limited to weight loss, smoking cessation, alcohol cessation, social support, conduct, or similar factors.

Hip or knee replacement

If you choose not to participate in the Centers of Excellence program for hip or knee replacement, the AMP may pay only limited benefits for covered services if you receive treatment outside the Centers of Excellence program. Absent a network exception, as discussed later in this chapter, services received outside the Centers of Excellence program will generally be considered out-of-network, even if the provider is a provider in your AMP option's network. In this case, the Centers of Excellence program's terms and conditions of coverage are as follows:

- If you are enrolled in the **Premier, Contribution, Saver Plan options in areas other than northwest Arkansas; central, northeast, or south Florida; Chicago metro; Oklahoma; or Texas**, you will be required to meet the out-of-network annual deductible before the AMP pays any costs for covered services. After your out-of-network deductible is met, the AMP will pay 50% of eligible medical expenses for covered services, regardless of whether the services are provided by a network or non-network provider. Coinsurance will not count toward your out-of-pocket maximum. See the **Requests for exceptions to coverage terms for hip or knee replacement or spine surgery** section on this page for details on how to request a network exception.
- If you are enrolled in the **Premier, Contribution, Saver Plan options in northwest Arkansas; central, northeast, or south Florida; Chicago metro; Oklahoma; or Texas**, you will be required to meet the network annual deductible before the AMP pays any costs for covered services. After your deductible is met, the AMP will pay 50% of the cost of covered services received from a *preferred* network provider (for northwest Arkansas, the AMP will pay 50% of the cost of covered services received from a network provider). Your coinsurance will not apply toward your out-of-network deductible, if applicable, or out-of-pocket maximum. The AMP will not pay any benefit if you receive services from a *nonpreferred* network provider or a non-network provider, if applicable. See the **Requests for exceptions to coverage terms for hip or knee replacement or spine surgery** section on this page for details on how to request a network exception.
- If you are enrolled in a **local plan** option, the AMP will not pay the cost of any services received outside the Centers of Excellence program unless you request and receive an exception. See the **Requests for exceptions to coverage terms for hip or knee replacement or spine surgery** section on this page for details on how to request a network exception.

If you request and receive a network exception, as discussed in the **Requests for exceptions to coverage terms for hip or knee replacement or spine surgery** section on this page, the AMP will pay the cost of covered services received outside the Centers of Excellence program for hip or knee replacement, subject to the AMP's regular terms and conditions of coverage.

Spine surgery

If you choose not to participate in the Centers of Excellence program for spine surgery, the AMP will not pay the cost of any services received outside the Centers of Excellence program unless a network exception is requested and received. If you request and receive a network exception, as discussed in the **Requests for exceptions to coverage terms for hip or knee replacement or spine surgery** section on this page, the AMP will pay the cost of covered services received outside the Centers of Excellence program for spine surgery, subject to the AMP's regular terms and conditions of coverage.

Physical therapy for hip or knee replacement and spine surgery

If you participate in the Centers of Excellence programs for hip or knee replacement or spine surgery, you may have access to digital physical therapy. This app-based approach is designed to help you prior to and after surgical procedures. Services will be at no cost to you unless you are enrolled in the Saver Plan. If you are in the Saver Plan, you must meet your annual network deductible before the AMP pays any benefit. This service is not available outside of the Centers of Excellence program, including when a network exception is granted for hip or knee replacement or spine surgery. Contact Contigo Health, the program administrator, for more details on this program.

Requests for exceptions to coverage terms for hip or knee replacement or spine surgery

You may request an exception to the general Centers of Excellence terms and conditions of coverage, described above. If you request and receive a network exception, the AMP will pay the cost of covered services received outside the Centers of Excellence program, after your deductible is met and subject to all other regular AMP terms and conditions of coverage. The network exception process is summarized, below, and discussed in more detail in the section in the **Claims and appeals** chapter titled **Spine surgery and hip and knee replacement: requesting network exception for coverage outside the Centers of Excellence program**.

Depending on whether you have already received services when you request a network exception, your request will be treated as a pre-service claim ("pre-service exception request") or a post-service claim ("post-service exception

request") as described in detail in the section in the **Claims and appeals** chapter titled **Spine surgery and hip and knee replacement: requesting network exception for coverage outside the Centers of Excellence program**. The section in this chapter only summarizes those rules.

Pre-service exception request: If you have not yet received treatment but are considering receiving services from a non-Centers of Excellence provider or facility, you may file a pre-service exception request if:

- There is significant risk that travel to the Centers of Excellence facility could result in paralysis or loss of life, or
- The Centers of Excellence facility does not recommend hip or knee replacement or spine surgery because it is not the appropriate medical course of treatment, or you are not an appropriate candidate for surgery.

Pre-service exception requests should be filed with Contigo Health at the address and in accordance with the procedures described in the section in the **Claims and appeals** chapter titled **Spine surgery and hip and knee replacement: requesting network exception for coverage outside the Centers of Excellence program**. An Independent Review Organization will review your request. If your request is granted, the AMP will pay the cost of covered services received outside the Centers of Excellence program, subject to the AMP's regular terms and conditions of coverage. If your request is denied, you will be permitted to file an internal appeal of the denial, which will be determined by an Independent Review Organization. Your request for an internal appeal should be filed with the AMP at the address and in accordance with the procedures described in the section in the **Claims and appeals** chapter titled **Spine surgery and hip and knee replacement: requesting network exception for coverage outside the Centers of Excellence program**. If the initial denial is overturned and the request is granted, the AMP will pay the cost of covered services received outside the Centers of Excellence program, subject to the AMP's regular terms and conditions of coverage. If your internal appeal is denied, you will be permitted to request an external review if the denial was based on medical judgment. Your request for an external review of the denial should be filed with the AMP at the address and in accordance with the procedures described in the **External appeal process for medical, pharmacy, or Centers of Excellence benefits** in the **Claims and appeals** chapter.

Post-service exception request: If you already have received services from a non-Centers of Excellence provider, you may file a post-service exception request if your circumstances called for immediate surgery, without which you would have likely suffered paralysis or loss of life.

Post-service exception requests should be filed with the AMP at the address and in accordance with the procedures described in the section in the **Claims and appeals** chapter titled **Spine surgery and hip and knee replacement: requesting network exception for coverage outside the Centers of Excellence program**. An Independent Review Organization will review your request. If your request is granted, the AMP will pay the cost of covered services received outside the Centers of Excellence program, subject to the AMP's regular terms and conditions of coverage. If your request is denied, you will be permitted to file an internal appeal of the denial, which will be determined by an Independent Review Organization. Your request for an internal appeal should be filed with the AMP at the address and in accordance with the procedures described in the section in the **Claims and appeals** chapter titled **Spine surgery and hip and knee replacement: requesting network exception for coverage outside the Centers of Excellence program**. If the initial denial is overturned and the request is granted, the AMP will pay the cost of covered services received outside the Centers of Excellence program, subject to the AMP's regular terms and conditions of coverage. If your internal appeal is denied, you will be permitted to request an external review if the denial was based on medical judgment. Your request for an external review of the denial should be filed with the AMP at the address and in accordance with the procedures described in the section in the **Claims and appeals** chapter titled **External appeal process for medical, pharmacy, or Centers of Excellence benefits**.

TRANSPLANTS

The Centers of Excellence program for transplants performed at Mayo Clinic covers liver, kidney, heart (including durable ventricular assist devices [VADs] and total artificial hearts), lung (including lung volume reduction surgery [LVRS]), pancreas, simultaneous kidney/pancreas, multiple organ, and bone marrow/stem cell transplants (including CAR T-cell treatment). Transplant services are subject to a 12-month waiting period. See the discussion of waiting periods on the following page.

Cornea and intestinal transplant services are not covered under the Centers of Excellence program but may be covered services under regular AMP terms and conditions of coverage. Cornea and intestinal transplants are subject to the 12-month waiting period. See the discussion of waiting periods on the following page.

You will be required to undergo a pretransplant evaluation at Mayo Clinic. Mayo Clinic will then make a recommendation regarding whether a transplant is an appropriate medical course of treatment or whether you are not an appropriate candidate for transplant services under the Centers of Excellence program.

If you are eligible to participate in the Centers of Excellence program for transplants, and choose to do so, the AMP will pay 100% of the cost of covered services received from Mayo Clinic. Eligible medical expenses will be paid before you meet your deductible unless you are enrolled in the Saver Plan option. If you are enrolled in the Saver Plan option, you must meet your annual network deductible before the AMP pays any benefit. Services unrelated to a transplant, as determined by Mayo Clinic, that are

performed at Mayo Clinic are not covered by the Centers of Excellence program for transplants. Those services will be subject to regular AMP terms and conditions of coverage. This includes certain gastric-sleeve procedures performed at Mayo Clinic during a liver transplant.

If you choose not to participate in the Centers of Excellence program for transplants, the AMP will not pay the cost of any services received outside the Centers of Excellence program, unless a network exception is requested and received.

If you request and receive a network exception, as discussed in the section in the **Claims and appeals** chapter titled **Transplant services: requesting network exception for coverage outside the Centers of Excellence program**, the AMP will pay the cost of covered services received outside the Centers of Excellence program for transplants, subject to the AMP's regular terms and conditions of coverage.

Coverage under the Centers of Excellence program is limited to transplantation of human organs. The AMP does not cover transplantation of body parts (e.g., face, hands, feet, legs, arms, uterus) under any circumstances.

Experimental and/or investigational transplant-related services are not covered under the Centers of Excellence program unless those services are recommended and performed by Mayo Clinic.

Benefits under the Centers of Excellence program for transplants end on the earlier of one year post-transplant or after a one-year post-transplant evaluation is performed.

Exception for pediatric transplant recipients under age 19: Pediatric transplant recipients under age 19 (except for cornea and intestinal transplants) must undergo a pre-transplant review at Mayo Clinic. If Mayo Clinic determines that a transplant is the correct treatment plan, and you choose to participate in the Centers of Excellence program and receive Centers of Excellence services at Mayo Clinic, the AMP will pay 100% of the cost of covered services as described above. If you choose not to participate in the Centers of Excellence program through Mayo Clinic, the AMP will pay the cost of covered services received outside the Centers of Excellence program for transplants, subject to the AMP's regular terms and conditions of coverage. In that case, a network exception will be provided.

Transplant donor expenses: The AMP will generally pay eligible medical expenses for covered services provided to a recipient (who is enrolled in the AMP option), unless another medical plan or insurer covers those services. Only covered services directly related to being a donor for the recipient (who is enrolled in the AMP option) are covered ("donor services"). If the donor is a living donor and requires post-transplant services (directly related to the transplant), the AMP will pay eligible medical expenses for covered services.

The AMP will pay eligible medical expenses for covered donor services received within 120 days of your transplant at the same benefit level as your transplant services.

The AMP may also pay travel expenses of the donor, provided those expenses relate directly to being a donor for you. Those travel expenses are generally subject to the same terms and conditions that apply to travel benefits available to you, the recipient. It is your responsibility to provide contact information for the Centers of Excellence program administrator to the eligible transplant donor, prior to appointments.

Cadaver organ acquisition and procurement expenses are covered only when the expenses are part of the provider's contracted rate with the AMP's TPA.

12-month waiting period

To be eligible for transplant, lung volume reduction surgery (LVRS), or CAR T-cell treatment coverage under the Centers of Excellence program, you must be enrolled in the AMP for at least 12 months. The 12-month waiting period does not apply to insertion of durable ventricular assist devices (VADs) or artificial hearts, regardless of whether the VAD is related to a transplant.

Cornea and intestinal transplant services are not covered under the Centers of Excellence program but may be covered services under regular AMP terms and conditions of coverage. However, the 12-month waiting period applicable to transplants that are covered under the Centers of Excellence program also applies to cornea and intestinal transplants.

If you are enrolled in the PPO Plan or an HMO plan option, you are not eligible for the Centers of Excellence program described in this chapter. However, if you later enroll in one of the eligible AMP options, your time enrolled in the PPO Plan or an HMO plan option will count toward the 12-month waiting period. Any time enrolled in critical illness insurance or accident insurance will not count toward the 12-month waiting period.

The 12-month waiting period applies to you and, separately, to each of your covered dependents, except as provided below; i.e., each covered individual must meet their own 12-month waiting period. However, if you enroll a new covered dependent in the AMP as the result of birth or adoption (must be under the age of 19) and that coverage is effective as of the child's birth or adoption date, respectively, the 12-month waiting period will be waived for your new dependent, provided you have met your 12-month waiting period, subject to other conditions in this section.

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

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

coverage, prior time enrolled in the AMP will not count toward the 12-month waiting period, and you must meet a new 12-month waiting period following your reenrollment.

For all types of transplant services—those covered under the Centers of Excellence program and those that are not—the 12-month waiting period may be waived if the covered individual's treating physician certifies that, absent the transplant, the covered individual's death is imminent within 48 hours. To request this waiver, you must file a preauthorization request. See the section in the **Claims and appeals** chapter titled **Special appeal procedures for Centers of Excellence** for information on requesting a waiver.

If your doctor recommends a transplant, call HealthSCOPE Benefits at **479-621-2830**.

Requests for exceptions to coverage terms for transplants

You may request a pre-service network exception to the general Centers of Excellence terms and conditions of coverage, described above, to receive transplant services at a facility other than Mayo Clinic. If you request and receive a pre-service network exception, the AMP will pay the cost of covered services received outside of the Centers of Excellence program, after your deductible is met and subject to all other regular AMP terms and conditions of coverage. The pre-service network exception process is summarized below, and discussed in more detail in the section in the **Claims and appeals** chapter titled **Transplant services: requesting network exception for coverage outside the Centers of Excellence program**.

Pre-service exception request: If you have not yet received treatment, you may request a pre-service network exception to receive transplant services at a facility other than Mayo Clinic if:

- There is significant risk that travel to Mayo Clinic could result in loss of life, or
- Mayo Clinic recommends that a transplant is not an appropriate medical course of treatment or you are not an appropriate candidate for transplant services.

Pre-service exception requests should be filed with the AMP at the address and in accordance with the procedures described in the section in the **Claims and appeals** chapter titled **Transplant services: requesting network exception for coverage outside the Centers of Excellence program**. An Independent Review Organization will review your request. If your request is granted, the AMP will pay the cost of covered services received outside the Centers of Excellence program, subject to the AMP's regular terms and conditions of coverage. If your request is denied, you will be permitted to file an internal appeal of the denial, which will be determined by an Independent Review Organization. Your request for an internal appeal should be filed with the AMP at the address and in accordance with the procedures described in the section in the **Claims and appeals** chapter titled **Transplant services: requesting network exception for coverage outside the Centers of Excellence program**.

If the initial denial is overturned and the request is granted, the AMP will pay the cost of covered services received outside the Centers of Excellence program, subject to the AMP's regular terms and conditions of coverage. If your internal appeal is denied, you will be permitted to request an external review if the denial was based on medical judgment. Your request for an external review of the denial should be filed with the AMP at the address and in accordance with the procedures described in the section in the **Claims and appeals** chapter titled **External appeal process for medical, pharmacy, or Centers of Excellence benefits**.

Transplant denials by Mayo Clinic are not subject to review under this process if Mayo Clinic decides not to: 1) treat you based on your refusal to follow the terms and conditions of the Centers of Excellence program, including the rules and policies listed elsewhere in this chapter, or 2) determines that the transplant is not appropriate because you refuse to comply with medical restrictions or requirements, including but not limited to weight loss, smoking cessation, alcohol cessation, social support, conduct, or similar factors.

WEIGHT LOSS SURGERY BENEFIT

The following weight loss surgeries are covered under the Centers of Excellence program for weight loss surgery: gastric bypass, gastric sleeve, and duodenal switch surgeries. You must be at least 18 years of age to participate. Services must be provided by a Centers of Excellence facility designated by the AMP.

If you are eligible to participate in the Centers of Excellence program for weight loss surgery and choose to do so, the AMP will pay 75% of the cost of covered services received from the Centers of Excellence program provider and facility after you meet your network deductible.

If you are eligible to participate in the Centers of Excellence program for weight loss surgery and choose not to do so, the AMP will not pay the cost of any services received outside the Centers of Excellence program. No exception is available.

To participate in the Centers of Excellence for weight loss surgery, you must meet the following requirements:

- You must have either:
  - A body mass index (BMI) of 40 or greater, or
  - A BMI of 35 or greater and at least one obesity-related comorbidity factor (type 2 diabetes, hypertension, cardiovascular disease, etc.).
- You must agree to comply with all requirements for the duration of the weight loss surgery treatment, including the rules and policies listed elsewhere in this chapter.

If you meet the requirements stated above and your doctor recommends weight loss surgery, call your health care advisor at the number on your plan ID card to obtain a request form, which must be completed by you and your physician. You must send the completed request form to Contigo Health at the address listed on the form. The submission of the form is the submission of a preauthorization request with Contigo Health. Contigo Health will determine your preauthorization request under the procedures for pre-service claims described in the **Claims and appeals** chapter.

If you had a previous laparoscopic adjustable gastric band procedure for weight loss purposes, and now need surgical removal based on medical complications, you can apply for the weight loss surgery benefit to be evaluated by a Centers of Excellence facility to determine if you would be an appropriate candidate for a conversion to a covered weight loss surgery, during or in conjunction with the removal of the gastric band. You will be required to provide documentation demonstrating that you met the required clinical criteria for bariatric surgery prior to the original lap band procedure. Contact Contigo Health for more information.

12-month waiting period

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

The 12-month waiting period applies to you and, separately, to each of your covered dependents who are at least 18 years of age; i.e., each covered individual must meet their own 12-month waiting period. Any time enrolled in the AMP prior to attaining age 18 counts toward the 12-month waiting period.

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

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

LIMITED COORDINATION OF BENEFITS

The AMP generally does not coordinate benefits with respect to claims under the Centers of Excellence program, other than coordination with Medicare in the case of certain transplant benefits or as otherwise required by law.

For all other Centers of Excellence services, if any portion of a Centers of Excellence benefit could have been paid by another health plan, including Medicare Part A or Part B, as primary plan, the AMP will not pay any amount of the claim.

Walmart Health

Walmart Health consists of primary health care facilities found in select Walmart stores. It offers retail primary care services, including office visits, lab tests, and some preventive care services, for individuals age two and older.

Office visits are offered to most covered associates at the discounted price of a $4 copay, regardless of residency or work location. However, if you are enrolled in the Saver Plan option you must pay the posted retail price when using a Walmart Health facility, until you have met your network deductible, unless the Walmart Health visit is limited to preventive services. HSA dollars may be used as payment for qualified medical expenses received at a Walmart Health facility.

Lab tests and immunizations that are not covered as preventive care under the AMP are available at a separate charge in addition to the visit charge.

Certain preventive services available at Walmart Health facilities are covered under all AMP options at no cost to you and your covered family members. See the **Preventive care program** section earlier in this chapter.

NETWORK COVERAGE FOR CERTAIN WALMART HEALTH FACILITIES

Your TPA may contract with an individual Walmart Health facility to be a network provider, but not all Walmart Health facilities are network providers.

If the Walmart Health facility is a network provider under your AMP option: The Walmart Health facility will file claims with the AMP. The $4 copay for the office visit (or posted retail price if you are in the Saver Plan and have not met your network deductible) will not count toward your annual deductible but will count toward your out-of-pocket maximum. Charges for other services, such as lab tests, will be subject to regular AMP terms.

If the Walmart Health facility is not a network provider under your AMP option: The Walmart Health facility will not file claims with the AMP. The $4 copay for the office visit (or posted retail price if you are in the Saver Plan and have not met your network deductible) and any additional charges for other services, such as lab tests, are not reimbursable under the AMP and will not be credited against your annual deductible or out-of-pocket maximum.

To find out whether a Walmart Health facility is a network provider, view your network provider directory or contact your third-party administrator.

Helping you manage your health

In addition to the specific covered services discussed in the prior sections, there are a number of services offered under the AMP that help you put all of the AMP's benefits to work for you. The chart below and on the following pages outlines these programs and services. Note that some services are located only in certain areas or with certain plan options, as indicated. If you are enrolled in the fully insured PPO Plan option, some of these programs are also available to you, as described in the chart. All services are voluntary and available at no cost to you, unless otherwise noted.

NAVIGATING YOUR BENEFITS

HEALTH CARE ADVISOR

Your health care advisor is your single point of contact for all inquiries. Depending on the nature of your issue, they will answer your question or direct you to the right place. Just call the number of the health care advisor on your plan ID card.

This service is available to you if the following apply:

- You are in the Premier, Contribution, or Saver Plan option, or local plan or PPO Plan option, and
- Your work location is not in Illinois (except Chicago metro), Indiana (except Lake or Porter counties), Missouri, North Carolina, South Carolina, or Virginia, or
- Your TPA is UMR and your work location is in Illinois, Indiana, Missouri, North Carolina, South Carolina, or Virginia.

PERSONAL HEALTHCARE ASSISTANT

Your Personal Healthcare Assistant is your single point of contact for all inquiries. You can find out what's covered under your AMP option, find a highly rated doctor based on your preferences, get personalized health care recommendations for new or existing conditions, and find information on care management services. Depending on the nature of your issue, the Personal Healthcare Assistant will answer your question or direct you to the right place. Just call the number of the Personal Healthcare Assistant on your plan ID card.

This service is available to you if all of the following apply:

- You are in the Premier, Contribution, or Saver Plan option, and
- UMR is not your TPA, and
- Your work location is in Illinois (except Chicago metro), Indiana (except Lake and Porter counties), Missouri, North Carolina, South Carolina, or Virginia.

INCLUDED HEALTH: PROVIDER SEARCH AND SECOND OPINIONS

Depending on your work location and AMP option, Included Health offers you a variety of services and tools that let you search for doctors and medical services online, view quality information, obtain expert second opinions, and get additional details about a provider's charges. Register at **IncludedHealth.com/Walmart** or by calling Included Health at **800-941-1384**. You can also download the Included Health app from the App Store or Google Play. There is no cost to you to use the Included Health tool, but any medical expenses you incur as a result of your use of these services and tools will be subject to AMP rules.

Provider search: Participants and dependents age 13 and over who are enrolled in the AMP are eligible to use the Included Health provider search functions.

Included Health self-service tool: Included Health will match you with highly rated network physicians and facilities suited for your clinical needs. You will also be able to view quality information for M.D./D.O. providers.

The self-service tool is available to you if the following applies:

- You are in the Premier, Contribution, or Saver Plan option, or local plan or PPO Plan option.

Included Health live support: Call Included Health at **800-941-1384** for help finding a highly rated network provider, scheduling, and preparing for an appointment. You will also be able to get quality information for physicians.

This service is available to you if all of the following apply:

- You are in the Premier, Contribution, or Saver Plan option, or local plan or PPO Plan option, and
- Your work location is not central, northeast, or south Florida; Chicago metro; select counties in Oklahoma or Texas; or northwest Arkansas, and
- UMR is not your TPA.

Expert second opinions

Participants and dependents who are enrolled in the AMP are eligible to obtain an expert second opinion with Included Health. Under certain circumstances, when you have received a diagnosis or been recommended for surgery or a certain treatment, the AMP will cover second opinions provided online through Included Health.

This service is available to you if the following applies:

- You are in the Premier, Contribution, or Saver Plan option, or local plan or PPO Plan option.

NAVIGATING YOUR BENEFITS

Travel benefit for complex care (not applicable to benefits under the Centers of Excellence program)
In some cases, the AMP may consult with Included Health to determine whether you are eligible for a travel benefit for complex care where in-person visits are required. You may be eligible for the benefit if you reside more than 100 miles from a provider who is qualified to provide covered services or you reside in a state where a qualified provider is prohibited from providing the covered service and you reside more than 100 miles from a provider that Included Health has determined is qualified and legally permitted to provide the covered services. If you are eligible, the AMP will pay covered travel costs if you travel to the provider designated by Included Health. Travel benefits may include airfare, mileage, lodging, and a daily expense allowance for food and other expenses, for both you and a caregiver. Some travel benefits are considered taxable earnings and will be reflected on your Form W-2.

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

- Services that are not covered by the AMP
- Services that are covered under the Centers of Excellence program
- Routine care, including routine primary care
- Audiology service for the purpose of obtaining hearing aids/devices
- Clinical trials that are not required to be covered under the Affordable Care Act
- Dental services
- Hospice care
- Preventive care/services
- Podiatry for purposes of insoles, bunions, etc.
- Reconstructive surgery (not breast cancer-related)
- Vision services related to routine vision checks

Travel benefits for complex care must be pre-approved by Included Health. If Included Health determines that you are eligible for the travel benefit, Included Health will designate a qualified provider that is closest to your residence and, at your request, will assist with scheduling an appointment with the designated qualified provider.

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

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

If travel benefits are pre-approved, they must be pre-arranged by HealthSCOPE Benefits.

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

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

This service is available to you if the following applies:

- You are in the Premier, Contribution, or Saver Plan option, or local plan option.

Claims advocacy
Included Health care team can assist you with the financial aspects of medical claims. Specialized claims experts can answer your questions regarding medical bills or explanations of benefits, organize insurance paperwork, audit provider and hospital charges, advocate on your behalf to resolve billing inaccuracies, and negotiate with providers and insurers as needed for claim denials.

This service is available to you if all of the following apply:

- You are in the Premier, Contribution, or Saver Plan option, and
- Your work location is not central, northeast, or south Florida; Chicago metro; select counties in Oklahoma or Texas; or northwest Arkansas, and
- UMR is not your TPA.

NAVIGATING YOUR BENEFITS

INCLUSIVE HEALTH

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

This service is available to you if the following applies:

- You are in the Premier, Contribution, or Saver Plan option, or local plan or PPO Plan option.

CARE MANAGEMENT

If you are enrolled in a plan offered by the AMP, you have the benefit of voluntary care management services, including a personal medical team. Care management brings consistency to the full range of care and services provided under the AMP. Care management aims to look at the whole individual rather than just the symptoms or conditions being diagnosed; it can result in higher quality of care, improvement in your experience with your providers, and potentially lower out-of-pocket medical expenses.

Circumstances in which a care manager may work with you include the following:

- You are sick or injured and hospitalized
- You are scheduled for surgery
- You find out you have a chronic illness or are dealing with an ongoing chronic illness
- You have a mental health/substance use disorder
- You are prescribed multiple prescription drugs with potential interactions
- You simply have a question about your health
- You are home from the hospital and need help understanding your discharge plan, or
- You are participating in the Life with Baby Maternity Program, or comparable maternity program offered by certain local plan options.

Your care manager, working with your medical team, can approve certain medically necessary services that are not otherwise covered by the AMP because they exceed a treatment limit (i.e., number of days or visits). The AMP's rules regarding annual deductibles and coinsurance continue to apply to any additional benefits authorized by the care management program. The services must also be medically necessary.

Your medical team may also be able to assist you with medical costs you may incur for "involuntary" out-of-network services. These are costs you incur when you cannot control your choice of provider (such as if you have surgery in a network hospital but your anesthesia is administered by an anesthesiologist who is a non-network provider) or when you have a reasonable basis for believing your provider is a network provider. In some cases, out-of-network benefits may be paid as network benefits (see **When network benefits are paid for out-of-network services** earlier in this chapter). In other cases, your third-party administrator may negotiate with non-network providers before or after services are rendered to reduce the billed charges for which you are responsible under the AMP's out-of-network benefit. There are no guarantees that any reduction in your out-of-network costs will occur.

When you communicate with your health care advisor or personal health care assistant, depending on the nature of your inquiry, you may be routed to your care manager. On other occasions, your care manager may reach out to you, for example to invite you to participate in a health management program or to assist you in locating certain resources and services in your community.

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

This service is available to you if the following applies:

- You are in the Premier, Contribution, or Saver Plan option, or local plan or PPO Plan option.

VIRTUAL PRIMARY CARE

In addition to using Doctor On Demand by Included Health for telehealth video visits for urgent care and mental health services, you can also use Doctor On Demand for Virtual Primary Care. You can get help with everyday health needs or serious ongoing health issues from a Virtual Primary Care doctor who can refer you to clinical specialists when necessary. Visit Doctor On Demand online at **DoctorOnDemand.com/WalmartCare** or call **855-377-2200**.

This service is available to you if the following apply:

- Your work location is in Alabama, Alaska, Arizona, Arkansas, Colorado, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Minnesota, Mississippi, Missouri, North Carolina, Ohio, South Carolina, Tennessee, Virginia, West Virginia, or Wisconsin, and
- You are in the Premier, Contribution, or Saver Plan option, or Banner or Mercy Arkansas Local Plan options.

NAVIGATING YOUR BENEFITS

QUIT TOBACCO PROGRAM

According to the National Institutes of Health, tobacco use is a leading cause of preventable disease and death in the United States. To help you kick the habit, the AMP offers a free Quit Tobacco program for you and your covered family members age 18 and older.

When you enroll in the program, a variety of services may be available to you, including:

- Online support from coaches and other quitters.
- Phone-based coaching with a trained health coach.
- Quit Guide handbook, available online or mailed to your home.
- Email support with tips to help you quit and stay motivated.
- Over-the-counter (OTC) medications, including free patches, gum, or lozenges. (You may hear these medications referred to as "nicotine replacement therapy" or "NRT.")

To enroll in a Quit Tobacco program call Kick Buts at **855-955-1905**. Learn more about the Quit Tobacco program at **One.Walmart.com/QuitTobacco**.

You are eligible for this program if the following applies:

- You are in the Premier, Contribution, or Saver Plan option, or local plan or PPO Plan option.

LIFE WITH BABY MATERNITY PROGRAM

Life with Baby is an exclusive prenatal care program offered at no cost to you, your covered spouse/partner, and other covered family members. The program is available to you if you are enrolled in the AMP options listed below, which provide comparable maternity programs for their participants. (Call your health care advisor or Personal Healthcare Assistant for more information.)

Whether you're starting a family, adding to one, or just thinking about it, Life with Baby can help you have a safe, successful pregnancy. The program is offered at no cost, but enrollment is not automatic. The program assists with preconception, pregnancy, delivery (including three lactation visits), and child development. Enroll in Life with Baby by calling your health care advisor at the phone number on your plan ID card. Once enrolled, you'll have the opportunity to talk confidentially with a registered nurse before, during, and after your pregnancy, as well as access to a maternity app through Ovia. Participation in the program is voluntary and does not affect your eligibility to participate in the AMP.

If your work location is in Georgia, Illinois, Indiana, or Louisiana and you are enrolled in the Premier, Contribution, or Saver Plan option, you are also eligible for doula services. See **When limited benefits apply to the AMP** later in this chapter for more details.

You are eligible for this program if the following applies:

- You are in the Premier, Contribution, or Saver Plan option, or Banner Local Plan or PPO Plan option.

SPECIALTY MEDICATION REDIRECTION PROGRAM

If you receive infused or injected specialty medications, this optional program supports a transition of services from a hospital setting to alternative sites of care such as a physician's office, infusion suite, or your home. Program clinicians evaluate appropriate infusion sites based on detailed case reviews and provide you with proposed alternative sites of care. For more information call OptumRx at **844-705-7493** or your health care advisor at the number on your plan ID card.

You are eligible for this program if the following applies:

- You are in the Premier, Contribution, or Saver Plan option, or a local plan option.

DIABETES SELF-CARE

Through myAgileLife, you will have access to lower copays for certain diabetes-related medications by enrolling for the diabetes self-care program. This is a voluntary program where incentives are based on participation in myAgileLife programs, not on achieving a health status.

The program features a text messaging-based coaching curriculum designed to help you develop behaviors that support stated health objectives and outcomes (i.e., medication adherence, diet, exercise, self-monitoring, and provider engagement/interaction as part of an effective diabetes self-management regimen to reduce A1C, improve quality of life, and avoid unnecessary health care utilization).

To continue in the program, you must comply with the formulary and sourcing requirements specified by the AMP, where applicable, and remain active in the program in accordance with program terms.

You are eligible for this program if the following applies:

- You are in the Premier, Contribution, or Saver Plan option, or a local plan or PPO Plan option.

NAVIGATING YOUR BENEFITS

MENTAL/EMOTIONAL HEALTH CARE

You will have the benefit of voluntary care management services through AiRCare, in addition to the other care management resources described in this section. The goal of all care management resources available to you under the AMP is to bring consistency to the full range of care and services provided to you by looking at you as a whole individual.

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

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

You are eligible for this program if the following apply:

- Your work location is in Arkansas, Florida, Georgia, North Carolina, or Texas; and
- You are in the Premier, Contribution, or Saver Plan option, or a local plan option.

PHYSICAL THERAPY THROUGH OMADA FOR JOINT AND MUSCLE HEALTH

You have access to Omada for Joint and Muscle Health, an app-based approach to physical therapy. Whether you want to prevent an injury, recover from one, or manage pain, Omada provides personalized care, workout kits, and includes unlimited chat and video visits, making it easier for you to stick to your care plan. Omada is subject to your deductible and any copays or coinsurance. Join today at **OmadaHealth.com/Walmart**.

You are eligible for this program if the following apply:

- Your work location is in Alabama, Alaska, Arizona, Arkansas, Colorado, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Minnesota, Mississippi, Missouri, North Carolina, Ohio, South Carolina, Tennessee, Virginia, West Virginia, or Wisconsin, and
- You are in the Premier, Contribution, or Saver Plan option, or a local plan option.

DIGESTIVE HEALTH CARE THROUGH GIThrive

You have access to GIThrive, an app-based program paired with a care team for gastrointestinal care. GIThrive offers a personalized digital health program for relief of digestive conditions and improvement of gut health. The GIThrive program can help provide relief for a wide range of digestive health symptoms, at no cost to you. GIThrive includes unlimited appointments with a registered dietitian and health coach, personalized action plans, an at-home gut microbiome test, and proven methods for coping with stress and anxiety affecting your gut health. Download the app at **GIThrive.com/Walmart**.

You are eligible for this service if the following apply:

- Your work location is in Alabama, Alaska, Arizona, Arkansas, Colorado, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Minnesota, Mississippi, Missouri, North Carolina, Ohio, South Carolina, Tennessee, Virginia, West Virginia, or Wisconsin, and
- You are in the Premier, Contribution, or Saver Plan option, or a local plan option.

Preventive care program

For a preventive care service to be eligible for 100% coverage, it must fall under a recommendation by one of the agencies responsible for maintaining U.S. preventive care guidelines, as required under the Affordable Care Act. Many of these guidelines are specific to gender, age, or risk factors for a disease or condition. Check with your third-party administrator for details. Review charts with coverage terms in the **AMP options available to you** section earlier in this chapter to determine when the AMP pays the entire cost of preventive services under your option. Preventive services may not be paid at the 100% benefit level if you receive services from a *nonpreferred* network or non-network provider, if you are in an AMP option that has *preferred* and *nonpreferred* network providers.

A special rule applies to preventive services performed during office visits. Preventive services may not be paid at the 100% benefit level if the preventive services are billed separately from an office visit or are not the primary purpose of an office visit. In contrast, preventive services are paid at the 100% benefit level when preventive services are not billed separately from an office visit and are the primary purpose of an office visit. In addition, the AMP may use reasonable medical management procedures, as permitted by law, when determining which preventive care services are paid at 100%, such as only covering generic drugs or requiring a prescription or that preventive care be performed by a network provider to be covered at 100%. If your attending physician believes that it is medically necessary for these preventive care services or drugs to be delivered in a different manner, you or your attending physician may request an exception. See **Preventive care exceptions process** later in this chapter.

Covered services include those listed on the following pages. Refer to your third-party administrator for information on preventive services not listed here. For the most up-to-date list of covered preventive services, go to **One.Walmart.com** or call your third-party administrator at the number on your plan ID card.

COVERED PREVENTIVE SERVICES FOR ADULTS

- **Abdominal aortic aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol misuse** screening and counseling
- **Blood pressure** screening for all adults
- **Colorectal cancer** screening for adults age 45 and over
- **Depression** screening for adults
- **Diabetes (type 2) and prediabetes** screening for adults age 35–70 who are overweight or obese, and offer or referral of preventive interventions for patients with prediabetes
- **Diet and physical activity** counseling for adults at higher risk for cardiovascular disease
- **Exercise or physical therapy** for community-dwelling adults age 65 and older who are at increased risk for falls
- **Hepatitis B** screening for all adults age 18 to 79
- **Hepatitis C** screening for adults at high risk
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults—doses, recommended ages and recommended populations vary:
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Herpes zoster
  - Human papillomavirus
  - Influenza (flu shot)
  - Measles, mumps, rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, diphtheria, pertussis
  - Varicella

  Learn more about immunizations and see the latest vaccine schedules at: **cdc.gov/vaccines/schedules**.
- **Latent tuberculosis infection (LTBI)** screening in populations at increased risk
- **Lung cancer** screening for certain adults age 50–80 who have a smoking history
- **Obesity** screening and counseling for all adults
- **Preexposure prophylaxis ("PrEP")** with effective antiretroviral therapy to persons who are at high risk of HIV acquisition
- **Sexually transmitted infection (STI)** prevention counseling for adults at higher risk
- **Skin cancer** counseling for young adults to age 24
- **Syphilis** screening for all adults at higher risk
- **Tobacco use** screening for all adults and cessation interventions for tobacco users
- **Unhealthy drug use** screening (i.e., asking questions) for adults age 18 and older

COVERED PREVENTIVE SERVICES FOR WOMEN, INCLUDING PREGNANT WOMEN

- **Anxiety** screening in adolescent and adult women, including those who are pregnant or postpartum
- **Aspirin (low dose)** for women 12 weeks pregnant who are at high risk for preeclampsia (prescription required). See **The pharmacy benefit** for more information.
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk; and, if indicated after counseling, BRCA testing
- **Breast cancer chemoprevention** counseling for women at higher risk
- **Breast cancer mammography** screenings every 1–2 years for women over 40
- **Breast cancer risk-reducing prescription medications** (such as tamoxifen or raloxifene or aromatase inhibitors) for certain women at increased risk for breast cancer
- **Breastfeeding** comprehensive support and three counseling visits from trained providers, as well as access to breastfeeding supplies for pregnant and nursing women. Check with your third-party administrator (TPA) for details on how to obtain a breast pump.
- **Cervical cancer** screening for women age 21–65
- **Chlamydia infection** screening for younger women and other women at higher risk
- **Contraception** Food and Drug Administration-approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs. See **The pharmacy benefit** for information about contraception.
- **Diabetes** screening for women with a history of gestational diabetes who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes
- **Domestic and interpersonal violence** screening and counseling for all women and, when needed, initial intervention services
- **Folic acid** supplements for women who may become pregnant (prescription required). See **The pharmacy benefit** for more information.
- **Gestational diabetes** screening for women 24–28 weeks pregnant and those at high risk of developing gestational diabetes
- **Gonorrhea** screening for younger women and other women at increased risk
- **Healthy weight and weight gain** counseling for pregnant women
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human immunodeficiency virus (HIV)** screening and counseling

- **Maternal depression** screening for mothers at certain well-child visits
- **Obesity prevention** counseling in midlife women aged 40 to 60 with normal or overweight body mass index
- **Osteoporosis** screening for women over age 65, and younger postmenopausal women depending on risk factors
- **Perinatal depression** counseling interventions or referrals for pregnant and postpartum women who are at increased risk of perinatal depression
- **Preeclampsia** screening for pregnant women, with blood pressure measurements throughout pregnancy
- **Rh incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Sexually transmitted infections (STI)** counseling for sexually active women
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Tobacco use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Urinary incontinence** screening annually, and referral for further evaluation and treatment if indicated
- **Well-woman visits** to obtain recommended preventive services for women

COVERED PREVENTIVE SERVICES FOR CHILDREN

- **Anemia** screening for children at 12 months
- **Autism** screening for children at 18 and 24 months
- **Behavioral/social/emotional screening** for children of all ages
- **Bilirubin** screening for newborns
- **Blood pressure** screening for children of all ages
- **Blood screening** for newborns
- **Cervical dysplasia** screening for sexually active females
- **Congenital hypothyroidism** screening for newborns
- **Critical congenital heart defect** screening for newborns
- **Depression and suicide risk** screening for adolescents
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride chemoprevention** supplements for children without fluoride in their water source and fluoride varnish to the primary teeth of all infants and children (prescription required)
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all children
- **Height, weight, length, head circumference, weight for length and body mass index** measurements for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **Hepatitis B** screening in adolescents at high risk
- **HIV** screening for adolescents
- **Immunization** vaccines for children from birth to age 18—doses, recommended ages, and recommended populations vary:
  - Dengue
  - Diphtheria, tetanus, pertussis (DTaP and Tdap)
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human papillomavirus
  - Inactivated poliovirus
  - Influenza (flu shot)
  - Measles, mumps, rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella

  Learn more about immunizations and see the latest vaccine schedules at **cdc.gov/vaccines/schedules**.
- **Lead** screening for children at risk of exposure
- **Medical history** for all children throughout development
- **Obesity** screening and counseling
- **Oral health** risk assessment for young children, newborn to 10 years
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Physical examination** for children of all ages
- **Sexually transmitted infection (STI)** prevention counseling and screening for adolescents at higher risk
- **Skin cancer** counseling for young adults to age 24 and parents of young children
- **Sudden cardiac arrest and sudden death** screening for adolescents
- **Tobacco, alcohol, or drug use assessment** for adolescents at higher risk
- **Tobacco use** interventions in school-aged children and adolescents who have not started to use tobacco
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children.

FLU VACCINE PROGRAM

An annual flu vaccination is a preventive service and covered according to the terms detailed in this section describing the **Preventive care program**. The vaccine may also be provided in participating Walmart and Sam's Club pharmacies.

COVID-19 PREVENTIVE SERVICES (INCLUDING VACCINES)

During the public health emergency declared by the Secretary of Health and Human Services as a result of COVID-19 (the "Public Health Emergency"), the AMP will cover any "qualifying coronavirus preventive service" (within the meaning of 29 CFR § 2590.715–2713 or otherwise required by law) with no cost-sharing, whether the service is provided by a network *preferred* provider, network provider, or non-network provider.

As of the date this *Associate Benefits Book* is printed, "qualifying coronavirus preventive service" includes certain COVID-19 vaccines. See **cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html** for the most up-to-date list of COVID-19 vaccines in this category. Thus, during the Public Health Emergency, the AMP will cover these COVID-19 vaccines with no cost-sharing, whether the vaccines are provided by a network *preferred* provider, network provider, or non-network provider. The AMP will also cover, without cost-sharing, the administration of the COVID-19 vaccines that are "qualifying coronavirus preventive services."

PREVENTIVE CARE EXCEPTIONS PROCESS

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

Mental health and substance use disorder

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

- Provides 24-hour inpatient care
- Residential treatment
- Partial hospitalization or outpatient care that requires six to eight hours of service per day, five to seven days per week, or
- Intensive outpatient care that requires two to four hours of service per day, three to five days per week.

What is covered by the AMP

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

- Not in excess of the maximum allowable charge
- Medically necessary (unless otherwise indicated)
- Not excluded under the AMP (see **What is not covered by the AMP** later in this chapter), and
- Not in excess of AMP limits.

MAXIMUM ALLOWABLE CHARGE

The "maximum allowable charge" (MAC) is the maximum amount the AMP covers or pays for any health care services, drugs, medical devices, equipment, supplies, or benefits covered by the AMP. The MAC applies both to network and out-of-network services.

For covered network services, the MAC is that portion of a provider's charge covered by the AMP, as determined by the provider's contract with the TPA. In the case of BlueAdvantage Administrators of Arkansas, this includes contracts with an independent licensee company of the Blue Cross Blue Shield Association.

From time to time, and notwithstanding any AMP provisions that state otherwise, the AMP may enter into an agreement with a non-network provider (directly or indirectly through a TPA) that sets the rate the AMP will pay for a service or supply. In these cases, the MAC will be the rate established in the agreement with the non-network provider.

For emergency services and certain services provided by non-network providers in network facilities, MAC will be determined under applicable law, which may include arbitration with a provider. You will not be responsible for any additional costs unless your provider follows the notice and consent process (if applicable) and you give written consent to be billed by the provider. You are not required to consent to be billed.

For covered out-of-network services, the MAC is determined by each TPA, as described on the following page. In certain circumstances, network benefits may be paid for out-of-network services, as described earlier in this chapter under **When network benefits are paid for out-of-network services**.

Aetna: The MAC is 125% of Medicare's maximum allowable charge for voluntary out-of-network services. For involuntary out-of-network service, the MAC also is 125% of Medicare's maximum allowable charge unless the provider is in Aetna's National Advantage Program (NAP). NAP provider charges are paid at a discount. If a Medicare maximum allowable charge is not published by the Center for Medicare and Medicaid Services for a specific service, Aetna uses a gap methodology to calculate the MAC that is based on the Medicare maximum allowable charge. Medicare's allowable rate is based upon the geographic area in which the service is furnished.

BlueAdvantage Administrators of Arkansas: The method for establishing the MAC for covered out-of-network services depends on whether the service is delivered by an individual health care provider (e.g., a physician), an ambulance or air ambulance service, or a hospital or facility. For services of individual providers and ambulance and air ambulance transport, the MAC is 125% of the Medicare allowed amount for such services on the date administered. For hospital and facility services or for other covered benefits (e.g., drugs, medical devices, products or implants, equipment, or supplies), the MAC for covered out-of-network services is limited to the allowance set by BlueAdvantage Administrators of Arkansas in its discretion. If BlueAdvantage Administrators of Arkansas does not have its own method or benchmark in a given case, the MAC for covered out-of-network services is limited to the pricing or allowance offered by the Blue Cross and Blue Shield Plan in the state where services are provided.

For covered out-of-network services, the AMP pays the lesser of the MAC or the provider's actual billed charges. If the provider's billed charges exceed the AMP's MAC, you are responsible for paying the difference.

HealthSCOPE Benefits: There is no benefit for out-of-network services sought voluntarily by participants in local plans administered by HealthSCOPE Benefits. For approved involuntary or emergency out-of-network services, HealthSCOPE Benefits will use a discount through a "wrap network," if available and consistent with the Affordable Care Act. (A wrap network is a group of non-contracted providers who have arranged to provide services to Plan participants at a discount.) If there is not a discount available through a wrap network, the MAC will be 125% of Medicare's maximum allowable charge. In cases where a Medicare maximum allowable charge is not published by the Center for Medicare and Medicaid Services for a specific service, HealthSCOPE Benefits will use a gap methodology to calculate the MAC. There may be some cases in which an individual agreement is reached with the non-network provider.

UMR: The MAC is 125% of Medicare's maximum allowable charge for voluntary and involuntary out-of-network services unless the out-of-network service is involuntary and the provider is in UMR's Shared Savings Program ("SSP"). SSP provider charges are paid at a discount. In cases where a Medicare maximum allowable charge is not published by the Center for Medicare and Medicaid Services for a specific service, UMR uses a gap methodology to calculate the MAC.

MEDICALLY NECESSARY

"Medically necessary" (or "medical necessity") generally means the TPA 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 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 procedure, service, equipment, or supply that can be safely provided.

"Most appropriate" means:

- There is valid scientific evidence demonstrating that the expected health benefits from the procedure, service, equipment, or supply are clinically significant and produce a greater likelihood of benefit, without disproportionately greater risk of harm or complications, for the AMP participant with the particular medical condition being treated than other possible alternatives
- Generally accepted forms of treatment that are less invasive have been tried and found ineffective or otherwise unsuitable, and
- For hospital stays, acute inpatient care is necessary due to the kind of services the participant is receiving or the severity of the medical condition, and safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

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

Prenotification

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

but no later than 24 hours after admission. Providing notification within 24 hours after admission is not, however, required as a condition of coverage.

The TPA's responses to your inquiries in a prenotification call do not guarantee payment or ensure coverage under the AMP, nor do any statements made by the TPA create a contract, bind the AMP or waive any AMP condition applicable to your claim for benefits. The TPA cannot make a final claim determination on the phone or by email. This means that any responses given by phone or email are always subject to further review based on the particular facts and under the written terms, conditions, limitations, and exclusions of the AMP.

Preauthorization

Some Plan services require prior authorization, or those services will not be covered. A list of types of services that require prior authorization is below.

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

You must file your preauthorization claim as described in the **Claims and appeals** chapter. Where preauthorization is required, these services will be considered "pre-service claims." If a pre-service claim is denied, you may appeal, as described in the **Claims and appeals** chapter.

Where preauthorization is not required, you still may want to prenotify your third-party administrator, as indicated above. Whether preauthorization is required or not, all services are still subject to the applicable AMP terms and conditions of coverage, including cost sharing and other limitations. Network and non-network providers must preauthorize the following services under AMP terms, regardless of TPA:

This is not an exhaustive list. For a complete list of services for which preauthorization is required, you or your provider should call your TPA at the phone number on your plan ID card. Review the **Resources** chart on the first page of this chapter for information regarding which entity determines preauthorization requests for your AMP option. Note that preauthorization requirements may vary by TPA, so it is important to check with your TPA for the latest list.

- Advanced imaging services—MRI and CT scans
- Services provided under the Centers of Excellence program, including:
  - Spine surgery
  - Hip and knee replacement
  - Family-building treatment and services
  - Transplants including liver, kidney, heart (including durable ventricular assist devices [VADs] and total artificial hearts), lung (including lung volume reduction surgery [LVRS]), pancreas, simultaneous kidney/pancreas, multiple organ, and bone marrow/stem cell transplants (including CAR T-cell treatment)
  - Weight loss surgery
- Travel benefits for complex care (see the **Filing a claim for travel benefits for complex care** section in this chapter for more information).

When limited benefits apply to the AMP

Some services are subject to specific restrictions and limitations in addition to annual deductible and coinsurance/copayment requirements. If you have a question on the coverage of a particular service, contact the third-party administrator at the number on your plan ID card.

The limitations and restrictions described below are in addition to other AMP rules, including deductibles, coinsurance/copayments, network requirements, and exclusions. Consideration may be given for additional coverage when authorized by your care manager, as described in the **Care management** section.

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

Ambulance: Coverage of ambulance or air ambulance transportation is limited to the nearest hospital or nearest treatment facility capable of providing care, and only if such transportation is medically necessary as compared to other transportation methods of lower cost and safety.

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

The AMP covers ambulance or air ambulance transportation between health care facilities if the treatment to be provided at the second facility is medically necessary and not available at the initial facility.

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

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

Ambulance charges for the sole convenience of the participant, caregiver, or provider are not covered.

Birth control/contraceptives: Prescribed FDA-approved contraceptive methods for women and female sterilization are covered under women's preventive care, including but not limited to:

- Diaphragms: fitting and supply
- Cervical cap: fitting and supply
- Intrauterine device (IUD): fitting, supply, and removal (including copper or with progestin)
- Birth control pills (including the combined pill, progestin-only, and extended/continuous use)
- Birth control patch
- Vaginal ring
- Injection (e.g., Depo-Provera) given by a physician or nurse every three months
- Implantable contraception (e.g., Implanon)
- Plan B, when prescribed
- Ella, when prescribed
- Female sterilization (including surgery and surgical sterilization implant)
- Vaginal sponge, when prescribed
- Female condom, when prescribed
- Spermicide, when prescribed.

The AMP covers generic contraceptives only when prescribed by a physician (and brand-name contraceptives when medically necessary). If your attending physician believes a brand-name contraceptive is medically necessary, you or your physician may request an exception for coverage of the brand-name drug. See **Preventive care exceptions process** in **The pharmacy benefit** chapter.

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

- Abortion
- Prescription abortifacient medication, including but not limited to RU-486
- Over-the-counter birth control methods that are not prescribed, including but not limited to Plan B, spermicides, condoms, vaginal sponges, basal thermometers, and ovulation predictor kits.

Clinical trials: Approved clinical trials are covered under limited circumstances. Routine patient costs associated with participation in Phases I–IV of approved clinical trials to treat cancer or other life-threatening conditions, as determined by the TPA and required by law. These costs are subject to the AMP's applicable deductibles and limitations and do not include costs of the investigational item, device, or service, items provided for data collection, or services that are inconsistent with established standards of care.

Doula services: The AMP covers doula services for pregnant women enrolled in an AMP option with work locations in Georgia, Illinois, Indiana, or Louisiana regardless of medical necessity. The benefit is limited to $1,000 per pregnancy. Coverage is not subject to the deductible, and no coinsurance or copay is required. Amounts paid for doula services do not apply to the deductible or out-of-pocket maximum. The doula must be certified through the National Black Doula Association or DONA International. Amounts for doula services are taxable to you.

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

DME is equipment that:

- Can withstand repeated use
- Is used mainly for a medical purpose rather than for comfort or convenience
- Generally is not useful in the absence of an illness or injury
- Is related to a medical condition and prescribed by a physician
- Is appropriate for use in the home, and
- Is determined to meet medical criteria for coverage to diagnose or treat an illness or injury, help a malformed part of the body to work well, help an impaired part of the body to work within its functional parameters, or keep a condition from becoming worse.

Coverage is also provided for home medical supplies, such as ostomy supplies, wound-care supplies, tracheotomy supplies, and orthotics. Supplies must be prescribed by a medical doctor (M.D.) or doctor of osteopathy (D.O.) to be covered. Surgical stockings are limited to 12 stockings per calendar year.

To be covered, a doctor must include a diagnosis, the type of equipment needed, and expected time of usage. Examples of DME include wheelchairs, hospital-type beds, and walkers. If equipment is rented, the total benefit may not exceed the purchase price at the time rental begins.

Repair of DME is covered when all the following are met:

- The patient owns the equipment
- The required repairs are not caused by the patient's misuse or neglect of the equipment
- The expense of repair does not exceed the expense of purchasing new equipment, and
- The equipment is not covered by warranty.

If patient-owned DME is being repaired, up to one month's rental for that piece of DME is covered. Payment is based on the type of replacement device provided, but will not exceed the rental allowance for the equipment under repair.

DME not covered: Motor-driven scooters, invasive implantable bone growth stimulators (except in the case of spinal surgeries), sitz bath, seat lift, rolling chair, vaporizer, urinal, ultraviolet cabinet, whirlpool bath equipment, bed pan, portable paraffin bath, heating pad, heat lamp, steam/hot/cold packs, devices that measure or record blood pressure (except when provided in conjunction with Virtual Primary Care through Doctor On Demand by Included Health), and other such medical equipment or items determined to be not medically necessary.

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

Foot care: For nonsurgical foot care in connection with treatment for the following conditions, the AMP allows a total of three provider visits per calendar year:

- Bunions
- Corns or calluses
- Flat, unstable, or unbalanced feet
- Metatarsalgia
- Hammertoe
- Hallux valgus/claw toes, or
- Plantar fasciitis.

Services must be prescribed by a medical doctor (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.).

Open-cutting surgical care (including removal of nail roots) and nonsurgical care due to metabolic and peripheral vascular disease are not subject to the calendar-year limit.

Orthotic devices for the feet may be covered if prescribed by a qualified doctor and custom-molded under the doctor's supervision, subject to the calendar-year limit described above. Orthopedic shoes prescribed by a doctor are limited to two shoes per calendar year.

Gender dysphoria treatment: Medically necessary services for treatment of gender dysphoria are covered:

- Gender reassignment surgery, including both male-to-female surgery and female-to-male surgery
- Hormone replacement therapy, including laboratory testing to monitor hormone therapy, and
- Psychotherapy visits.

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

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

Home nursing care: In-home private-duty professional nursing services are covered if provided by a state-approved licensed vocational nurse (L.V.N.), licensed practical nurse (L.P.N.), or registered nurse (R.N.). Services cannot be rendered by a relative or by someone in the same household as the patient. Home nursing care benefits are payable up to a maximum of 100 visits per calendar year. A visit is defined as two hours or less.

Hospice care: Hospice care is an integrated program providing comfort and support services for the terminally ill. Hospice care is covered if you have an estimated life expectancy of 12 months or less, as attested by the physician treating the illness. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual, and respite care for the terminally ill person, and support for immediate family members, including partners, while the covered person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.

Inpatient and outpatient hospice care are covered up to 365 days per illness. Participants may continue to receive treatment and participate in approved clinical trials while obtaining hospice services. Coverage for additional days may be available if determined to be medically necessary.

Infertility treatment: Services for the diagnosis and correction of an underlying condition of infertility generally are covered under otherwise applicable AMP terms. Fertility services, such as IVF and IUI may be covered under the Centers of Excellence program even if not medically necessary. Refer to the **Centers of Excellence** section in this chapter for information on covered fertility services. Refer to **What is not covered by the AMP** later in this chapter for a list of non-covered infertility services.

International business travel medical coverage: The company provides international business medical insurance through an insurance policy from GeoBlue. If you participate in the Saver Plan, you are not eligible to make HSA contributions for any month in which you are traveling on company business outside the U.S. and are covered under the GeoBlue policy, which provides health benefit coverage for associates traveling internationally on business. You are encouraged to consult with your tax advisor if you have questions about the amount to reduce your contributions based on your individual circumstances.

Nutritional counseling: Nutritional counseling for children is covered if it is medically necessary for a chronic disease (e.g., PKU, Crohn's disease, celiac disease, galactosemia, etc.) or an eating disorder in which dietary adjustment has a therapeutic role when prescribed by a physician and furnished by a provider (e.g., a registered dietician, licensed nutritionist, or other qualified licensed health professional) recognized under the AMP. Benefits are limited to three visits per condition per year for chronic diseases. See the **Preventive care program** section for additional benefits related to nutritional and obesity counseling for adults and children.

Off-label use of cancer chemotherapy injectable drugs: These drugs are covered when medically necessary, recommended by one of the following three drug compendia, and not recommended against by one or more of the same compendia (appropriate to the date of service):

- AHFS Drug Information
- Clinical Pharmacology, or
- National Comprehensive Cancer Network (consensus) or category 1 (the recommendation is based on high-level evidence and there is uniform NCCN consensus) or category 2A (the recommendation is based on lower-level evidence and there is uniform NCCN consensus).

If you or your physician are unsure about the AMP's coverage for any type of prescription drug, verify coverage details by calling the TPA of your medical plan at the number on your plan ID card. You can also call OptumRx at **844-705-7493**.

Off-label use of non-cancer chemotherapy injectable drugs: These drugs are covered when medically necessary and recommended under one of the following drug compendia (appropriate to the date of service):

- AHFS Drug Information, or
- Clinical Pharmacology.

The AMP does not cover any drug determined by the FDA to be contra-indicated or not advisable. Coverage for FDA-approved drugs is subject to the AMP's applicable requirements and limitations.

Oral treatment: Charges for care of teeth and gums are covered when submitted by a doctor or dentist, including but not limited to:

- Prescriptions
- Emergency department services for mouth pain
- Treatment of fractures/dislocations of the jaw resulting from an accidental injury
- Accidental injury to natural teeth up to one year from the date of the accident (does not include injuries resulting from biting or chewing; those may be covered under the dental plan)
- Dental procedures necessitated by either severe disease (including but not limited to cancer) or traumatic event, as long as the dental service is medically necessary and the service is incidental to and an integral part of service covered under AMP medical benefits. Examples of services include but are not limited to the extraction of teeth prior to or following chemotherapy or radiation therapy of the head and neck. Treatment of oral tissues related to chemotherapy must be supported by documentation of a direct link between the destroyed bone or gums and the chemotherapy.
- Non-dental cutting procedures in the oral cavity
- Medical complications that are the result of a dental procedure, or
- Expenses for dental services performed in a hospital setting, including facility and professional charges, for extensive procedures that prevent an oral surgeon from providing general anesthesia in an office setting, or for circumstances that limit the ability of the oral surgeon to provide services in an office setting. Such circumstances include but are not limited to situations in which the covered person is:
  - A child under age 4
  - Between the age of 4 and 12, when either:
    - Care in a dental office has been attempted unsuccessfully and usual methods of behavior modification have not been successful; or
    - Extensive amounts of care are required, exceeding four appointments.
  - An individual with one of the following medical conditions, requiring hospitalization or general anesthesia for dental treatment:
    - Respiratory illness
    - Cardiac conditions
    - Bleeding disorders
    - Severe disability (including but not limited to cerebral palsy, autism, developmental disability)
    - Other severe disease (including but not limited to cancer or neurological disorder), or
    - Compromised airway.
  - An individual of any age whose condition requires extensive procedures that prevent an oral surgeon from providing general anesthesia in the office setting.

Outpatient physical/occupational therapy: Charges for outpatient physical/occupational therapy are covered when services are:

- Prescribed by a medical doctor (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.), and
- Provided by a licensed physical therapy provider or licensed occupational therapy provider or by one of the types of doctors listed above.

This benefit is payable to a maximum of 20 visits for physical therapy and 20 visits for occupational therapy per calendar year. Additional visits may be covered if deemed appropriate by the care manager. This maximum does not apply to mental health conditions.

Pregnancy benefits: Pregnancy expenses are covered the same as any other medical condition. See **Doula services** earlier in this section for information about doula services in select pilot locations. (Eligible prenatal services are covered under the preventive care program.)

Benefits are paid for pregnancy-related expenses of dependent children. The newborn is covered only if the newborn is a covered dependent of the covered associate. See **How to change your elections due to an election change** event in the **Eligibility, enrollment, and effective dates** chapter for information on enrolling a newborn for coverage.

Prostate-specific antigen (PSA) tests: Covered only when conducted as part of a clinical diagnosis.

Prosthetics: Prosthetic devices (such as artificial limbs) are covered if medically necessary and prescribed by a physician, subject to the terms and conditions of the AMP. Replacement prostheses are allowed only with a change of prescription. A licensed prosthetician must perform replacements of artificial limbs.

Rehabilitative care: Inpatient and/or day rehabilitation is covered to a maximum of 120 days per condition for the following clinical groups if clinical criteria are met:

- Stroke
- Spinal cord injury
- Brain injury
- Congenital deformity
- Neurological disorders
- Amputation
- Severe or advanced osteoarthritis involving two or more weight-bearing joints
- Rheumatoid, other arthritis
- Systemic vasculitis with joint inflammation
- Major multiple trauma, or
- Burns.

Specialty care: Medical care commonly provided at the following types of facilities is covered if you are admitted to this level of care subsequent to an eligible acute care hospital confinement:

- Extended care facility
- Long-term acute care specialty facility
- Subacute care facility
- Skilled nursing facility, or
- Transitional care facility.

Benefits are limited to a maximum of 60 calendar days per disability period. Successive periods of confinement due to the same or related causes are considered one disability period unless separated by a complete recovery.

Speech therapy: Therapy of up to 60 visits per calendar year is covered when:

- Prescribed by a medical doctor (M.D.) or doctor of osteopathy (D.O.), and
- Provided by a licensed speech therapist.

Initial and ongoing plans of treatment and progress reports may be requested from the prescribing doctor. To be covered, speech therapy must be for a residual speech impairment resulting from:

- A cerebral vascular accident
- Head or neck injury
- Partial or complete paralysis of voice cords or larynx
- Head or neck surgery, or
- Congenital and severe developmental speech disorders.

The visit limit does not apply to mental health conditions.

Telehealth visits: Except for Doctor On Demand by Included Health, which is paid at 100% for most AMP plan options, other telehealth visits with your provider are covered subject to the same terms as in-person visits, including cost sharing and coverage based on network or non-network status of the provider.

Termination of pregnancy: Charges for procedures, services, drugs, and supplies related to the termination of pregnancy, including abortion services, are not covered, except, where legally permissible: 1) when a woman's attending physician determines that her health would be in danger if the fetus were carried to term, the fetus could not survive until the time of delivery or the birthing process, or death of the fetus would be imminent after birth, 2) in cases where a woman is pregnant due to rape or incest, or 3) in the event of an ectopic pregnancy or miscarriage. See **Travel benefit for complex care** in the **Navigating your benefits** chart for more information about travel services that may be available.

Transplant services: See the **Centers of Excellence** section in this chapter for information on transplant services that are covered under the Centers of Excellence program. Cornea and intestinal transplant services are not covered under the Centers of Excellence program but are covered services under otherwise applicable AMP terms. For all transplant services, you must be enrolled in the AMP for at least 12 months. With respect to the 12-month wait only, refer to the **Centers of Excellence** section in this chapter for details, including requesting a waiver to the waiting period. Transplantation of body parts (e.g., face, hands, feet, legs, arms, uterus) is not covered under any circumstance.

Vision services: Diagnosis and treatment of injury or disease of the eye, including but not limited to diabetic retinopathy, glaucoma, and macular degeneration, are covered. Charges for routine eye care, including but not limited to vision analysis, eye examinations, or eye surgeries for nearsightedness or correction of vision, are not covered, except for vision screening for children covered under preventive care guidelines. Some of these services may be covered under the vision plan. See **The vision plan** chapter.

Weight loss treatment: Weight loss surgery is covered only under the Centers of Excellence program when you meet specific eligibility guidelines and clinical criteria. Weight loss treatments, including but not limited to medications, diet supplements, and surgeries outside the scope of the Centers of Excellence program, are not covered. See the **Centers of Excellence** section of this chapter for information about weight loss surgery.

What is not covered by the AMP

In addition to the exclusions and limitations listed in the **When limited benefits apply to the AMP** section of this chapter, the following list represents services not covered by the AMP. Network discounts do not apply to these services.

If you are enrolled in the Saver Plan, you may be able to use your HSA funds for these and other qualified medical expenses. For information, contact your HSA administrator.

If you have a question regarding whether a service is covered under the AMP, call the TPA at the number on your plan ID card or see **For more information** at the end of this book for contact details.

Acupuncture

Administrative services and interest fees: Charges for the completion of claim forms, missed appointments, additional charges for weekend or holiday appointments, interest fees, collection fees, or attorney fees.

Alternative/nontraditional treatment (including homeopathy, naturopathy, hypnosis, and massage therapy).

Autopsy

Beyond the scope of licensure or unlicensed: Services rendered by a non-credited or a non-licensed physician, health care worker or institution, or services rendered beyond the scope of such person's or entity's license, or services provided in a jurisdiction where such services may not be legally provided.

Biofeedback

Breast reconstruction/reduction: Any expenses or charges resulting from breast enlargement (augmentation), including implant insertion and implant removal, whether male or female, are not covered except when the implant is removed as the result of implant damage or rupture. Replacement of a damaged or ruptured implant is not covered unless the original implant was placed for conditions eligible to be paid by the AMP.

Any expenses or charges resulting from breast reductions, implantations or total breast removal, whether male or female, are not covered, unless directly related to treatment of a mastectomy, as provided by law (see **The Women's Health and Cancer Rights Act of 1998** later in this chapter), or unless an AMP medical review determines the procedure is medically necessary.

Chiropractic care: Spinal manipulation, joint manipulation, or soft-tissue manipulation, regardless of the type of provider performing the service, except for limited coverage for network services provided to participants enrolled in the Mercy Arkansas Local Plan.

Copays and/or discounts, deductibles, and/or coinsurance

Cosmetic health services or reconstructive surgery: Except for congenital abnormality, services covered by law (see **The Women's Health and Cancer Rights Act of 1998** later in this chapter), or conditions resulting from accidental injuries, tumors or diseases.

Custodial or respite care: Care or services provided in a facility or home to maintain a person's present state of health, which cannot reasonably be expected to significantly improve.

Drugs, items, and equipment not FDA-approved

Educational services: Including any services for learning and educational disorders (which include but are not limited to reading disorders, alexia, developmental dyslexia, dyscalculia, spelling disorders, and other learning difficulties), but excluding services that are preventive services described in the **Preventive care program** section.

Elective inpatient and outpatient stays or services outside the U.S.

Expenses related to missed appointments, review or storage of your health care information or data

Experimental, investigational, and/or treatments and services that are not medically necessary: Experimental and/or investigational medical services are those defined as experimental and/or investigational according to protocols established by your TPA. For Centers of Excellence services, the Centers of Excellence TPA makes this determination.

Extracorporeal shock wave therapy: For plantar fasciitis and other musculoskeletal conditions.

Government compensation: Charges that are compensated for or furnished by local, state, or federal government, or any agency thereof, unless payment is legally required.

HMO copays

Illegal occupation, assault, felony, riot, or insurrection: Charges for medical services, supplies, or treatments that result from or occur while being engaged in an illegal occupation, commission of an assault, felony, or criminal offense (except for a moving violation), or participation in a riot or insurrection.

Infertility services, including:

- Charges to reverse a sterilization procedure; and
- Charges for, or related to, the services of a surrogate.

Some fertility services may be provided under the Centers of Excellence—see the **Centers of Excellence** section in this chapter.

Judgments/settlements

Late claims: Charges received more than 18 months past the date of service. See **Filing a medical claim** later in this chapter for information about coordination of benefits. In the event a participant establishes that a claim was filed within the stated time period, but the claim was mistakenly filed with the company or any TPA of the AMP, that time shall not count toward the filing period above.

Marital, family, or relationship counseling: Or counseling to assist in achieving more effective intra- or interpersonal development.

Military-related injury or illness: Including injury or illness related to, or resulting from, acts of war, declared or undeclared.

Neurofeedback

Nonaccredited/nonlicensed providers or institutions

Non-covered services:

- Services not specifically included as a benefit in this *Associate Benefits Book*
- Services provided after exceeding the benefit maximum for specified services
- Services for which you are responsible for payment, such as non-covered out-of-network charges
- Services delivered in a jurisdiction where such services may not be legally provided
- Charges for services above the contracted rates to providers, or
- Charges for medical records.

Out-of-pocket expenses

Over-the-counter medications and equipment: Except for specific preventive care medications. See **The pharmacy benefit** chapter for more information.

Personal care items: Primarily for personal comfort or convenience, including but not limited to diapers, bathtub grabbers, handrails, lift chairs, over-bed tables, bedboards, incontinence pads, ramps, snug seats, recreational items, home improvements and home appliances, spas, wigs, and knee braces for sports.

Services provided by a member of the patient's immediate family

Services provided by a government entity while incarcerated

Sexual dysfunction services and pharmaceuticals: Including therapy, treatment, or pharmaceuticals for the treatment of sexual dysfunction, except for sexual dysfunction resulting from an accidental injury or treatment for an illness or condition (e.g., erectile dysfunction resulting from a prostatectomy or spinal cord injury).

Sports/school physicals: Charges for physical examinations performed for the purpose of clearing an individual for participation in a sport or school activity.

Surrogate parenting: Fees related to surrogacy (other than maternity care costs for an enrollee otherwise covered under the AMP), whether paying for another's services or serving as a surrogate.

Talking aids: Assistive talking devices, including special computers or devices designed to assist in therapy treatment to enhance motor and/or psychological abilities.

Travel and lodging, except as specified under Centers of Excellence or travel benefits for complex care: See **Travel benefit for complex care** in the **Navigating your benefits** chart for more information about travel services that may be available.

Vitamins: Charges for nonprescription vitamins (whether oral or injectable), minerals, nutritional supplements, or dietary supplements, except as outlined in the **Preventive care program** section of this chapter.

Walmart Health-provided services: Charges for non-preventive services, except where the Walmart Health facility is considered a network provider.

Work hardening or similar vocational programs

Workers' compensation: Treatment of any compensable injury, as defined by applicable workers' compensation law, regardless of whether or not you file a timely claim for workers' compensation benefits.

Filing a medical claim (other than travel benefits for complex care)

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 yourself. Claim forms are located on **One.Walmart.com/Medical**. You must file within 18 months from date of service.

If you need to file a claim, it should include the following information:

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

See your plan ID card 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. Claims are determined under the time frames and requirements outlined in the **Claims and appeals** chapter.

When you incur medical expenses and file a claim, or a claim is filed on your behalf, benefits are paid directly to the provider for network services. Payment to the provider discharges the AMP's obligation to you for the benefit.

If your plan provides coverage for non-network providers and you use a non-network provider, payment may be made directly to you upon your showing proof of payment in full to the provider. You are responsible for your cost-sharing, plus any amount above the maximum allowable charge. As a convenience to you, payment may also be made to a non-network provider 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. The AMP prohibits the assignment of any benefit or any legal right, claim, or cause of action (whether known or unknown).

You have the right to appeal a claim denial, as described in the **Claims and appeals** chapter.

Filing a claim for travel benefits for complex care

If Included Health does not pre-approve your travel benefits for complex care and you disagree with that determination, you may file a written pre-service claim for benefits. Claim forms are located on **One.Walmart.com/Medical** or you can call Included Health at **800-941-1348** to request a paper copy.

Claims for travel benefits for complex care will be decided under the general procedures and time frames for pre-service claims discussed in the **Medical, pharmacy, Centers of Excellence, dental, and vision benefits claims process** section of the **Claims and appeals** chapter. See the claim form at **One.Walmart.com/Medical** for information on where to file a claim.

If you have coverage under more than one medical plan

The AMP has the right to coordinate with other plans under which you are covered so the total medical benefits payable do not exceed the level of benefits otherwise payable under the AMP. "Other plans" refers to the following types of medical coverage:

- Coverage under a governmental program provided or required by statute, including no-fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation
- Group insurance or other coverage for a group of individuals, including coverage under another employer plan or student coverage obtained through an educational institution
- Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans
- Any coverage under governmental plans, such as Medicare or TRICARE, but not including a state plan under Medicaid or any governmental plan when, by law, its benefits are secondary to those of any private insurance, nongovernmental program, 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 the amount of 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 or transplants (except where the other plan is Medicare).

If you reside in a state where automobile no-fault coverage, personal injury protection coverage, or medical payment coverage is mandatory, that coverage is primary and the AMP is secondary. The AMP reduces benefits for an amount equal to the state's mandatory minimum requirement.

Other rules:

- The AMP has first priority with respect to its right to reduction, reimbursement, and subrogation.
- The AMP does not coordinate benefits with an HMO or similar managed care plan where you pay only a copayment or fixed dollar amount.
- The AMP does not coordinate with any other plan other than Medicare with respect to a covered transplant.

HOW THE AMP COORDINATES WITH OTHER PLANS

	Example 1	Example 2	Example 3
If another plan pays primary at:	80%	80%	0%
And the AMP's payment is:	75%	100%	75%
The AMP's total benefit is:	0%	20%	75%

DETERMINING WHICH PLAN IS PRIMARY

A plan without a coordinating provision is always primary. The AMP has a coordinating provision. If all plans have a coordinating provision, the following provisions apply:

- The AMP always is the secondary payer to any motor vehicle policy available to you, including personal injury protection or no-fault coverage. If the AMP pays benefits as a result of injuries or illnesses you sustain and another party (e.g., an insurance company) bears primary responsibility for your covered medical expenses, the AMP has a legal right to reimbursement of benefits. See the **Claims and appeals** chapter for more information.
- The plan covering the participant for whom the claim is made, other than as a dependent, pays first and the other plan pays second.
- If the plan participant is covered under a retiree medical plan that includes a coordination of benefits provision, that provision governs.
- For dependent children's claims, the plan of the parent whose birthday occurs earlier in the calendar year is primary.
- When the birthdays of both parents are on the same day, the plan that has covered the dependent for the longer period of time is primary.
- When the parents of a dependent child are divorced or separated, or the domestic partnership or legal relationship is terminated, and the parent with custody has not remarried, that parent's plan is primary.
- When the parent with custody has remarried, or entered into a domestic partnership with another individual, that parent's plan is primary, the stepparent's plan pays second and the plan of the parent without custody pays last.
- When there is a court decree that establishes financial responsibility for the health care expenses of the child, the plan that covers the parent with financial responsibility is primary.
- If these rules do not establish an order of benefit determination, the plan that has covered the participant for whom the claim is made for the longest period of time is primary.
- If you are covered under a right of continuation coverage pursuant to federal or state law (for example, COBRA) and you are also covered under another plan that covers you as an employee, member subscriber, or retiree (or as that person's dependent), the latter plan is primary and the continuation coverage is secondary. If the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule does not apply.

IF YOU OR A DEPENDENT IS COVERED UNDER MEDICAID

If you or your dependent is a participant in the AMP and 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 FOR 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 AMP be the primary payer if you or your dependent is eligible for or enrolled in Medicare Part A, or Parts A and B, and meet one of the following criteria:

- You are employed by the company and are age 65 or older
- You are 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 enrolled in Medicare due to end-stage renal disease after the 30-month coordination period with Medicare is exhausted.

IF YOU ARE AGE 65 OR OLDER AND AN ACTIVE ASSOCIATE

If you are still working for 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.

LEGALLY MANDATED AUTOMOBILE PERSONAL INJURY OR MEDICAL PAYMENT COVERAGE

If you reside in a state where automobile no-fault coverage, personal injury protection coverage, or medical payment coverage is mandatory, that coverage is primary and the AMP is secondary. The AMP reduces benefits for an amount equal to, but not less than, the state's mandatory minimum requirement.

Break in coverage

There may be occasions in which you must make special arrangements to pay your 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 **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** 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, enrollment, and effective dates** 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 last day for which premiums were paid. See **Paying for your benefits** in the **Eligibility, enrollment, and effective dates** chapter for information. There is no right to continue coverage under COBRA when coverage is canceled due to nonpayment of required contributions.

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

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** section of the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave the company and are rehired

If you are a part-time or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work. For details regarding the impact to your deductible, out-of-pocket maximum, and HRA, see below.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave the company and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work. For details regarding the impact to your deductible, out-of-pocket maximum, and HRA, see below.

Impact to deductible, out-of-pocket maximum, and HRA:

- If you terminate and then return to work within 30 days of your termination date, your deductible, out-of-pocket maximum, and HRA (if applicable) will not reset unless you terminate in one calendar year and return to work in the following calendar year.*
- If you terminate and then return to work more than 30 days but less than 13 weeks from your termination date, your deductible, out-of-pocket maximum, and HRA (if applicable) will reset.*
- If you terminate and then return to work 13 weeks or more from your termination date, you will be considered a new associate and will be required to complete any applicable eligibility waiting period or other requirements. See the **Eligibility, enrollment, and effective dates** chapter for details.*

*If you or an eligible dependent were enrolled in the AMP and had accrued amounts toward, or had reached, the maximum lifetime benefit applicable to fertility benefits under the Centers of Excellence family building program, no portion of the maximum lifetime benefit will reset for any reason.

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 will be subject to the otherwise applicable annual deductibles and coinsurance/copayment provisions under the AMP. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. For additional information, call People Services at **800-421-1362**.

A NOTE ABOUT MATERNITY ADMISSIONS

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

The pharmacy benefit

The information in this chapter describes pharmacy benefits that may be available to you if you are enrolled in the Associates' Medical Plan. See **The medical plan** chapter for details.

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

The pharmacy benefit

Keep you and your eligible dependents in good health with your pharmacy benefit. It's automatically included with your medical plan.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Find a Walmart or Sam's Club pharmacy	Go to **One.Walmart.com** or **OptumRx.com/Walmart**	
Contact Walmart Specialty Pharmacy	Go to **One.Walmart.com**	Call Walmart Specialty Pharmacy at **800-284-9770**
Find an OptumRx network pharmacy	Go to **OptumRx.com**	Call OptumRx at **844-705-7493**
Get information about Walmart Home Delivery Pharmacy	Go to **One.Walmart.com**	Call Walmart Home Delivery Pharmacy at **866-855-0740**
For pharmacy benefit inquiries		Call OptumRx at **844-705-7493**
Get the list of covered brand-name drugs	Go to **One.Walmart.com** or **OptumRx.com/Walmart**	Call OptumRx at **844-705-7493**

What you need to know about the pharmacy benefit

- You are automatically covered under the pharmacy benefit if you are enrolled in the Premier, Contribution, or Saver Plan option or one of the local plan options available under the Associates' Medical Plan (AMP). If you are enrolled in an HMO plan or the PPO Plan, your pharmacy benefits are provided through the HMO or PPO, respectively.
- The pharmacy benefit covers only prescription drugs specifically listed on the pharmacy benefit's formulary.
- The pharmacies discussed in this chapter include:
  - Walmart or Sam's Club pharmacy—including an in-store or in-club pharmacy.
  - Walmart Home Delivery Pharmacy—mail-order pharmacy for Walmart.
  - Walmart Specialty Pharmacy—mail-order specialty pharmacy for Walmart.
  - OptumRx network pharmacy—including a Walmart or Sam's Club pharmacy and any pharmacy in the OptumRx network.
- Where prescriptions must be filled depends on the type of drug that has been prescribed:
  - Maintenance medications (drugs taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes, or asthma, among others) must be filled through Walmart Home Delivery Pharmacy or any Walmart or Sam's Club pharmacy. See **Maintenance medications** later in this chapter for details.
  - Specialty medications (except for fertility drugs, as described in this chapter) must be filled through Walmart Specialty Pharmacy.
  - All other medications must be filled at a Walmart or Sam's Club pharmacy, unless an exception applies. See **The pharmacy benefit** section of this chapter.

The pharmacy benefit

The pharmacy benefit covers eligible prescription drugs purchased from certain retail and mail-order network pharmacies. No pharmacy benefits are paid if you use a non-network pharmacy. The specific retail and mail-order network pharmacies that you are required to use depend on the type of prescription you are filling. You must enroll in medical coverage under the AMP to obtain prescription drug coverage under the pharmacy benefit. If you enroll in medical coverage, your prescription drug coverage is effective on the date your medical coverage under the AMP is effective and ends on the date your medical coverage ends.

PHARMACY OPTIONS

If you are enrolled in the Premier, Contribution, or Saver Plan option, or one of the local plan options, maintenance medications must be filled through any Walmart or Sam's Club pharmacy or Walmart Home Delivery Pharmacy. See **Maintenance medications** later in this chapter. Specialty medication (except for fertility drugs, as described later in this chapter) must be filled through Walmart Specialty Pharmacy. See **Specialty medications** later in this chapter. All other medications must be filled at a Walmart or Sam's Club pharmacy, unless an exception applies.

Under limited circumstances, you may fill prescriptions at an OptumRx network pharmacy, including:

- If the AMP determines that any covered medication is out of stock and not available at a Walmart or Sam's Club pharmacy for or through Walmart Specialty Pharmacy for an extended time.
- If the AMP determines that any covered medication is unavailable at a Walmart or Sam's Club pharmacy, Walmart Home Delivery, or Walmart Specialty.
- If an emergency prescription fill is needed outside Walmart or Sam's Club pharmacy hours.
- If a non-maintenance medication is necessary to address an immediate health issue.

For information, call OptumRx at **844-705-7493**.

NOTE: Certain restrictions apply to filling prescriptions for narcotics and other controlled substances. Call OptumRx at **844-705-7493** for more details.

COVERED PRESCRIPTION DRUGS

The pharmacy benefit covers only prescription drugs specifically listed on the pharmacy benefit's formulary, which is a list of generic and brand-name medications that have been tested for quality and effectiveness and are believed to be a necessary part of a quality treatment program. The formulary is maintained by OptumRx. You can view an abbreviated list on **One.Walmart.com** or you can call OptumRx at **844-705-7493** for a full list. If you don't see your medication on the list, call OptumRx to see if it is on the formulary. The formulary is subject to change without prior notice at any time during the calendar year.

The pharmacy benefit has a closed formulary. This means that your prescription drugs, whether they fall under the generic, brand-name, or specialty drug category, must be included on the formulary for pharmacy benefits to be paid.

YOUR COST SHARING FOR COVERED PRESCRIPTION DRUGS

See the **Pharmacy benefits** chart on the next page for details about copays and coinsurance.

If you are in the **Premier Plan, Contribution Plan, or a local plan option**, you are required to pay the copay or coinsurance out of your own pocket when you purchase your prescription drugs. (If you are covered under the Contribution Plan, HRA funds cannot be used to purchase prescriptions or to reimburse copays or coinsurance related to prescriptions.) Your copays are applied toward your medical plan's annual out-of-pocket maximum. Once you meet your annual out-of-pocket maximum, eligible prescriptions are paid at 100% for the rest of the calendar year.

If you are in the **Saver Plan** option, in most cases you will pay the full price for your prescription drugs until you meet the Saver Plan's network annual deductible. Once you meet your network annual deductible, you will pay the required copay or coinsurance. (The exceptions are medications on the OptumRx list of approved preventive medications, which are not subject to the Saver Plan's network annual deductible. See **Preventive medications not subject to the Saver Plan's network annual deductible** later in this chapter for details.) Your copays are applied toward the Saver Plan's annual out-of-pocket maximum. Once you meet your annual out-of-pocket maximum, eligible prescriptions are paid at 100% for the rest of the calendar year.

For all AMP options, the pharmacy benefit provides discounted prices on generic and brand-name medications that are covered on the formulary and filled at an eligible network pharmacy. If, at the time your prescription is filled, the discounted price available is lower than your copay, you will be charged the lower amount, which may include a dispensing fee.

PHARMACY BENEFITS		
Formulary generic drugs* Up to 30-day supply 31- to 60-day supply 61- to 90-day supply *High-cost generic drugs are not covered when a therapeutically equivalent, lower-cost generic is available.*	$4 copay $8 copay $12 copay	**Filling your prescriptions** • Present your plan ID card at a Walmart or Sam's Club pharmacy. • Prescription refills are available after 75% of your previous prescription has been used. • See **Pharmacy options** on the previous page for additional information. • If the AMP determines that any covered drug is not available at Walmart/Sam's Club pharmacy, Walmart Home Delivery, or Walmart Specialty Pharmacy for an extended time, you may be able to obtain the drug from an OptumRx network pharmacy—see details about exceptions under **Pharmacy options**.
Formulary brand-name drugs* Up to a 30-day supply. *More than a 30 day-supply must be purchased through mail order.*	Greater of $50 or 25% of allowed cost	
Non-formulary drugs	Not covered	
Specialty drugs *Available only at Walmart Specialty Pharmacy (except for fertility medications)*	Greater of $50 or 20% of allowed cost	
*Maintenance medications must be filled at Walmart Home Delivery Pharmacy or any Walmart or Sam's Club pharmacy. See **Maintenance medications** below.		
When purchasing mail-order drugs: • You must use Walmart Home Delivery Pharmacy or any Walmart or Sam's Club pharmacy for drugs that are considered "maintenance medications." See **Maintenance medications** below. Your cost for a 90-day supply is three times the cost of a 30-day supply purchased at a Walmart or Sam's Club pharmacy, as listed above. You can get a 30-, 60-, or 90-day supply through mail order when you use Walmart Home Delivery Pharmacy.		

TYPES OF DRUGS

Generic drug: A generic drug is a lower-cost equivalent of a brand-name drug. When a generic equivalent becomes available, the brand-name drug will no longer be covered. Generic equivalents work like the brand-name drug in dosage, strength, performance, and use, and must meet the same quality and safety standards. All generic drugs must be reviewed by the United States Food and Drug Administration (FDA). For more information, visit **One.Walmart.com**.

Brand-name drug: A covered brand-name drug is a drug manufactured by a single manufacturer that has been evaluated for safety and effectiveness when compared to similar drugs treating the same condition and identified for inclusion on the covered brand-name drug list.

Specialty drug: Specialty drugs are used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Specialty drugs require an enhanced level of service, whether administered by a health care professional, self-injected, or taken orally. (Medications used to treat diabetes are not considered specialty medications.) See the following page for special rules for fertility specialty drugs.

MAINTENANCE MEDICATIONS

Effective January 1, 2023, if you are enrolled in the Premier, Contribution, Saver Plan option or a local plan option, you must use Walmart Home Delivery Pharmacy or any Walmart or Sam's Club pharmacy for drugs that are considered "maintenance medications." Maintenance medications are drugs commonly prescribed to treat a chronic or long-term medical condition and are taken on a regular, recurring basis. Examples of maintenance medications include but are not limited to ones which are used to treat high blood pressure, heart disease, diabetes, asthma, arthritis, etc. See the formulary for a list of maintenance medications. You can view an abbreviated list on **One.Walmart.com** or you can call OptumRx at **844-705-7493** for a full list.

If you were using an OptumRx network pharmacy to fill your maintenance medications before January 1, 2023, you must transfer those prescriptions to Walmart Home Delivery Pharmacy or to any Walmart or Sam's Club pharmacy to receive the AMP pharmacy benefit. Through Walmart Home Delivery Pharmacy, you can get a 30-, 60-, or 90-day supply of most maintenance medications and the convenience of having them shipped directly to you. Need help? Call Walmart Home Delivery Pharmacy at **866-855-0740** to move your maintenance medications to mail order.

SPECIALTY MEDICATIONS

Effective January 1, 2023, you must use Walmart Specialty Pharmacy for specialty medications. See the formulary for a list of specialty medications. You can view an abbreviated list on **One.Walmart.com** or you can call OptumRx at **844-705-7493** for a full list. If you were using OptumRx Specialty Pharmacy to fill your specialty medications before January 1, 2023, you must transfer those prescriptions to Walmart Specialty Pharmacy. A prior authorization is required for specialty medications. OptumRx will work with your doctor to make sure the medication is clinically necessary for your treatment. If you have received a prior authorization for a specialty medication and that prior authorization is still in effect on January 1, 2023, it will be transferred to Walmart Specialty Pharmacy. Some specialty medications are only available at certain specialty pharmacies. These drugs are classified as limited distribution drugs (LDD). If a certain LDD is not available at Walmart Specialty Pharmacy, that medication will be transferred to OptumRx Specialty Pharmacy or another network specialty pharmacy to be dispensed. If you have questions concerning specialty medications, call OptumRx at **844-705-7493**. See below for special rules for fertility specialty medications.

FERTILITY MEDICATION

The AMP medical benefit covers FDA-approved fertility medications, when prescribed by Kindbody, the Plan's family-building Centers of Excellence provider. These medications are unique to fertility treatment and will be filled through Kindbody's specialty pharmacy, Schraft's Pharmacy, and processed under the terms and conditions as described in the **The medical plan** chapter.

MEDICATIONS THAT REQUIRE PRIOR AUTHORIZATION

Prior authorization is required before some medications can be covered by the AMP, including specialty medications. OptumRx may ask your physician to provide additional information. This is called a "coverage authorization."

After OptumRx receives the required information, it will notify you and your physician (usually within two business days) to confirm whether coverage is authorized. If it is determined that the prescription is not a covered drug or you are not eligible for the drug under the AMP, it will not be paid. You may appeal this decision, as described in the **Claims and appeals** chapter. If you choose to fill the prescription without prior authorization, you must pay the full retail cost, even if the prescription would have been authorized if you had waited. The amount paid will not be applied toward your out-of-pocket maximum.

For questions about prior authorizations, call OptumRx at **844-705-7493**.

SPECIALTY REDIRECTION PROGRAM

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

MEDICATIONS WITH QUANTITY LIMITS

Certain medications have limits on the quantity you can receive per prescription, based on FDA dosage guidelines. A list of these medications can be found on **One.Walmart.com**.

Medications for quantities greater than the FDA-approved quantity are not covered under the AMP. If you choose to fill the prescription, you must pay the full retail cost.

Preventive care

CONTRACEPTIVES FOR WOMEN

The AMP covers all FDA-approved contraceptive methods, including approved over-the-counter (OTC) variations for women, as required by the Affordable Care Act. The AMP covers certain FDA-approved generic contraceptives (and brand-name contraceptives when medically necessary) at 100%, with no deductible, for women who are capable of bearing a child, when the drug is prescribed by a physician. If your attending physician believes a brand-name contraceptive is medically necessary, see **Preventive care exceptions process** in this section.

HIV PREVENTION

The AMP covers preexposure prophylaxis ("PrEP") with effective antiretroviral therapy at 100%, with no deductible, when the drug is prescribed by a physician to a person at high risk of becoming infected with HIV.

PREVENTIVE MEDICATIONS NOT SUBJECT TO THE SAVER PLAN'S NETWORK ANNUAL DEDUCTIBLE

If you are enrolled in the Saver Plan, certain preventive medications are covered under the Saver Plan before you meet the Plan's network annual deductible. Prescription medications that can keep you from developing a health condition are considered "preventive medications." If you are taking prescribed medications for certain

health issues, such as high blood pressure, diabetes, high cholesterol, etc., you may be eligible to get these medications at no cost before you meet your Saver Plan's network annual deductible. OptumRx maintains the list of approved preventive medications. For more information, call OptumRx at **844-705-7493** or visit **One.Walmart.com** to see a formulary list.

PREVENTIVE OVER-THE-COUNTER MEDICATIONS

The AMP covers certain generic over-the-counter (OTC) preventive care medications at 100% when they are prescribed by a physician and purchased at a Walmart or Sam's Club pharmacy. You will need to present your plan ID card and a prescription from your physician at the time of purchase. Covered OTC preventive care medications are those required under the Affordable Care Act. If your physician believes a brand-name preventive OTC medication is medically necessary rather than a generic, see the **Preventive care exceptions process** on this page.

Some common preventive OTC medications identified by the United States Preventive Services Task Force (USPSTF) are listed in the **Preventive over-the-counter medications** chart below. For a current list of covered preventive care OTC medications, call OptumRx at **844-705-7493** or visit **One.Walmart.com** to see a formulary list.

PREVENTIVE OVER-THE-COUNTER MEDICATIONS Recommended by the U.S. Preventive Services Task Force (USPSTF)	
Oral fluoride	By prescription when appropriate for children 6 months to 6 years of age
Folic acid	By prescription for all women planning or capable of pregnancy
Generic aspirin	Low-dose aspirin (81mg/d) by prescription after 12 weeks of gestation in pregnant women at high risk for preeclampsia
Bowel prep agents	By prescription when appropriate for a screening colonoscopy for adults age 45 and over

PREVENTIVE CARE EXCEPTIONS PROCESS

As noted earlier in this chapter, the Plan covers generic contraceptive and preventive care medications as required by the Affordable Care Act. If your attending physician thinks a brand-name contraceptive or preventive care drug is medically necessary, the provider can prescribe that brand-name medication, and an exception will be granted. For more information, your physician may call OptumRx at **844-705-7493**.

What is not covered by the pharmacy benefit

Medications not covered by the pharmacy benefit include but are not limited to:

- Compound medications, which consist of two or more ingredients that are measured, prepared or mixed according to a prescription order. Select compounded ingredients will not be covered. These may include ingredients that are not approved by the FDA or are available over-the-counter.
- Over-the-counter medication, with the exception of insulin, when a state does not require a prescription for it. Certain over-the-counter medication are covered as part of the preventive care benefit under the Affordable Care Act, when a prescription is provided. See **Preventive over-the-counter medications** earlier in this chapter for more information.
- Prescriptions filled at a pharmacy other than a Walmart or Sam's Club pharmacy or Walmart Home Delivery Pharmacy (except as noted).
- Prescriptions filled by a pharmacy that is not an eligible pharmacy for your medical plan option.
- Prescription drugs that are not included on the formulary.
- Prescription drugs with over-the-counter equivalents.
- Prescription drugs purchased through a pharmacy discount program.
- Drugs for which prior authorization has not been secured, in cases where prior authorization is required.
- Prescription drug claims that are reduced, subsidized, or paid by another health plan, insurance provider, or pharmacy discount program. The AMP does not coordinate benefits for pharmacy claims.
- Prescription drugs that are dispensed, infused, or injected during an in-patient treatment or that are covered by the AMP as a medical benefit rather than a pharmacy benefit.

This list is not meant to be an all-inclusive list of excluded drugs and medications. For questions about excluded medications, call OptumRx at **844-705-7493**.

Pharmacy discounts for prescriptions not covered

If a prescription is covered by the pharmacy benefit, the appropriate copay or coinsurance will apply. However, if the prescription is covered under the AMP but ineligible for coverage under the pharmacy benefit (e.g., it is being filled too soon or is prescribed for off-label use), the prescription will not be covered by the pharmacy benefit and is not eligible for the pharmacy discount described in this section.

If you are enrolled in the AMP, you are eligible for a pharmacy discount on certain medications not covered by the pharmacy benefit. The discount varies depending on the medication prescribed. Prescriptions purchased with the retail pharmacy discount do not count toward your network annual deductible or out-of-pocket maximum.

To use the pharmacy discount, present your plan ID card to the pharmacy when you pick up your prescription. If the prescription is not covered by the pharmacy benefit, the retail pharmacy will automatically discount the cost of the drug.

For information, contact OptumRx at **844-705-7493**.

Manufacturer assistance and other discounts or coupons

Discounts, coupons, pharmacy discount programs, debit cards, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug discounts/coupons provided to pharmacies when you fill a prescription) do not count toward your annual out-of-pocket maximum. In addition, if you have coverage under the Saver Plan, these charges do not count toward your annual deductible.

Filing a pharmacy benefit claim

When you fill a prescription at an eligible network pharmacy, you do not need to file a claim. However, if you are unable to use your card at a network pharmacy or if you disagree with the amount you must pay, you can file a claim with OptumRx. Your claim must be submitted in writing within 18 months of the date you had the prescription filled (or attempted to have it filled). If the prescription is an eligible prescription, it will be paid in accordance with the terms of the pharmacy benefit.

Where the Plan requires prior authorization, you must file a pre-service claim with OptumRx prior to filling your prescription.

Call OptumRx at **844-705-7493** for a claim form, or visit **One.Walmart.com**. Claims are processed according to the terms described in the **Claims and appeals** chapter.

If your claim is denied, you have a right to appeal. Appeals are processed according to terms described in the **Claims and appeals** chapter.

Privacy and security

When you purchase prescription drugs through a Walmart or Sam's Club pharmacy, Walmart Home Delivery Pharmacy, Walmart Specialty Pharmacy, or if eligible, an OptumRx network pharmacy, your personal and medical information is kept confidential. All network pharmacies are covered by and adhere to applicable state and federal regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which protects the privacy of personal health information. Walmart values the trust that our associates place in us. Earning that trust is consistent with our core value of respect for the individual. For more information, see **HIPAA notice of privacy practices** in the **Legal information** chapter.

Health savings account (HSA)

Health savings account for Saver Plan participants

If you are enrolled in the Saver Plan and want to save money on qualified medical expenses, the HSA is a great option. Your HSA contributions are tax-free and the company will match them dollar-for-dollar, up to set limits. Your account balance earnings are also tax-free and, as the money grows from year to year, you can use it to pay for current or future medical expenses.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Establish an account or change your contribution amount	Log on to **One.Walmart.com**	Call People Services at **800-421-1362**
Access your HSA	Log on to **MyHealthEquity.com** If you are logging in for the first time as a member and have not already established a user ID and password, click "Create username and password."	Call HealthEquity at **866-296-2860** HealthEquity is the HSA administrator and custodian.
Get a list of qualified medical expenses (I.R.C.§ 213(d)) Get information on contribution limits, eligibility, and tax reporting responsibilities associated with an HSA	**irs.gov** **IRS Publication 502**, *Medical and Dental Expenses* **IRS Publication 969**, *Health Savings Accounts and Other Tax-Favored Health Plans*	Call HealthEquity at **866-296-2860** or contact your tax advisor

What you need to know about the HSA

- You must be enrolled in the Saver Plan to open and contribute to an HSA through this program.
- The company will match on a pretax basis each dollar you contribute, up to the matching limit.
- The HSA allows you to pay for qualified medical expenses (as defined by the IRS) with tax-free dollars.
- The HSA accepts rollover contributions from other eligible HSAs.
- You are not eligible to make HSA contributions for any month in which you travel on company business outside the U.S. and are covered under GeoBlue international business travel medical insurance, which provides health benefits for associates traveling internationally on business. Consult your tax advisor if you have questions about the amount to reduce your contributions based on your individual circumstances.
- The health savings account is offered through HealthEquity.

HSA advantages: tax breaks and Walmart contributions

If you are enrolled in the Saver Plan, the HSA offers you:

- Company contributions to your HSA to match your pretax contributions, dollar-for-dollar up to the matching limit.
- The ability to contribute pretax dollars to your HSA through payroll deductions.
- The ability to roll over funds from prior HSAs.
- The ability to pay for qualified medical expenses with tax-free dollars through the account, including easy access to the money in your account using the debit card you will receive from HealthEquity. You can also access the funds in your account by logging in to **MyHealthEquity.com**.

HealthEquity is the HSA administrator/custodian with which the company has contracted to receive HSA contributions made through payroll deductions and matching contributions from the company. To receive company matching contributions to your HSA or make pretax contributions through payroll deductions, you must maintain an open account with HealthEquity and continue to be enrolled in the Saver Plan. If you have an HSA with another custodian, the company will not allow you to make pretax contributions through payroll deductions for that HSA or make matching contributions to that HSA. You may move your funds to another HSA custodian at any time, but the company will support ongoing payroll deductions and provide company matching contributions only for HSAs established with HealthEquity.

Interest earnings and capital gains on the balance in your account are not taxed during the period in which the funds remain in your account. In addition, all HSA funds withdrawn for qualified medical expenses are tax-free.

You will have the opportunity to invest your account balance once that balance reaches a certain amount. Investments are not guaranteed or FDIC-insured.

The balance in your HSA rolls over from year to year, increasing your savings for future medical expenses. You own the balance in your account, and can save it, invest it in funds offered through HealthEquity, or spend it on qualified medical expenses.

NOTE: State tax law with respect to HSAs may differ from federal tax law in certain states, including California and New Jersey, which do not exempt HSA contributions from state income tax. Please consult your tax advisor or HealthEquity if you have questions about either the federal or state tax implications of a health savings account.

HSA eligibility

You must be enrolled in the Saver Plan to contribute to an HSA through this program. The Saver Plan is a qualified high-deductible health plan (HDHP) subject to ERISA and to requirements of federal law that allow you to contribute to an HSA. The company does not, however, insure the HSA described in this chapter. It is the company's intention to comply with U.S. Department of Labor guidance specifying that an HSA is not subject to ERISA when the employer's involvement with the HSA is limited. Accordingly, the HSA is not established or administered by the company or the Plan. Instead, the HSA is established by you during the benefits enrollment process and administered by HealthEquity.

Even if you are enrolled in the Saver Plan, you are not eligible to make HSA contributions if:

- You are covered under any other health plan that is not a qualified high-deductible health plan, including a general purpose health care flexible spending account (FSA) or health reimbursement account (HRA). This also includes a general purpose FSA or HRA of a spouse or other family member under which you have coverage. There are some exceptions for "limited purpose" FSAs/HRAs, which can be used for dental or vision or preventive care coverage only; "post-deductible" FSAs/HRAs, which provide coverage only after you satisfy the deductible under an HDHP; some disease-specific coverage; dental, vision, long-term care, and disability coverage; accident policies such as critical illness insurance and accident insurance, and others. However, if you are enrolled in the Saver Plan and also enrolled in critical illness insurance offered under the Plan, you are not eligible for the major organ transplant rider under the critical illness insurance due to IRS guidance suggesting that such coverage would be viewed as non-high-deductible health plan coverage. For information, contact HealthEquity by phone at **866-296-2860** or online at **MyHealthEquity.com**.
- You are enrolled in Medicare.
- You are enrolled in Medicaid.
- You are covered under TRICARE.
- You have received medical services from the U.S. Department of Veterans Affairs during the preceding three months, other than benefits for preventive care or a service-connected disability. Mere eligibility for Veterans Affairs benefits does not disqualify you from contributing to an HSA.
- You have received medical services at an Indian Health Service (IHS) facility during the preceding three months.
- You can be claimed as a dependent on another person's tax return.

You are also not eligible to make HSA contributions for any month in which you are traveling on company business outside the U.S. and are covered under GeoBlue international business travel medical insurance, which provides health coverage for associates traveling internationally on business. Consult your tax advisor if you have questions about the amount to reduce your contributions based on your individual circumstances.

Other restrictions may apply. For further information, please call HealthEquity at **866-296-2860**. You are responsible for determining if you are eligible for an HSA.

Your dependent's status does not affect your ability to contribute to an HSA. For example, your covered spouse/partner's Medicare status will not affect your ability to contribute to an HSA.

During the Plan year, you may be required to confirm account eligibility to continue contributions (for example, if you become Medicare-eligible because of your age, you may be asked to verify that you have not enrolled in Medicare). In certain cases, Medicare enrollment can be retroactive (such as if you delay your enrollment past age 65) and, if that occurs, you will also lose eligibility to make HSA contributions retroactively. If you are eligible for, or are enrolling in, Medicare, you should carefully evaluate your participation in the HSA to avoid penalties for excess contributions.

If you make or receive an ineligible contribution to your HSA, excise taxes may apply unless you remove the contribution by certain deadlines. For more information about Medicare, HSA eligibility, or how to correct ineligible contributions, contact your tax advisor or review **IRS Publication 969**, *Health Savings Accounts and Other Tax-Favored Health Plans*. You can also call **800 Medicare** (**800-633-4227**), or visit **medicare.gov**.

Opening your HSA

When you enroll online in the Saver Plan, you choose the amount you want to contribute to your HSA through payroll deductions. You may change your contribution amount at any time. See **Setting up or changing your contribution amount** later in this chapter.

You will receive a welcome kit at the home address that the company has in its records directly from HealthEquity, generally within the following time frames:

- By the end of December if you enroll during Annual Enrollment, or
- Within two to three weeks after your HSA is opened if you enroll at any other time.

Your debit card will be included within the welcome kit. Activate your debit card online at **MyHealthEquity.com** or by calling HealthEquity at **866-296-2860**.

No pretax contributions or employer matching contributions will be deposited to your HSA until it is open and your Saver Plan coverage is effective. Your account will not be considered open until you have successfully passed the customer identification process required to open an HSA. If HealthEquity requires additional information to complete this process, it will contact you.

Once HealthEquity confirms that your account is open and you have completed your HSA election online, your pretax contributions and the company's matching contributions will begin the following pay period. If any pretax contributions or employer matching contributions are made before your HSA is open, HealthEquity will hold those contributions and deposit them into your HSA when it is open. If your account is not opened within a reasonable amount of time, the funds withheld from your pay will be refunded to you through your payroll check (less applicable payroll taxes) and reported as wages on your Form W-2. The employer contribution, if any, will be returned to the company.

Your right to receive company matching contributions to your HSA is contingent upon your opening your HSA in a timely manner, and company matching contributions will not be earned or available unless you have opened your HSA in a timely manner. If you do not open your HSA by December 1 of the Plan year, you will forfeit your right to the company's matching contributions for that year, even if you are enrolled in the Saver Plan during that year.

For questions about your account status, welcome kit, or debit card, call HealthEquity at **866-296-2860** or go online to **MyHealthEquity.com**.

To transfer funds from a prior HSA, contact HealthEquity at **866-296-2860**.

HSA FEES

The company pays the monthly HSA maintenance fees if you are enrolled in the Saver Plan and your HSA custodian is HealthEquity. However, if you are enrolled in COBRA, terminate employment with the company, otherwise become ineligible for AMP coverage, or are no longer enrolled in the Saver Plan, you will be responsible for paying the monthly maintenance fees. These fees will be deducted automatically from your HSA balance if any of these events occur. Call HealthEquity at **866-296-2860** to learn about the fees for various HSA services. It is your responsibility to check your HSA balance prior to using funds to pay for services. Current rate and fee schedules are available online at **MyHealthEquity.com**. The fee schedule is also included in the welcome kit.

The company does not pay overdraft fees, excess contribution fees, or lost card fees. The company also does not contribute funds or pay any fees associated with an HSA for your spouse or partner enrolled in the Saver Plan through your family coverage.

HSA STATEMENTS AND INFORMATION

Your right to receive a statement regarding your HealthEquity HSA balance and other information regarding your HealthEquity HSA is governed by the terms of the HealthEquity custodial agreement. To review information regarding your HSA, including the HealthEquity custodial agreement, please go to **MyHealthEquity.com**.

Contributions to your HSA

Once you open your HSA, contributions to your HSA will be made under the following terms (as long as your account is open and you are enrolled in the Saver Plan):

- You may make pretax contributions to your HSA through payroll deductions in any amount (of $5 or more each pay period) up to the legal limit, taking into account the company's contributions. Contributions are generally based annually on 26 pay periods.
- The company will match your pretax contributions dollar-for-dollar, up to the matching limit described in the chart below.
- Pretax contributions and company matching contributions are deposited into your HSA shortly after each payroll deduction period ends.
- In addition to making pretax contributions by payroll deduction, you may contribute money directly to your HSA by mailing a check to HealthEquity, or by electronic funds transfer (EFT) once you have linked a personal bank account on the HealthEquity website. Any such contributions count toward the contribution limit stated in the chart below. These personal contributions are made on an after-tax basis and are not eligible for the company matching contribution. Although you may be able to claim an income tax deduction for contributions made directly to your HSA, there is no corresponding deduction for Social Security or Medicare taxes that may have been imposed on the funds used to make the direct contributions. (By comparison, pretax contributions made through payroll deductions are exempt from Social Security and Medicare taxes, as well as federal income tax and, in many cases, state income tax.) The company does not track your after-tax HSA contributions; you bear the responsibility of making sure you do not exceed the annual contribution limit.
- If your requested HSA contribution for a specific pay period exceeds the amount of your paycheck after deductions, no pretax contribution or company match will be made to your HSA for that pay period.
- With respect to your final paycheck, your HSA pretax contributions and corresponding company match may be reduced because of state law restrictions on salary reduction or because your requested HSA contribution exceeds the net amount of your payroll check after deductions.

If you experience an election change event and switch from associate-only coverage to family coverage under the Saver Plan during the year, the company will increase its matching contribution to correspond with the matching contribution limit for family coverage. If you switch from family coverage to associate-only coverage during the year, the matching contributions that the company made prior to the change will not be reduced. If this results in your having contributions in your account above the annual contribution limit, the excess contributions must be withdrawn by the tax-filing deadline to avoid additional taxes.

ANNUAL CONTRIBUTION LIMITS

By law, there is a maximum amount that may be contributed to your HSA during the year. The annual maximum contribution is the total contribution from all sources (pretax and after-tax contributions made by you and any company matching contributions). For 2023, the maximum annual contribution that can be made to your HSA is:

- $3,850 for individual coverage, or
- $7,750 for family coverage.

These amounts are indexed annually by the federal government and are subject to change each year. You can consult IRS Publication 969 for the indexed amounts applicable to a particular year.

YOUR CONTRIBUTIONS AND THE COMPANY'S CONTRIBUTIONS TO THE HSA

Your Saver Plan network annual deductible	Company matching contribution: $1 for $1 up to	2023 maximum annual contribution (associate and company contributions combined)*
$3,000 (associate-only coverage)	$350	$3,850
$6,000 (family coverage)	$700	$7,750

*If you are age 55 or over by 12/31/2023, you can contribute an additional $1,000 in 2023.

Your maximum annual HSA contribution may be lower than the maximum set by law if there are any months during the year for which you are not HSA-eligible. You are HSA-eligible for a month if you have qualifying high-deductible health coverage on the first day of the month (such as coverage through the Saver Plan) and you do not have any disqualifying health coverage on the first day of the month (such as coverage under Medicare or a "low deductible" health plan). If you are not HSA-eligible for one or more months during the year, your maximum annual HSA contribution is prorated for the number of months that you are HSA-eligible. For example, if you are only HSA-eligible for nine months of the year, your maximum annual HSA contribution is 9/12 (75%) of the annual maximum set by law. You are responsible for determining your maximum annual HSA contribution.

It is important to monitor contributions to your HSA—there are adverse tax consequences if your contributions exceed the annual limit. Changes in coverage during the year or enrollment after the beginning of the year can affect your contribution limits. If you become aware during the year that combined contributions to your HSA exceed the annual limit, you can withdraw the excess contribution and the related interest earnings before your income tax return for the year is due (including extensions). For assistance and information, call HealthEquity at **866-296-2860**.

IF YOU ARE AGE 55 OR OLDER

If you are age 55 or older in 2023, you can make additional "catch up" contributions to your HSA by payroll deduction, just like your regular contribution. For 2023, the catch-up contribution limit is $1,000. Call HealthEquity at **866-296-2860** for information.

IF YOU HAVE FAMILY COVERAGE

If you also cover your spouse under the Saver Plan and you are legally married, you are both eligible to contribute to individual HSAs, but the contribution limit for 2023 for both accounts combined is based on the maximum amount that can be contributed for a family: $7,750. This limit can be shared between you and your spouse in any way you agree. If either you or your spouse is age 55 or older in 2023, the total combined contribution is increased by $1,000 for each participant age 55 or older. However, the extra $1,000 can only be contributed by each spouse to their own individual HSA. The company does not contribute funds or pay any fees associated with an HSA for your spouse.

If you cover an eligible partner under the Saver Plan and you are not legally married, you and your partner are each eligible to contribute to individual HSAs up to the maximum family contribution limit of $7,750 (provided that neither you nor your partner can be claimed as a tax dependent on any individual's federal tax return). If either you or your partner is age 55 or older in 2023, the maximum contribution is increased by $1,000 for each participant age 55 or older, but this extra $1,000 can only be contributed by each partner to their own individual HSA. The company does not contribute funds or pay any fees associated with an HSA for your partner.

Call HealthEquity at **866-296-2860** for information on opening an HSA for your eligible spouse/partner.

EARNING INTEREST ON YOUR HEALTH SAVINGS ACCOUNT

The uninvested balance in your HSA earns interest. For interest rate information on your account, contact HealthEquity at **866-296-2860** or go online to **MyHealthEquity.com**. Your current interest earned, along with the interest rate schedule, is available on your monthly statements.

SETTING UP OR CHANGING YOUR CONTRIBUTION AMOUNT

You may change your contribution amount online at any time during the year on a prospective basis.

To set up or change your contribution amount, log on to **One.Walmart.com**. Contact People Services at **800-421-1362** if you need help setting up your payroll deductions.

NOTE: Once you make the maximum annual contribution (as stated in the chart on the previous page), your payroll contributions automatically cease. It is your responsibility to make a new contribution decision at the next Annual Enrollment for the following calendar year.

Paying qualified medical expenses through your HSA

When you have an eligible medical expense, you can decide whether to pay out of your pocket or use the funds in your HSA. Some people use their HSA for current expenses, while others prefer to use the HSA as an account for future health care expenses. Eligible medical include health plan deductibles and coinsurance, most medical care and services, dental and vision care, prescription drugs, and over-the-counter drugs. In addition, amounts paid for certain menstrual care products such as tampons and pads are eligible medical expenses. These expenses must not already be covered by your medical plan, and health insurance premiums generally do not qualify. Only medical expenses incurred after you have established an HSA are eligible for payment or reimbursement through an HSA. Refer to IRS Publications 969 and 502 at **irs.gov** for information about qualified medical expenses. You can also find information about qualified medical expenses on **One.Walmart.com** and **MyHealthEquity.com**.

THE HSA AND YOUR INCOME TAX RETURN

The funds in your HSA belong to you, but any money used for nonqualified medical expenses is subject to federal income tax as well as a 20% penalty if you are under age 65. Make sure you save your receipts and other records to show that you used your HSA funds for eligible medical expenses. Remember that you are responsible for the tax consequences associated with contributions to and withdrawals from your HSA. Consult your tax advisor if you have questions about your HSA and taxes.

Investing your HSA

Once your HSA reaches a minimum balance of $1,000, you can invest any amount over that balance in a selection of over 20 investment funds available through HealthEquity. Review the funds and learn more at **MyHealthEquity.com** under "Investments." You are responsible for your own investment decisions. Amounts that are invested are not guaranteed or FDIC-insured and may lose value.

If you leave the company or are no longer enrolled in the Saver Plan

The funds in your HSA belong to you as the account holder, even if you enroll in COBRA, change medical plans, change jobs, or leave the company. In these events, all fees associated with the account become your responsibility.

Closing your HSA

All funds in your HSA belong to you. You may use these funds for qualified medical expenses on a tax-free basis now and in the future. If you do not choose to maintain the account, call HealthEquity at **866-296-2860** for information on closing your account. If you withdraw funds from your HSA upon closing the HSA, you may be subject to taxes on the withdrawn amounts.

The dental plan

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

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

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

The dental plan

The dental plan covers a wide range of services, with no deductible for preventive care or orthodontics. Plus, when you use network dentists, you'll save money while protecting one of your biggest assets—your smile.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get a listing of Delta Dental network dentists	Go to **One.Walmart.com** or **deltadentalar.com**	Call Delta Dental at **800-462-5410** or People Services at **800-421-1362**
Get answers to questions about your dental claims and to contact Delta Dental Customer Service	Go to **deltadentalar.com** and select "Login/Register" to create your account	Call Delta Dental at **800-462-5410**
Get a claim form if you use a nonparticipating dentist	Go to **One.Walmart.com** or **deltadentalar.com**	

What you need to know about the dental plan

- If you are an eligible associate, you may purchase dental coverage to assist with preventive, basic, and major dental care as well as with orthodontia expenses. See the **Eligibility, enrollment, and effective dates** chapter for information on eligibility.
- Delta Dental of Arkansas administers the dental plan benefit.
- Once you meet the dental plan's annual deductible, the dental plan pays benefits of up to $2,500 per covered person per calendar year and a lifetime maximum orthodontia benefit of $1,500 per covered person. The annual deductible does not apply for preventive and diagnostic services or orthodontia.
- Dental plan coverage must remain in effect for two full calendar years.
- Orthodontia is covered after a 12-month waiting period.
- If you have medical coverage with the Associates' Medical Plan (AMP), both the dental and medical information are on your plan ID card. If you are enrolled in an HMO or if you have dental-only coverage, you will receive a Delta Dental ID card. Your ID cards will be mailed to your home address on record at Walmart.

Your dental plan

The dental plan is available to you if you are an hourly or management associate. Coverage is also available to your eligible dependents, with the exception of spouses/partners of part-time associates, temporary associates, and part-time truck drivers. The dental plan is administered through Delta Dental.

The dental plan benefit is self-insured, which means benefits are not paid by an insurance company.

Delta Dental administers the dental plan and has been delegated the fiduciary authority to make determinations with respect to claims for benefits and the first-level appeal of a claim that has been denied.

Once you enroll in the dental plan, your coverage must remain in effect for two full calendar years. You can add or remove a dependent during Annual Enrollment or due to an election change event, but you must maintain a minimum of associate-only coverage for two full calendar years.

CHOOSING A COVERAGE TIER

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

- Associate only
- Associate + spouse/partner (except for part-time hourly associates, temporary associates, or part-time truck drivers)
- Associate + child(ren), or
- Associate + family (except for part-time hourly associates, temporary associates, or part-time truck drivers).

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

How the dental plan works

The dental plan covers four types of dental services:

- **Preventive and diagnostic care** coverage includes oral examinations and cleanings and related services. You do not have to meet the annual deductible before the dental plan covers these services. Charges you incur for preventive and diagnostic care, if any, do not apply toward your deductible.
- **Basic care** coverage includes fillings, nonsurgical periodontics, and root canal therapy, and begins after you meet the annual deductible.
- **Major care** coverage includes surgical periodontics, crowns, and dentures, and begins after you meet the annual deductible.
- **Orthodontia** coverage begins after an individual receiving orthodontia services has been covered under the dental plan for 12 months; you do not have to meet the annual deductible before receiving orthodontia benefits. Charges you incur for orthodontia care do not apply toward your deductible.

NOTE: The 12-month waiting period for orthodontia coverage is waived for:

- Localized associates and their covered dependents, and
- Enrolled participants who have previously met their full waiting period.

COVERAGE UNDER THE DENTAL PLAN			
Annual deductible Waived for preventive and diagnostic care and orthodontia care	$75 per person/$225 per family		
Maximum benefit Does not apply to orthodontia care	$2,500 per covered person per calendar year		
	Delta Dental PPO dentists	**Delta Dental Premier dentists**	**Non-network dentists**
Preventive and diagnostic care Charges (if any) do not count toward annual deductible	100% covered; no annual deductible applies	80% covered;* no annual deductible applies	80% of maximum plan allowance; no annual deductible
	*In areas served by an insufficient number of PPO dentists, as determined by facility location, services are covered at 100%. Go to **One.Walmart.com** for details.		
Basic care Including fillings, non-surgical periodontics, and root canal therapy	80% of maximum plan allowance after annual deductible is met		
Major care Including surgical periodontics, crowns, and dentures	50% of maximum plan allowance after annual deductible is met		
Orthodontia (12-month wait) Charges do not count toward annual deductible or maximum benefit	80% of maximum plan allowance up to $1,500 lifetime maximum orthodontia benefit per person; no annual deductible applies		

After you meet the annual deductible (if applicable) and complete any applicable waiting period, the dental plan pays a percentage of the maximum plan allowance (MPA) for covered expenses.

MAXIMUM PLAN ALLOWANCE (MPA)

The MPA is the maximum amount the dental plan pays for covered dental services. The MPA applies to network and out-of-network dental services.

For covered network services, the MPA is that portion of a provider's charges covered by the dental plan as determined by the provider's contract with Delta Dental of Arkansas. Network providers agree to accept an amount negotiated by Delta Dental for covered services as payment in full, subject to applicable deductible and coinsurance amounts.

For covered out-of-network services, the MPA can differ by state and is derived from a variety of factors, including data from fees on claims and fee filings submitted by the dentist. If you see a non-network dental provider, the dental plan pays a percentage based on the lesser of the MPA or the provider's actual billed charges for a covered procedure. If the provider's billed charges exceed the Plan's MPA, you are responsible for paying 100% of the difference. For additional information, call Delta Dental at **800-462-5410**.

KNOW WHAT YOU'LL OWE: GET A PRETREATMENT ESTIMATE

You are not required to get pre-approval of any dental treatments. But by having your dentist submit a proposed treatment plan, you can learn how much you can expect the dental plan to pay for a procedure or course of treatment before the work is done. It is recommended that a proposed treatment plan be submitted for treatment expected to cost $800 or more. Delta Dental will provide a pretreatment estimate of the amount that will be covered and may suggest an alternate treatment plan if part of your dentist's treatment plan is ineligible for coverage.

To get a pretreatment estimate, ask your dentist to complete a regular dental claim form and check the "predetermination" box. The form should be mailed to:

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, Arkansas 72231-5965

Delta Dental's pretreatment estimate is not a guarantee of payment. You still must file a claim for the services rendered, as set out in the **Claims and appeals** chapter.

SAVE MONEY BY USING NETWORK DENTISTS

As a dental plan participant, you can use any dentist and receive benefits for covered expenses under the Plan. You will save money, however, when you use Delta Dental PPO and Premier dentists. Providers contracted with Delta Dental agree to accept the dental plan's maximum plan allowance as payment in full for a covered procedure, so you pay no more than the dental plan's applicable coinsurance percentage (after you meet any applicable annual deductible). In addition, you may save time when you use Delta Dental PPO or Premier dentists because they will file your claims for you.

The Delta Dental PPO network is an extensive nationwide network of dentists, but is not as widely available as the Delta Dental Premier network. Refer to the chart entitled **Coverage under the Dental Plan** earlier in this chapter for details on how coverage terms for preventive and diagnostic care may differ based on the availability of PPO dentists in your area. To find a Delta Dental PPO or Delta Dental Premier dentist, see **Dental plan resources** at the beginning of this chapter.

IT PAYS TO USE NETWORK DENTISTS		
	Delta Dental Premier dentists and PPO dentists	**Non-network dentists**
Dentist files claim forms for you	Yes	No
Dentist accepts maximum plan allowance as payment in full, subject to annual deductible and coinsurance	Yes	No
Dentist offers discounted prices on services covered by the dental plan for Delta Dental participants	Yes	No

Filing a dental claim

If you use a Delta Dental PPO or Premier dentist, your dentist will file the claim for you. If you use a non-network dentist, you may need to file a claim. The dentist may be paid directly from the dental plan if the dentist is a Delta Dental PPO or Premier dentist. If you use a non-network dentist, the payment will be made to you.

Mail your claim to:

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, Arkansas 72231-5965

You or your dental provider must file a claim in accordance with the claims procedure within 18 months from date of service, or your claim will be denied. Not following the

claims procedure described in the **Claims and appeals** chapter, such as failure to mail your claim to the correct address, may result in the denial of your claim.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial.

IF YOU HAVE COVERAGE UNDER MORE THAN ONE DENTAL PLAN

If you or 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.

What is covered under the dental plan

The dental plan covers the services listed in this section, subject to some limitations. If you have questions about what is covered under the dental plan, call Delta Dental at **800-462-5410**.

PREVENTIVE AND DIAGNOSTIC CARE

Preventive and diagnostic care are covered without having to meet the annual deductible.

Bitewing X-rays: Limited to four per calendar year. Combined with panoramic X-ray if done by same provider on same day and processed as a full mouth series. Limited to two films per visit for children under age 10.

Cleaning (dental prophylaxis): One prophylaxis, including cleaning, scaling and polishing of the teeth, is covered twice during a calendar year. Two additional cleanings are allowed during a pregnancy and up to three months following delivery. Two additional cleanings are allowed for heart disease, diabetes, and periodontal disease. Additional periodontal maintenance (up to four per calendar year) allowed for periodontal disease. The additional benefit may not be combined for a patient with more than one of the above conditions.

Fluoride treatment: Covered once in any consecutive 12-month period for participants under age 19. One additional application per calendar year is covered for eligible dependents under age 19 who are identified at moderate or high risk (as defined by the American Dental Association's Dental Procedure Codes) for developing caries. Application of silver diamine fluoride is covered two times per calendar year per tooth. Restorations within two months of a silver diamine fluoride application are not covered. Sealants and preventive restorations are not covered if silver diamine fluoride has been applied to the tooth. Silver diamine fluoride is not covered on the same day as a restoration of the same tooth.

Full-mouth debridement: Limited to once per lifetime.

Full-mouth series or panoramic X-rays: Limited to one procedure in any consecutive 60-month period. A full-mouth series is any combination of 14 or more periapical and/or bitewing X-rays taken on the same date. If the combination of separately billed intraoral images (i.e., bitewings and periapicals) equals or exceeds the number of films allowed for a full mouth series, the charges for the images will be combined and deemed to comprise a full mouth series. A benefit is paid only if no other full mouth series or panoramic radiographic image has been paid during the preceding 60 consecutive months.

Oral evaluations: Benefits are payable as follows:

- **Routine oral evaluation:** Two evaluations covered during a calendar year.
- **Comprehensive detailed oral evaluation or periodontal evaluation:** Initial comprehensive oral evaluation are payable subject to the routine oral evaluation time limitations. Subsequent oral evaluations submitted by the same provider within three years are processed as routine oral evaluations.

Emergency evaluations performed by dentists are not subject to the calendar year restriction.

Periapical X-rays: Covered as needed.

Preventive resin restoration: Covered for first and second permanent molars with unrestored occlusal surface for participants under age 19. Limited to one treatment per tooth every five years.

Pulp vitality tests: Covered if same provider does no other definitive procedure the same day.

Risk assessment: Covered once every three-year period for children age 3 through age 18.

Sealant repair: Covered for first and second permanent molars with unrestored occlusal surface for participants under age 16. Not covered during the first 24 months of the initial placement of the sealant. Limited to one treatment per tooth every 24 months. Not covered when the tooth has previously received a preventive resin restoration.

Sealants: Covered for first and second permanent molars with unrestored occlusal surface for participants under age 16. Limited to one treatment per tooth per lifetime. Not covered when the tooth has previously received a preventive resin restoration.

Space maintainers: Covered for participants age 13 and under. Limited to one appliance per space (quad/arch) extraction site in any consecutive 60-month period. Repair of a space maintainer is not covered.

BASIC CARE

After you meet the annual deductible, the Plan pays 80% of the maximum plan allowance for basic care.

Amalgam and composite resin fillings: Benefits are payable once per tooth surface in any consecutive 24-month period.

Endodontics: Includes pulp therapy and root canal therapy. See **Root canal therapy** in **Major care** below.

Extractions: Nonsurgical extractions are covered once per tooth.

Nonsurgical periodontics: Provided once per quadrant in any consecutive 24-month period.

Occlusal orthotic device (TMJ appliance): Benefits are payable once every five years. Adjustments within six months are not covered. One adjustment covered per year thereafter.

Periodontal maintenance: Periodontal maintenance is covered only if done 30 days or more after the completion of surgical or nonsurgical periodontal treatment. Thereafter, periodontal maintenance is allowed up to four times per calendar year. This benefit is combined with any routine cleanings performed during the same calendar year with a combined limitation of four for that year.

MAJOR CARE

After you meet the annual deductible, the Plan pays 50% of the maximum plan allowance for major care.

Anesthesia/general anesthetics and IV sedation: Covered only when provided in the following circumstances:

- The patient suffers from a medical condition that prevents him or her from holding still (including but not limited to dystonia, Parkinson's disease, autism)
- The patient is under age 4, or
- In connection with certain covered oral surgical procedures.

Complete and partial removable dentures and partial fixed bridges: Covered when the denture or bridge is the professionally accepted, standard course of treatment.

- Includes replacement or addition of teeth to dentures, partials, or fixed bridgework.

- When alternate treatment plans are available, the dental plan covers the professionally accepted, standard course of treatment. For example, a bridge is allowed only when a partial denture will not suffice. See **Alternative treatment plans** in **Limited benefits** later in this chapter.
- Full or partial or removable dentures or fixed bridges are not payable for patients under the age of 16.
- A denture that replaces another denture or fixed bridge, or a fixed bridge that replaces another fixed bridge, is covered only if the existing denture, partial denture, or fixed bridge is at least five years old and cannot be repaired.

Crowns, cast restorations, inlays, onlays, and veneers: Covered only when the tooth cannot be restored by amalgam or composite resin filling.

- Replacement is not covered unless the existing crown, cast restoration, inlay, onlay, or veneer is more than five years old and cannot be repaired.

  NOTE: Accidents as a result of biting or chewing are not an exception to the five-year wait for crown replacements.
- For participants under age 12, benefits for crowns on vital teeth are limited to resin or stainless steel crowns unless there is a history of root canal therapy or recession of the pulp.
- Treatment is determined according to the alternate treatment plan limitation. See **Alternative treatment plans** in **Limited benefits** later in this chapter.

Implants: Surgical placement of an implant body is covered once in every five-consecutive-year period.

- The abutment to support a crown is covered once in every five-consecutive-year period.
- An implant or abutment-supported retainer is covered once in every five-consecutive-year period.
- An implant maintenance procedure is covered once in any 12-consecutive-month period.
- Implant removal is covered once in a lifetime per tooth. Implants are not payable for patients under the age of 16.

Occlusal adjustment (limited): Covered only if done six months or more after completion of initial restorative, prosthodontic and implant procedures that include the occlusal surface.

Oral surgery: Surgical extractions and extractions of wisdom teeth, including preoperative and postoperative care, except for those services covered under the Associates' Medical Plan. Oral sedation and/or nitrous oxide (analgesia) are not covered. If oral surgery is performed in a hospital setting, the dental plan covers oral surgeon fees for such services for covered individuals not enrolled in the Associates' Medical Plan.

Outpatient or inpatient hospital costs and additional fees charged by the dentist for hospital treatment: See **Hospital charges** in **What is not covered under the dental plan** later in this chapter.

Root canal therapy: Includes bacteriological cultures, diagnostic tests, local anesthesia, and routine follow-up care. Payable once per tooth.

- Therapeutic pulpotomy is payable once per tooth until age 21.
- Retreatment of a previous root canal is allowed once in a consecutive 24-month period.

Surgical periodontics: Treatment of the gums—osseous surgery/soft tissue graft, provided in the same area once in any consecutive 36-month period.

ORTHODONTIA

After you have been a participant in the dental plan for 12 months, you are eligible for orthodontia assistance for yourself (the associate). Each of your covered dependents must also participate in the dental plan for 12 months before becoming eligible for orthodontia assistance. If your (or your covered dependent's) coverage ends for any reason and you or your covered dependent reenroll after having met the 12-month eligibility waiting period, your prior time enrolled for coverage will count toward the 12-month waiting period. If your (or your covered dependent's) coverage ends for any reason and you or your dependent had not met the 12-month waiting period prior to reenrollment, the 12-month waiting period will start over.

NOTE: The 12-month waiting period for orthodontia coverage is waived for:

- Localized associates and their covered dependents, and
- Enrolled participants who have previously met their full 12-month waiting period.

If the dentist submits a statement at the beginning of a period of orthodontic treatment showing a single charge for the entire treatment, benefits are paid in the following manner:

- The dentist receives an initial payment of up to $150
- A prorated portion of the remainder is paid every three months based on the estimated period for treatment and on continued eligibility, and
- The amount and number of payments are subject to change if the charge or treatment period changes.

The dental plan covers only orthodontic treatment that begins after the covered individual becomes eligible for orthodontia assistance. Active orthodontic treatment is deemed started on the date the active appliances are first placed. Active orthodontic treatment is deemed completed on the earlier of:

- The date on which treatment is voluntarily discontinued, or
- The date on which the active bands or appliances are removed.

Repair or replacement of an orthodontic appliance is not covered.

There are certain orthodontia assistance benefits that are not covered. See **What is not covered under the dental plan** below.

Limited benefits

Alternative treatment plans: When alternative treatment plans are available, the dental plan covers the professionally accepted, standard course of treatment.

Transfer of treatment: If you transfer from the care of one dentist to another during the course of treatment, or if more than one dentist renders services for one dental procedure, the dental plan pays no more than the amount it would have paid if only one dentist had rendered services.

What is not covered under the dental plan

The dental plan does not pay benefits for all types of services. To determine if a service is covered, call Delta Dental or submit a pretreatment estimate of benefits form. Services that are not covered by the plan include, but are not limited to, the following:

Accidental injury to sound, natural teeth: Expenses for treatment of accidental injury to sound, natural teeth may be covered under the medical plan. This exclusion does not apply to accidental injuries as a result of biting or chewing; these charges may be covered under the dental plan.

Beyond the scope of licensure or unlicensed: Services rendered by a dentist beyond the scope of their license, or any services provided by an unlicensed dentist.

Bridgework: Repair of bridgework during the first six-month post-delivery period, and such services received more often than once every 60-consecutive-month period. Recementation of bridgework during the first six-month post-delivery period, or such services received more than once every 12-consecutive-month period.

Cosmetic purposes: Services performed for cosmetic purposes or to correct congenital, hereditary, or developmental malformations. This exclusion does not apply to orthodontic services for the correction of malposed teeth.

Dentures: Repair or relining of dentures during the first six-month post-delivery period, and such services received more often than once every five years for repairs and once every three years for relines and rebases. Immediate denture relining during the first three-month post-delivery period.

Elective non-emergency dental services outside the U.S.

Elective non-necessary services: Services that are not dentally necessary or that do not meet generally accepted standards of care for treating the particular dental condition, including decoration, personalization or inscription of any tooth, device, appliance, crown, or other dental work.

Experimental or investigational: Charges for treatment or services, including hospital care, that are experimental, investigational, or inappropriate, under protocols established by Delta Dental.

Governmental agency: Services provided or paid for by any governmental agency or under any governmental program or law, except charges for legally entitled benefits under applicable federal laws.

Hospital charges: Services performed in a hospital or outpatient hospital setting, including but not limited to provider and facility charges. This exclusion does not apply to oral surgeon fees for participants not enrolled in the Associates' Medical Plan, subject to terms of the dental plan.

Occlusal guards: Devices serving to minimize effects of bruxism (grinding) or other occlusal factors. This exclusion does not apply to occlusal orthotic devices to treat TMJ disorders.

Oral sedation: Oral sedation and/or nitrous oxide (analgesia).

Orthodontia care: Services in connection with treatment for the correction of malposed teeth during the first 12 consecutive months that a participant is covered under the dental plan.

Periodontal splinting: Charges for complete occlusal adjustments or stabilizing the teeth through the use of periodontal splinting.

Permanent restorations: Charges for bases, liners, and anesthetics used in conjunction with permanent restorations (fillings).

Prescription drugs and medicines: Written for dental purposes.

Prosthetics, duplicates: Duplicate prosthetic devices or appliances.

Retainers: Separate charges for retainers (appliances intended to retain orthodontic relationship) or habit appliances to address harmful behaviors such as thumb-sucking or tongue-thrusting.

Services undertaken prior to effective date or during the waiting period for orthodontia services: Charges for courses of treatment, including prosthetics and orthodontics, which are begun prior to the effective date of coverage or before you are eligible to receive benefits for orthodontia services.

Surgical corrections: Charges for services related to the surgical correction of:

- Temporomandibular joint dysfunction (TMJ)
- Orofacial deformities, and
- Specified oral surgery procedures covered by the Associates' Medical Plan.

Tooth structure: Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.

OTHER CHARGES NOT COVERED

- Any procedure performed for a temporary purpose
- Charges in excess of the maximum plan allowance
- Extraoral grafts
- Hypnosis or acupuncture
- Oral hygiene instruction and dietary instruction
- Plaque control programs
- Services covered by the Associates' Medical Plan
- Services for which there is no charge
- Teledentistry
- Any other services not specifically listed as covered
- Charges covered by workers' compensation or employers' liability laws
- Services provided by a member of the participant's family, or
- Charges incurred as a result of war.

Break in coverage

There may be occasions in which you must make special arrangements to pay your dental 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 **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** 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, enrollment, and effective dates** chapter). All benefits cease on the date coverage ends, except for completion of operative procedures in progress at the time coverage ends. "Operative procedures" are limited to individual crowns, dentures, bridges, and implants, and are considered "in progress" only if all procedures for commencement of lab work are completed and all operative procedures are completed within 45 days of termination. The dental plan does not pay benefits if you or a covered dependent receive benefits for these post-termination expenses from another plan. You and/or your enrolled dependents may be eligible for continued coverage through the Consolidated Omnibus Reconciliation Act of 1985, as amended (COBRA). See the **COBRA** chapter for information regarding COBRA continuation coverage.

If your coverage is canceled due to nonpayment of premiums, coverage ends on the cancellation date. See **Paying for your benefits** in the **Eligibility, enrollment, and effective dates** chapter for information.

If you voluntarily drop coverage after an election change event or at Annual Enrollment (after completing two full calendar years of coverage), coverage ends as follows:

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave the company and are rehired

If you are a part-time or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work. For details regarding the impact to your required minimum enrollment period, deductible, and waiting period for orthodontia assistance, see below.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave the company and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work. For details regarding the impact to your required minimum enrollment period, deductible, and waiting period for orthodontia assistance, see below.

Impact to required minimum enrollment period, deductible, and waiting period for orthodontia assistance:

- If you terminate and then return to work within 30 days of your termination date, your deductible will not reset unless you terminate in one calendar year and return to work in the following calendar year. Your waiting period for orthodontia assistance will also not reset.
- If you terminate and then return to work more than 30 days but less than 13 weeks from your termination date, your deductible will not reset when you return to work in the same calendar year in which you terminated. Your deductible will reset when you terminate in one calendar year and return to work in the following calendar year. Your waiting period for orthodontia assistance will reset unless you have already met the 12-month wait. If you have already maintained the required minimum enrollment period of two years, you may drop dental coverage within 60 days after returning.
- If you terminate and then return to work 13 weeks or more from your termination date, you will be considered a new associate and will be required to complete any applicable eligibility waiting period or other requirements. See the **Eligibility, enrollment, and effective dates** chapter for details.

The vision plan

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

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

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

The vision plan

The vision plan helps you pay for routine eye exams, lenses, frames, and contact lenses, so you can see clearly for years to come.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Locate a Walmart Vision Center or Sam's Club Optical provider	Go to **One.Walmart.com**	
For detailed information about vision plan coverage or to locate a VSP network provider	Go to **Walmart.VSPforme.com** and enter your member number	Call VSP at **866-240-8390**
Get the cost for vision plan coverage	Go to **One.Walmart.com**	Call People Services at **800-421-1362**

What you need to know about the vision plan

- Coverage under the vision plan is separate from the medical plan, which generally does not cover charges for routine eye care. If you are interested in coverage for vision services not covered by the medical plan, you must enroll separately in the vision plan.
- You may see any Walmart Vision Center, Sam's Club Optical, or VSP network provider for care and receive the same level of benefits. No benefits are available if you see a non-network provider. **NOTE:** There may be rare instances where a provider at a Walmart Vision Center or Sam's Club Optical facility is not a VSP provider. You should verify that a provider is a VSP network provider before receiving services.
- You may purchase contact lenses online at **WalmartContacts.com** or **SamsClubContacts.com**, or from a VSP network provider. VSP coordinates the amount of your purchase eligible for coverage. Go to **Walmart.VSPforme.com** or call VSP at **866-240-8390** for details about the contact lens benefit.
- If you have medical plan coverage with the Associates' Medical Plan (AMP), the VSP phone number will appear on your plan ID card. If you are enrolled in an HMO or if you enroll for vision coverage only, you will receive a VSP ID card, which will be mailed to your home address.

The vision plan

Walmart offers the vision plan to help you pay for routine eye care. The vision plan is administered through VSP. You may access care under the vision plan through a Walmart Vision Center or Sam's Club Optical facility, or through a provider in VSP's nationwide network. Vision plan coverage is available to you if you are an hourly or management associate. Coverage is also available to your dependents, with the exception of spouses/partners of part-time associates, temporary associates, and part-time truck drivers. **NOTE:** There may be rare instances where a provider at a Walmart Vision Center or Sam's Club Optical facility is not a VSP provider. You should always verify that a provider is a VSP network provider before receiving services.

CHOOSING A COVERAGE TIER

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

- Associate only
- Associate + spouse/partner (except for part-time hourly associates, temporary associates, or part-time truck drivers)
- Associate + child(ren), or
- Associate + family (except for part-time hourly associates, temporary associates, or part-time truck drivers).

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

How the vision plan works

The vision plan covers a routine eye exam once every calendar year, lenses once every calendar year, frames once every calendar year, or contact lenses once every calendar year. The vision plan pays benefits for prescription contact lenses or prescription eyeglasses. If you choose contact lenses, you will not be eligible for lenses or frames again until the next calendar year. Benefits are paid as shown in the chart below. Walmart providers and VSP network providers have agreed to provide their services to covered associates for a prearranged fee; all you pay is the applicable copay and the cost of any non-covered or elective items. VSP pays the rest directly to the provider.

VISION PLAN BENEFITS			
	Walmart Vision Center	**Sam's Club Optical**	**VSP network providers**
Routine exam copay Once every calendar year	$4 *Low-vision services, such as supplemental testing and supplemental aids for visual problems not correctable with regular lenses, are a plan benefit when specific criteria are met and when prescribed by a VSP network provider. Low-vision services may be available less frequently than once every calendar year. Call VSP for more information on eligibility criteria.*		
Materials copay	$4 *Applies with purchase of frames or lenses (but not contact lenses). Copay is charged only once when frames and lenses are purchased together.*		
Progressive lens copay	$55		
Lenses • Single vision • Lined bifocal • Lined trifocal • Lenticular	100% covered after copay The following options are also covered at 100%: • Scratch coating • Polycarbonate lenses • UV (ultraviolet) protected *Standard lenses are covered after applicable copay. Check with your optical team for lenses offered under benefit.*		
Frames Once every calendar year	$130 allowance *Charges above the frame allowance are your responsibility.*		
Elective contact lenses Once every calendar year in lieu of all other lenses and frame benefits	$130 contact lens allowance *Charges above the contact lens allowance are your responsibility.* *You may be charged an additional fee of up to $60 for fitting and evaluation.*		
Necessary contact lenses Once every calendar year in lieu of all other lenses and frame benefits	100% covered after copay once every calendar year. Includes professional fees and materials. *Non-elective contact lenses are a Plan benefit when specific criteria are met and when prescribed by a VSP network provider. Call VSP for more information on eligibility criteria.*		
NOTE: Sales taxes may apply and will reduce the vision benefit.			

Benefits will be paid only for covered services provided through any Walmart Vision Center, Sam's Club Optical, or VSP network provider. No benefits are available if you see a non-network provider. **NOTE:** There may be rare instances where a provider at a Walmart Vision Center or Sam's Club Optical facility is not a VSP provider. You should always verify that a provider is a VSP network provider before receiving services.

Additional charges. Charges for any of the following items are your responsibility. Call VSP at **866-240-8390** for more information.

- Blended lenses
- Oversize lenses
- Photochromic or tinted lenses other than Pink 1 or 2 allowance
- Laminated lenses
- High-index lenses
- Anti-reflective coating
- Color coating
- Mirror coating
- Optional cosmetic processes
- Low vision care
- Cosmetic lenses, and
- Frames or contacts that cost more than your allowance.

How to use the plan

Follow these steps for your vision care.

STEP 1	To find a Walmart Vision Center or Sam's Club Optical provider, go to **One.Walmart.com**; to find a provider in the VSP network, call **866-240-8390** or go to **Walmart.VSPforme.com** and enter your member number. **NOTE:** There may be rare instances where a provider at a Walmart Vision Center or Sam's Club Optical facility is not a VSP provider. You should always verify that a provider is a VSP network provider before receiving services.
STEP 2	When you make an appointment, identify yourself as a VSP member and give the office your name and date of birth, plus the patient's name (if different). The provider's office contacts VSP to verify your eligibility.
STEP 3	At your visit, pay your copay and any other required amount directly to the Walmart Vision Center or Sam's Club Optical or VSP network provider. The provider's office arranges for reimbursement and handles any other administrative tasks required.

What is not covered

Some expenses are not covered under the vision plan, including:

- Charges for eye exams, lenses, or frames that:
  - you are not legally obligated to pay for or for which no charge would be made in the absence of vision coverage
  - exceed plan maximums
  - are not necessary according to accepted standards of ophthalmic practice, or not ordered or prescribed by the attending physician or optometrist
  - do not meet accepted standards of ophthalmic practice, including charges for experimental or investigational services or supplies
  - are received as a result of eye disease, defect, or injury due to an act of declared or undeclared war
  - are for any condition, disease, ailment, or injury arising out of and in the course of employment compensable under a workers' compensation or employers' liability law and were ordered before the patient became eligible for coverage or after coverage ends
  - are received free from any governmental agency by compliance with laws or regulations enacted by any federal, state, municipal, or other governmental body
  - are paid for by another insurance plan (see **If you have coverage under more than one vision plan** later in this chapter), or
  - are payable under any health care program supported in whole or in part by federal funds or any state or political subdivision.
- Medical or surgical treatment or supplies
- Professional services or eyewear connected with orthoptics, vision training, subnormal vision aids, aniseikonic lenses and tonography, and other services/materials not covered by the vision plan
- Replacement of broken lenses or frames after one year from purchase
- Replacement of lost lenses or frames unless the patient is otherwise eligible under the frequency provisions, as detailed in the **Vision plan benefits** chart on the previous page
- Service contract fees
- Plano lenses (nonprescription lenses less than .50 diopter)
- Services from any non-network providers
- Two pairs of glasses instead of bifocals
- Contact lens modification, polishing, or cleaning
- Refitting of contact lenses after the initial (90 day) fitting period
- Local, state, or federal taxes, except where VSP is required by law to pay.

Breakage and loss of eyewear

If you damage your eyewear within one year of purchase, you may be eligible for replacement or repair. Check with your provider for warranty details. Warranties may vary depending on the product and manufacturer.

Lost eyewear is not covered under the vision plan.

Filing a vision claim

When you use the vision plan, claims for services are generally not required; see **How to use the plan** for a description of payment arrangements. When it's necessary to file a claim—for example, if you are newly enrolled in the vision plan when you see a provider and your personal information is not yet on file with VSP—return to the provider after your information is in the system and ask the provider to file the claim on your behalf. Claims are processed according to the terms described in the **Claims and appeals** chapter.

IF YOU HAVE COVERAGE UNDER MORE THAN ONE VISION PLAN

If you or a family member have coverage under the vision plan and are also covered under another vision plan (for example, your spouse/partner's company vision plan), coordination of benefits may apply. The vision plan has the right to coordinate with other plans under which you are covered so the total vision benefits payable will not exceed the level of benefits otherwise payable under the vision plan. Under the vision plan, "other plans" refers only to other plans administered by VSP. There is no coordination-of-benefits provision with vision coverage providers other than VSP. Plans referred to as "other plans" are described in **If you have coverage under more than one medical plan** in **The medical plan** chapter.

Break in coverage

There may be occasions in which you must make special arrangements to pay your vision 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 **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

If you have received covered vision services prior to your leave, any applicable benefit frequency limitation under the vision plan (i.e., eyeglass frames every calendar year) will continue to apply after your return.

When vision coverage ends

Your coverage ends on your last day of employment or when you are no longer eligible under the terms of the Plan. Dependent coverage ends when your coverage ends or when a dependent is no longer an eligible dependent (as defined in the **Eligibility, enrollment, and effective dates** chapter). You and/or your enrolled dependents may be eligible for continued coverage through the Consolidated Omnibus Reconciliation Act of 1985, as amended (COBRA). See the **COBRA** chapter for information regarding COBRA continuation coverage.

If your coverage is canceled due to nonpayment of premiums, coverage ends on the cancellation date. See **Paying for your benefits** in the **Eligibility, enrollment, and effective dates** chapter for information.

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

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave the company and are rehired

If you are a part-time or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave the company and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

Resources for Living®

Resources for Living®

Resources for Living (RFL) gives you confidential mental health support and well-being information. It's available at no cost to you and your family members from your date of hire. Call a trained professional 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 work-life specialist to identify resources and solutions for everyday needs or a licensed professional for mental health challenges		Call **800-825-3555**
Access articles, videos, self-assessment tools, and resources across a wide range of topics	Go to **One.Walmart.com/RFL** 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/RFL** 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, regardless of whether you enroll in a Walmart medical plan.

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:

- Building strong mental health and resiliency
- 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, face-to-face 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 a challenge 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 use
- 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 face-to-face or televideo counseling sessions per person, per issue, per year, with a licensed therapist in the RFL network, 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, and how to access the 10-session benefit.

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
- Access a library of legal documents for a variety of needs (such as automobile bill of sale or lease agreement)
- 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. If you need more legal, financial, or identify-theft support beyond the initial consultation, you can continue to work with that professional for an additional discounted fee.

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
- Emergency financial needs
- 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
- Access to helpful community-based resources

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 at **One.Walmart.com/RFL**.

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.

COBRA

COBRA

If you and/or your covered dependents lose medical, dental, or vision coverage because of a qualifying event, a federal law known as "COBRA" may allow you to continue that coverage for a set period of time at your own expense.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Contact People Services within 60 calendar days of a divorce, legal separation, termination of a relationship with a partner, or ineligibility of dependents		Call People Services at **800-421-1362** or provide notification in writing to: **Walmart People Services** **508 SW 8th Street** **Bentonville, Arkansas 72716-3500**
Contact WageWorks (a HealthEquity company), the COBRA administrator, for questions regarding eligibility, enrollment, premiums, or notification of a second qualifying event	Go to **mybenefits.wageworks.com**	Call **800-570-1863**

What you need to know about COBRA

- "COBRA," which stands for Consolidated Omnibus Budget Reconciliation Act of 1985, may apply if a "qualifying event" occurs that would otherwise cause you or a covered dependent to lose medical, dental, or vision coverage. Qualifying events are described in this chapter. The Plan extends COBRA continuation coverage to you and all your covered dependents.
- For medical, dental, and vision benefits, COBRA continuation coverage can continue up to 18 or 36 months, depending on the qualifying event. The 18 months can be extended to 29 months under certain circumstances when a disability is involved.
- If you experience a qualifying event and become eligible for COBRA benefits, your 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 WageWorks, a third-party administrator, to administer COBRA. References to COBRA in this section are to the Plan's continuation coverage, which may be more favorable to participants and dependents than the continuation coverage legally required under COBRA.
- There are strict notification rules and time limits for enrolling in COBRA continuation coverage, as described in this chapter. Please read this chapter carefully—failure to adhere to these rules can result in the loss of your right to elect COBRA continuation coverage. If you have any questions or need assistance with enrollment, please call **800-570-1863**.

COBRA continuation coverage

If medical, dental, or vision coverage under the Plan ends for you or your eligible dependents, you and/or your eligible dependents may be able to continue your coverage under the Plan's continuation coverage provisions, which comply with COBRA. COBRA continuation coverage applies to medical, dental, and vision coverage; it does not apply to other benefits described in this *Associate Benefits Book*.

An event that makes you and/or your eligible dependents eligible for COBRA continuation coverage is called a "qualifying event," such as termination of employment or loss of benefits eligibility. Under COBRA, each person who would lose coverage after a qualifying event is considered a "qualified beneficiary." Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

You must have had medical, dental, or vision coverage under the Plan on the day before the date of your qualifying event to be eligible for COBRA coverage, unless coverage ended during a leave of absence, as described on this page. You may choose a lesser coverage tier or select an alternate medical plan, if applicable.

If you change medical plans when you elect COBRA coverage, your annual deductible and out-of-pocket maximum will reset, and you will be responsible for meeting the new deductible and out-of-pocket maximum in their entirety.

If you have HMO coverage at the time of your qualifying event and the state where you live has more favorable coverage continuation rules than federal COBRA, the HMO generally follows state rules. For PPO Plan participants, the PPO Plan also follows state rules. For information on state continuation rights, contact your HMO provider or the PPO Plan, as applicable.

IF YOU ARE ON LEAVE OF ABSENCE

Generally, if your leave ends and you do not return to work, you and any eligible dependents who were enrolled in medical, dental, or vision coverage under the Plan during your leave will be offered COBRA, which will run from the date following your employment termination date.

If you and any eligible dependents were enrolled in medical, dental, or vision coverage under the Plan on the day before your leave began but you dropped coverage during your leave or your coverage was canceled due to nonpayment of premiums during the leave, you will still be offered COBRA when your employment terminates. If you elect COBRA coverage, it will run from the date following your employment termination date. This means that if you or any eligible dependent elects COBRA at the end of a leave of absence during which coverage was dropped or canceled, the elected COBRA coverage will not be effective retroactive to the date coverage was dropped or canceled, but will be effective on the date following your employment termination date.

COBRA qualifying events

You are eligible for COBRA if your medical, dental, or vision coverage ends because:

- Your employment with the company ends for any reason, or
- You are no longer eligible for medical coverage because the number of hours you regularly work for the company 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 the company ends for any reason
- Your spouse or partner is no longer eligible for medical, dental, or vision coverage because the number of hours you regularly work for the company has decreased, making them ineligible for coverage under the Plan
- You and your spouse divorce or legally separate
- You and your partner no longer meet the definition of having a "partnership" for purposes of the Plan (refer to the **Eligibility, enrollment, and effective dates** chapter for the definition of "partner")
- You enroll in Medicare benefits Part D, causing your medical coverage to terminate (you must contact People Services by calling **800-421-1362** within 60 days of enrolling in Medicare Part D), 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 the company ends for any reason
- Your eligible dependent is no longer eligible for medical, dental, or vision coverage because the number of hours you regularly worked for the company has decreased, making them ineligible for coverage under the Plan
- You enroll in Medicare benefits Part D, causing your medical coverage to terminate. (You or your eligible dependent must contact People Services by calling **800-421-1362** within 60 days of enrolling in Medicare Part D.)
- Your dependent child no longer meets eligibility requirements, as described in the **Eligibility, enrollment, and effective dates** chapter (e.g., the end of the month in which a dependent turns age 26), or
- You die.

NOTIFICATION

In general, the company will notify WageWorks, the Plan's third-party administrator for COBRA, if you or your dependents become eligible for COBRA continuation coverage because of your death, termination of employment, a reduction in hours of employment that makes you ineligible for coverage under the Plan, or you enroll in Medicare Part D. You or your dependent must notify People Services if you enroll in Medicare Part D. The company 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 People Services of your divorce, legal separation, termination of your relationship with a partner, or a child's loss of dependent status. You will need to notify People Services, even if you made changes online to modify your coverage as a result of one of these life events. The notification must be made within 60 days after the qualifying event (or the date on which coverage would end because of the qualifying event, if later). You or your eligible dependent can provide notice on your behalf or on behalf of any eligible dependent affected by the qualifying event. Provide notice of the qualifying event to People Services by calling **800-421-1362** or writing to:

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

The notice must include the following information:

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

If you do not contact People Services within the 60-day period, your covered dependent will lose their right to elect COBRA continuation coverage. To protect your covered dependent's rights, let People Services know about any changes in addresses of family members. You should keep a copy of any notices you send to People Services and/or WageWorks for your records.

Federal law places responsibility upon you or your eligible dependent to notify People Services within 60 calendar days after the later of the date of a divorce, legal separation, termination of your relationship with a partner, or a child becoming ineligible due to loss of dependent status, or the date on which coverage under the Plan is terminated as a result of one of these events. If you or your eligible dependent do not notify People Services within 60 days, your dependent will not be eligible for COBRA.

You or your eligible dependent must also notify the COBRA administrator by phone or in writing of a second qualifying event or Social Security disability in order to extend the period of COBRA coverage. Other forms of notice will not bind the Plan. If notice is not provided by phone or in writing of a second qualifying event or extension request within 60 days from the later of the date of the second qualifying event or the date on which you lost (or will lose) coverage as a result of a second qualifying event, COBRA continuation rights will expire on the date that your or your eligible dependent's initial COBRA coverage period expires.

COBRA ENROLLMENT

Within 14 days after the COBRA administrator receives notification that a qualifying event has occurred, the COBRA administrator, on behalf of the Plan, will send a COBRA election notice to you and your eligible dependent at your last known address. The election notice describes your right to continue medical, dental, or vision coverage under COBRA. (If you do not receive this notification, please contact People Services.) To receive COBRA continuation coverage, you must elect coverage through the COBRA administrator within 60 calendar days from the date you lose coverage or the date of the election notice, if later. To enroll, you must complete and mail your COBRA election notice to the address on the election notice or go online at **mybenefits.wageworks.com**. If you elect COBRA, notify the COBRA administrator of any change of address. Refer to **Paying for COBRA coverage** on the next page for information on making COBRA payments. If you need assistance, call **800-570-1863**.

NOTE: You may be asked to provide documentation of the qualifying event.

You and each of your eligible dependents have independent election rights. You may elect COBRA coverage for all of your 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**.

ELECTION CHANGE EVENTS WHILE ON COBRA CONTINUATION COVERAGE

After the COBRA election period, you or your eligible dependent may not change the elected COBRA coverage without an election change event outside Annual Enrollment or a subsequent qualifying event. For information about election change events, see **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter. If an election change event occurs (such as if a child is born), you must notify the COBRA administrator within 60 calendar days of the event. Supporting documentation may be required. You will have the right to make changes to your coverage during any Annual Enrollment while you are on COBRA.

Unless otherwise provided in the Plan, if you add a spouse or partner or other eligible dependent due to an election change event while on COBRA, each person must individually meet any applicable benefit waiting period (for example, for transplant coverage or weight loss surgery) and is subject to any applicable Plan limitations. If you change medical plans due to an election change event, your annual deductible and out-of-pocket maximum will reset, and you will be responsible for meeting the new deductible and out-of-pocket maximum in their entirety. If you change from the Contribution Plan to another plan, your HRA balance under the Contribution Plan will be forfeited.

If you are covered as a dependent and you experience a qualifying event that affects your status as a dependent and makes you eligible for your own continuation coverage under COBRA, you will receive credit toward your deductible and out-of-pocket maximum under the Associates' Medical Plan for expenses incurred as a covered dependent, unless you change plan options as described above. You will also receive credit toward any waiting periods.

In the event of an election change event, you or your eligible dependent may change benefit coverage to another benefit tier under the Plan only if the change in coverage is consistent with the election change event.

If you move to a new location and this affects your medical coverage (i.e., moving from an HMO area to a non-HMO area), you will have 60 calendar days from the date you notify the COBRA administrator of the address change to select a different plan. If you do not submit your selections within 60 days, you may automatically be enrolled in a predetermined plan.

Paying for COBRA coverage

The COBRA premium is the amount you were paying before the qualifying event, plus the amount the company was paying, plus a 2% administrative fee (50% administrative fee in cases of the 11-month disability extension, as described later in this chapter). The letter sent to you and your eligible dependents following notice of a qualifying event will include the monthly premium cost for COBRA coverage.

Initial COBRA premium: Your first payment is due 45 days after you elect COBRA and must cover the cost of COBRA coverage from the day following 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, which is the 45th day after the date of your COBRA election. Ongoing premiums are due the first day of each month, with a 30-day grace period. So your December payment must be received no later than December 31, the end of the 30-day grace period for the December coverage period.)

If your initial premium payment is not made in the allowed time frame, you will not be eligible for COBRA coverage.

Continuing premiums: Monthly premiums are due on the first day of each month following the due date of the initial premium. If you make your payment on or before the first day of each month, your COBRA coverage under the Plan will continue for that month. To eliminate any possible delay in the updating of your eligibility information, it is recommended that you pay your premiums 7-10 days in advance of the due date.

You are allowed a 30-day grace period from the premium due date before coverage is canceled. However, if you make your payment on the first day of the month or later, your coverage will be suspended and any claims incurred, including pharmacy benefits, will not be paid until coverage is paid through the current month. If you do not pay this premium, you will be responsible for claims incurred. If the 30th day falls on a weekend or holiday, you have until the first business day following to have your payment postmarked or paid.

As a courtesy, the COBRA administrator will send you a COBRA premium payment invoice, unless you make your payments by Automated Clearing House (ACH) debit, in which case you will not receive an invoice. To avoid interruption or cancellation of coverage, it is recommended that you pay your premiums 7-10 days in advance of the due date. Using the ACH debit through the COBRA administrator can cause eligibility delays since these drafts are taken on the first business day of the month. Premium payments are due regardless of your receipt of a payment invoice. If you pay by mail, attach your payment to the invoice and mail it to:

WageWorks
P.O. Box 660212
Dallas, Texas 75266-0212

To pay online, log on to **mybenefits.wageworks.com**. To pay by phone, call **800-570-1863**.

If your COBRA coverage is canceled due to nonpayment of premiums, your COBRA coverage will end on the last day for which you paid your full COBRA premium on time, and it will not be reinstated.

COBRA is month-to-month coverage, and if you do not want to continue coverage, it can be terminated in the following ways:

- Simply stop paying premiums, and your COBRA coverage will be terminated for nonpayment.
- Enter a support request in the WageWorks online message center.
- Send a letter to WageWorks requesting termination of your COBRA coverage, mailed to:

  WageWorks
  P.O. Box 226101
  Dallas, Texas 75222-6101

If you choose to cancel coverage, it cannot be reinstated. Coverage will be automatically canceled if your payment is not postmarked on or before the deadline date of the month your premium is due.

How long COBRA coverage may last

The maximum duration of your COBRA coverage depends on the qualifying event making you eligible for COBRA coverage, as shown in the chart below.

MAXIMUM DURATION OF COBRA COVERAGE

Event	Associate	Dependents
• Your employment with 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 you enrolled in Medicare
You enroll in Medicare Part D	Not applicable	36 months from the date you enrolled in Medicare Part D
Disability extension is obtained	29 months from the date of the original qualifying event	29 months from the date of the original qualifying event
Second qualifying event—you must notify the COBRA administrator within 60 days of the second qualifying event or the date of loss of coverage, if later	Not applicable	Up to 36 months from the date of the original qualifying event

IF YOU ARE ENTITLED TO MEDICARE

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, 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 **800-570-1863** 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 are 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 to grant the extension and is submitted to the COBRA administrator within the time frames listed above.

If you and/or your eligible dependent qualify for the disability extension, a new invoice will be mailed to you and/or your eligible dependent before the end of the initial 18-month COBRA coverage period, unless you make your payments by Automated Clearing House (ACH) debit, in which case you will not receive an invoice. Contact the COBRA administrator for details about paying premiums during a disability extension.

The COBRA premium for the 19th through the 29th month of COBRA coverage generally is the amount you were paying before the qualifying event, plus the amount 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 during the 29-month coverage period, in the event of a disability extension).

The following can be second qualifying events:

- Your death
- Your divorce, legal separation, or termination of a relationship with a partner
- Your child is no longer eligible for medical, dental, or vision coverage (e.g., a dependent turns age 26), 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 maximum COBRA coverage period. See **How long COBRA coverage may last** in this chapter to find out which maximum COBRA coverage period applies to you.

COBRA coverage may be terminated before the end of the 18th, 29th, or 36th month if:

- The company no longer provides medical, dental, or vision coverage to any associates
- After the initial 45-day payment period you do not make a COBRA payment within 30 calendar days of the due date (if the 30th day falls on a weekend or non-postal delivery day, you have until the next business day to have your payment postmarked or paid)
- You or your eligible dependent becomes covered by another group health, dental, or vision plan after electing COBRA coverage
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, terminates as of the later of (a) the first day of the month that is more than 30 days after a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled, or (b) the end of the coverage period that applies without regard to the disability extension), or
- You or your eligible dependent submits a fraudulent claim or fraudulent information to the Plan.

FILING AN APPEAL

You have the right to appeal an enrollment or eligibility status decision related to your COBRA coverage. See **Appealing an enrollment or eligibility status decision** in the **Claims and appeals** chapter for more information.

Full-time hourly short-term disability

The information in this chapter describes short-term disability benefits that may be available to you if:

- You are an eligible full-time hourly associate
- You have met all requirements for coverage to be effective, including actively-at-work requirements, and
- You have enrolled in a timely manner (if applicable).

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

Full-time hourly short-term disability

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

RESOURCES		
Find What You Need	**Online**	**Other Resources**
To request a leave or to file a basic or enhanced claim, file a maternity benefit claim, or get more information	Go to **One.Walmart.com/LOA > mySedgwick**	Call Sedgwick at **800-492-5678**
If you work in one of the states listed below, file a claim with Sedgwick, which will manage your leave and notify Lincoln of the claim. Hawaii New Jersey New York	Go to **One.Walmart.com/LOA > mySedgwick**	Call Sedgwick/Lincoln at **800-492-5678**
If you work in one of the states or localities listed below, file a claim with Sedgwick in addition to filing with your state or locality. For maternity benefit information, see the **Maternity benefit** section later in this chapter.		
California	Go to **edd.ca.gov**	Call **800-480-3287**
Connecticut	Go to **ctpaidleave.org**	Call **877-499-8606**
Massachusetts	Go to **paidleave.mass.gov**	Call **833-344-7365**
Rhode Island	Go to **www.dlt.ri.gov/tdi**	Call **401-462-8420**
Washington, D.C.	Go to **dcpaidfamilyleave.dc.gov**	Call **202-899-3700**
Washington state	Go to **paidleave.wa.gov**	Call **833-717-2273**

What you need to know about full-time hourly short-term disability

- This chapter describes disability benefits available to you under two plan options: the short-term disability basic plan and the short-term disability enhanced plan.
  - The **short-term disability basic plan**
    - The *short-term disability basic benefit* replaces 50% of your average weekly wage for up to 25 weeks, with no weekly maximum (however, if you work in New York there is a maximum of $6,000 per week).
    - The *short-term disability maternity benefit* replaces 100% of your average weekly wage for up to nine weeks.
  - The **short-term disability enhanced plan** replaces 60% of your average weekly wage for up to 25 weeks, with no weekly maximum (however, the New York short-term disability enhanced plan has a maximum of $6,000 per week).
- Some states and localities have legally mandated plans. Variations in laws and administrative procedures may affect your eligibility to participate in a Walmart short-term disability plan, as well as the amount of your disability benefit.
- If you work in California, Hawaii, New Jersey, or Rhode Island, you are not eligible for the short-term disability enhanced plan or the basic benefit under Walmart's short-term disability basic plan because the states in which you work have legally mandated disability plans. However, you are eligible for the maternity benefit under the short-term disability basic plan to supplement any legally mandated maternity benefits offered by the state.
- If you work in Connecticut, Massachusetts, New York, Washington, D.C., or Washington state, you are eligible to participate in one of Walmart's short-term disability plans, but it will only supplement your state or locally mandated benefit.
- Legally mandated plans are not part of the Associates' Health and Welfare Plan, and benefits paid under those legally mandated plans are not provided under a Walmart short-term disability plan. Legally mandated plans are not discussed in detail in this chapter, except where relevant to benefits under a short-term disability plan.

Your short-term disability benefit

If you become disabled as defined in the **When you qualify for benefits** section later in this chapter, the short-term disability basic plan provides a basic weekly benefit of 50% of your average weekly wage for up to 25 weeks of an approved disability, after a waiting period of seven calendar days, with no maximum weekly benefit (however, if you work in New York there is a maximum weekly benefit of $6,000). For more information about your average weekly wage, see **Calculating your benefit** later in this chapter.

If you become disabled as defined in the **When you qualify for benefits** section later in this chapter, the short-term disability enhanced plan provides a weekly benefit of 60% of your average weekly wage for up to 25 weeks of an approved disability, after a waiting period of seven calendar days, with no maximum weekly benefit (however, if you work in New York, the New York short-term disability enhanced plan has a maximum weekly benefit of $6,000).

If your disability is due to pregnancy, the short-term disability basic plan provides a maternity benefit of 100% of your average weekly wage for the first nine weeks, after an initial waiting period of seven calendar days. If you are eligible for legally mandated short-term disability benefits, the maternity benefit supplements your state benefits. The combined total of the maternity benefit available to you under the short-term disability basic plan and the maternity benefit available to you under any state or locally mandated plan will not exceed 100% of your average weekly wage for nine weeks. If you remain disabled and are eligible for benefits after the first nine weeks of maternity benefits, and Walmart's short-term disability basic and enhanced plans are available at your work location, the short-term disability plan will pay the basic benefit or the benefit under the enhanced plan, depending on the plan in which you are enrolled, for up to 16 additional weeks of benefit payments (for a total of up to 25 weeks of benefit payments). See **Maternity benefit** for more information.

How short-term disability benefits are funded

The short-term disability basic plan is provided by the company at no cost to you. However, you and the company share the cost of the short-term disability enhanced plan. If you participate in the short-term disability enhanced plan, your cost is based on your biweekly earnings and your age. If you have no earnings in a particular pay period, no contributions are required during that pay period. Your contributions are intended to cover the costs of benefits.

Except for associates who work in New York, the short-term disability plans are self-insured. This means no insurance company collects premiums and pays benefits. However, the maternity benefit is self-insured for all associates, including those who work in New York. The company currently funds benefits under the self-insured short-term disability plan from the company's general assets.

For associates who work in New York, benefits provided under the short-term disability basic plan and the New York short-term disability enhanced plan are insured by Lincoln.

How the Walmart short-term disability benefit is administered

Except as otherwise provided, the short-term disability plans are administered by Sedgwick Claims Management Services, Inc. (Sedgwick). With respect to any benefit payments made under a short-term disability plan that is administered by Sedgwick, the Plan Administrator has delegated the fiduciary authority to Sedgwick for determining claims for benefits and hearing-related appeals.

Details follow regarding the administration of non-maternity disability coverage available for associates in states and localities with legally mandated plans. For details regarding the administration of short-term disability plan maternity benefits, see **Maternity benefit** later in this chapter.

When you qualify for benefits

To be eligible to receive short-term disability benefits under either short-term disability plan, you must meet the following requirements:

- Your coverage must be effective.
- Your disability must have occurred on or after the effective date of your coverage.
- You must be on active status at the time of your disability unless:
  - You are on leave of absence or layoff as described later in this chapter under **If you go on a leave of absence or experience a temporary layoff**, or
  - You are unable to work because you have experienced medical complications during pregnancy or post-partum and have exhausted the nine-week short-term disability maternity benefit, as described later in this chapter under **Maternity benefit**.

LEGALLY MANDATED PLANS

If you work in a state or locality with a legally mandated plan, differences in laws and administrative procedures affect your eligibility to participate in a Walmart short-term disability plan, as well as the amount of your disability benefit. See below for general information. Call the number listed in the **Resources** chart for details about benefits in these states or localities. See **Maternity benefit** for information about the maternity benefit, including information about administration.

Legally mandated plans, administered by your state	If you work in **California** or **Rhode Island**, you are not eligible to participate in a Walmart short-term disability plan. Your disability benefit is administered by the state. You may still be eligible for the maternity benefit* under the Walmart short-term disability basic plan.
Legally mandated plans, administered by Lincoln	If you work in **Hawaii** or **New Jersey**, you are not eligible to participate in a Walmart short-term disability plan. Your disability benefit is provided in accordance with the state program and is insured and administered by Lincoln. You may still be eligible for the maternity benefit* under the Walmart short-term disability basic plan. If you work in **New York**, you are eligible to participate in the Walmart short-term disability basic plan and the New York short-term disability enhanced plan to supplement your state benefit. Your benefits under these plans are insured and administered by Lincoln.
Legally mandated plans, administered by Sedgwick	If you work in **Connecticut**, **Massachusetts**, **Washington, D.C.**, or **Washington state**, you are eligible to participate in a Walmart short-term disability plan to supplement your legally mandated benefits, which are administered by Sedgwick.*

*The amount of any benefit paid under a Walmart short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates you are eligible to receive from the state or locality, regardless of whether you apply for that legally mandated benefit. If the benefit available to you under any state or locally mandated plan is less than the benefit available to you under a Walmart short-term disability plan, the combined total of the benefit available to you under a Walmart short-term disability plan and the benefit available to you under any state or locally mandated plan will not exceed the benefits that would have been available under the Walmart short-term disability plan you are enrolled in, if you had not worked in a state with a legally mandated plan. You will be required to provide your award letter from the state or locality to Sedgwick. If Sedgwick overestimated what your legally mandated benefit would be, meaning that you were paid less under the short-term disability plan than you were entitled to, you will be paid the difference in a lump sum payment. If Sedgwick underestimated what your legally mandated benefit would be, meaning that you were paid more under the short-term disability plan than you were entitled to, you must repay any amount overpaid to you. See the **Right to recover overpayment** section later in this chapter.

- Except as otherwise provided in the **Maternity benefit** section, you must submit medical evidence provided by a qualified doctor that you are disabled as defined below (for purposes of this chapter, the term “doctor” includes legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors [M.D.], osteopaths [D.O.], nurse practitioners, physician’s assistants, psychologists, or other medical practitioners whose services would be eligible for reimbursement if submitted for reimbursement under the Associates’ Medical Plan).
- You must receive approval by Sedgwick or Lincoln (as applicable) of your claim.

These conditions apply whether you are enrolled in the short-term disability basic or enhanced plan or the New York short-term disability enhanced plan. Sedgwick or Lincoln may require written proof of your disability, as defined below, or additional information before making a decision on your claim. A statement by your doctor that you are unable to work does not by itself prove that you are disabled. Approval of a medical leave of absence also does not prove that you are disabled.

Except as otherwise provided in the **Maternity benefit** section, for purposes of benefits provided under a short-term disability plan, as described in this chapter, “disabled” or “disability” means that (i) you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or

physical illness or injury, or pregnancy, and (ii) you are under the continuous care of a qualified doctor and are following the course of treatment prescribed by your doctor.

Disability benefits are payable during a loss of license only while you are disabled and pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria, and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. Loss of license by itself is not sufficient for meeting the definition of disability. The determination of whether you are disabled is made by Sedgwick (or Lincoln, as applicable) on the basis of objective medical evidence, which consists of facts and findings, including but not limited to X-rays, laboratory reports, tests, consulting physician reports, as well as reports and chart notes from your doctor.

If your disability is caused by a mental illness or substance use disorder, you are encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, licensed counselor, drug and alcohol counselor, or clinical social worker who specializes in mental health and/or substance use disorders, and is licensed pursuant to state law. See the **Resources for Living** chapter for information on resources that are available if you are experiencing the effects of a mental illness or substance use disorder.

If Sedgwick or Lincoln requests that you be examined by an independent doctor, you must attend the exam to be considered for benefits. The company will pay the cost of any such examination.

The maximum length of any one period of disability during which disability benefits are paid, even if the disability is the result of more than one cause, is 25 weeks, after the initial waiting period of seven calendar days. See also **If you return to work and become disabled again**.

See the **Maternity benefit** section for additional details regarding the maternity benefit.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that:

- Arose before your coverage became effective
- Is not under the care of and being treated by a qualified doctor
- Is caused by taking part in an insurrection, rebellion or a riot or civil disorder
- Resulted from your commission of or attempt to commit a crime (e.g., assault, battery, felony, or any illegal occupation or activity), or
- Resulted from doing any work for pay or profit (for example, an illness or injury that is related to work outside of Walmart or related to your Walmart work for which workers' compensation benefits are paid, or may be paid, if properly claimed).

Filing a claim

If you become disabled, file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption in your wages, or the denial of your claim. To file a claim for short-term disability benefits, follow these steps:

STEP 1: Contact Sedgwick by going to **One.Walmart.com/LOA > mySedgwick**, or calling **800-492-5678** to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury, or pregnancy. Sedgwick will send you an initial packet providing the information you will need and describing any actions you will need to take. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated. Your claim cannot be fully processed until you have stopped working.

Unless you work in Hawaii, New Jersey, or New York, you must submit your short-term disability claim to Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

If you work in Hawaii, New Jersey, or New York, you must submit your claim to Sedgwick within 30 days of the date your disability begins. Sedgwick will notify Lincoln, which then manages your disability claim.

If you work in California, Connecticut, Massachusetts, Rhode Island, Washington, D.C., or Washington state, you must request and file a disability claim with the state or locality. You must submit your short-term disability claim to Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late. Your state or locality may have a different filing period, and you are advised to promptly apply to your state or locality for state-mandated benefits. Refer to the **Resources** chart at the beginning of the chapter for contact information. If you work in Washington, D.C., you will generally not receive benefits for periods prior to the date of application for benefits, except in emergency situations, so it's important to file with the state as soon as you can. If you work in a state or locality where you are not eligible to participate in a Walmart short-term disability plan, you may still be eligible for the maternity benefit. See the **Maternity benefit** section for additional details.

STEP 2: Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide medical information, including:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, and
- Doctor visit notes.

You must sign a form authorizing your doctor to release this information. (This release will be included in the initial packet that you receive from Sedgwick; however, if you are filing your claim online, an electronic signature is accepted.)

STEP 3: Follow up with your doctor to ensure that information was forwarded to Sedgwick. Any delay in sending information to Sedgwick could result in a delay, or denial, in the processing of your claim and the payment of benefits.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

You may be required to provide written proof of your disability or additional medical information before your claim is approved.

When benefits begin

If your short-term disability claim is approved, the benefits will begin after a waiting period of seven calendar days, on the eighth calendar day after your disability begins. If your claim for short-term disability benefits is retroactively approved, any benefit payments that would have otherwise been paid to you while your claim decision was pending will be made to you in a lump sum payment when approved.

For your pay to continue during the initial waiting period of seven calendar days, you may use paid time off (PTO). You should not use PTO beyond the initial seven-day waiting period while a claim decision is pending or for any period for which short-term disability benefits are approved. If you are later found to be ineligible for short-term disability benefits, you may go back and use PTO for any time that was unpaid. Walmart and/or Sedgwick may seek repayment of any PTO used for days when disability benefits were approved. Upon repayment, any PTO balance will be restored.

If you are receiving short-term disability benefits at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information. You do not accrue additional PTO while receiving short-term disability benefits.

Calculating your benefit

The amount of your weekly short-term disability benefit is based on:

- Your average weekly wage
- The duration of your disability, and
- Whether you are enrolled in the short-term disability basic plan or enhanced plan.

Your average weekly wage is defined as follows:

AVERAGE WEEKLY WAGE	
Length of employment	**How average weekly wage is determined**
Employed 12 months or more	Your earnings for the 26 pay periods* immediately preceding your last day worked ÷ 52 weeks For example, the average weekly wage for an associate with earnings of $36,400 for the prior 26 pay periods is $700 ($36,400 ÷ 52)
Employed less than 12 months	Earnings since date of hire ÷ number of weeks worked For example, the average weekly wage for an associate with earnings of $8,400 for 12 weeks of work is $700 ($8,400 ÷ 12)
*Any pay periods in which you have no earnings are excluded, decreasing the number of pay periods used for the calculation. To the extent your earnings were paid on a weekly basis during the 12-month period, the number of pay periods used to calculate your average weekly wage will be adjusted accordingly. Your short-term disability benefits are paid biweekly. If your disability benefit is payable for less than a week, your disability benefit for each day that you are disabled during that week will be 1/7 of the weekly benefit.	
Earnings used to determine average weekly wage include: • Regular earnings for the 26 pay periods prior to your last day worked • Overtime • Regularly scheduled target incentive bonuses that you and associates in similarly situated job types or job levels are eligible to earn • Paid time off and similar pay that replaces regular earnings (e.g., bereavement leave, jury duty leave, and sick time) Earnings used to determine average weekly wage exclude: • Any previously paid disability benefits • Commissions or any other extra compensation or fringe benefits not listed above If you have been employed less than 12 months, an annualized average of earnings will be used.	

A hypothetical benefit calculation is shown in the next column, using an average weekly wage of $700.

YOUR SHORT-TERM DISABILITY BENEFIT: AN EXAMPLE	
If you have	**Your benefit is**
Short-term disability basic plan coverage	50% of your average weekly wage Average weekly wage: $700 50% of $700: $350
Short-term disability enhanced plan coverage	60% of your average weekly wage Average weekly wage: $700 60% of $700: $420 weekly benefit (While calculated weekly, short-term disability benefits are paid biweekly.)
NOTE: If you are eligible for legally mandated benefits as well as benefits under a Walmart short-term disability plan, the amount of the benefit under the Walmart short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates that you will receive. See **Legally mandated plans** earlier in this chapter.	

MATERNITY BENEFIT

See the **When you qualify for benefits** section for general requirements applicable to all disability benefits under a short-term disability plan, including the maternity benefit. There are some exceptions to those general rules that apply to the maternity benefit. Those exceptions are discussed in this section.

If you work in California, Hawaii, New Jersey, or Rhode Island, the discussion applies to you, unless as otherwise indicated.

The maternity benefit is 100% of your average weekly wage for up to the first nine weeks of leave, after an initial waiting period of seven calendar days. Disability payments begin on the eighth calendar day after your disability begins.

If your disability is due to pregnancy, the date of your disability is generally on or up to two weeks prior to your expected date of delivery. If you begin your short-term disability leave during this time frame, you will be deemed to meet the definition of disability. If you begin your leave more than two weeks prior to your expected delivery date, you will be required to provide objective medical evidence to demonstrate you are disabled, as defined in the **When you qualify for benefits** section. If you are disabled, as defined in that section, you will begin your short-term disability maternity benefit on the date you are determined to be disabled. In no event will the maternity benefit exceed nine weeks.

If you do not begin your short-term disability leave on your delivery date, you must meet the plan's definition of disabled, as defined in the **When you qualify for benefits** section. In that case, any disability benefit will be subject to rules applicable to non-maternity disability benefits and depend on whether you are eligible for a Walmart short-term disability plan. To the extent you are eligible for a disability benefit,

that benefit would be determined under the short-term disability basic benefit or the short-term disability enhanced plan. You will not be eligible for the maternity benefit described in this section.

If you experience medical complications during pregnancy or post-partum and are eligible for non-maternity disability benefits under a short-term disability plan and continue to meet the definition of disability after the first nine weeks of maternity benefits, the short-term disability basic plan will pay up to 50% of your average weekly wage and the enhanced plan will pay up to 60% of your average weekly wage, from week 10 up to 25 weeks of benefit payments.

If you work in California, Hawaii, New Jersey, or Rhode Island, and if your disability is due to pregnancy, your eligibility for the maternity benefit under the short-term disability basic plan is subject to the following:

- If you are eligible for legally mandated short-term disability benefits as a result of your pregnancy, the Walmart short-term disability maternity benefit supplements the legally mandated short-term disability benefit, as shown in the chart below.
- If you are not eligible for legally mandated short-term disability benefits as a result of your pregnancy, the short-term disability maternity benefit is equal to 100% of your average weekly wage up to the first nine weeks, after an initial waiting period of seven calendar days. The short-term disability maternity benefit will end after nine weeks.

If you work in Hawaii, New Jersey, or New York, your short-term disability plan maternity benefit is administered by Lincoln and Sedgwick. If you work in any of these states, you should file a claim for maternity benefits with Sedgwick, who will notify Lincoln (see **Filing a claim**, Step 1, earlier in this chapter). Sedgwick administers short-term disability plan maternity benefit for associates who work in all other states and localities.

The maternity benefit, as described above, is summarized here:

MATERNITY BENEFIT

Your work location (state or locality)*	Up to 9 weeks**	Beyond 9 weeks** (up to 25 total weeks)
If you work in a state or locality with no legally mandated plan	100% of your average weekly wage after an initial waiting period of 7 calendar days.	If you experience medical complications during pregnancy or post-partum, benefits may be payable under the short-term disability basic or enhanced plan, as described above.
If (i) you work in a state or locality with a legally mandated plan, (ii) *you are eligible* to receive the state benefit due to your pregnancy, and (iii) you work in a location eligible for the Walmart short-term basic or enhanced plan	100% of your average weekly wage, reduced by any legally mandated benefits that are payable at the applicable state or local government rate, after an initial waiting period of 7 calendar days.	Additional benefits may be available through your state or local government and benefits may be payable under the short-term disability basic or enhanced plan, as described above.
If (i) you work in a state or locality with a legally mandated plan, (ii) *you are eligible* to receive the state benefit due to your pregnancy, and (iii) you do not work in a location eligible for the Walmart short-term disability basic or enhanced plan	100% of your average weekly wage, reduced by any legally mandated benefits that are payable at the applicable state or local government rate, after an initial waiting period of 7 calendar days.	Additional benefits may be available through your state or local government.
If (i) you work in a state or locality with a legally mandated plan, (ii) *you are not eligible* to receive the state or local government benefit due to your pregnancy, and (iii) you work in a location eligible for the Walmart short-term disability basic or enhanced plan	100% of your average weekly wage after an initial waiting period of 7 calendar days.	If you experience medical complications during pregnancy or post-partum, benefits may be payable under the short-term disability basic or enhanced plan, as described above.
If (i) you work in a state or locality with a legally mandated plan, (ii) *you are not eligible* to receive the state or local government benefit due to your pregnancy, and (iii) you do not work in a location eligible for the Walmart short-term disability basic or enhanced plan	100% of your average weekly wage after an initial waiting period of 7 calendar days.	The Walmart short-term disability basic and enhanced plans are not available; maternity benefits end after the first 9 weeks of benefit payments.

Benefits are paid biweekly through your payroll check.

*If you work in California, Hawaii, New Jersey, or Rhode Island, Sedgwick will estimate the benefit available to you under the state plan, regardless of whether you have applied for state benefits.

You may be eligible for parental pay equal to 100% of your average weekly wage under Walmart's Parental Pay Policy. You cannot receive parental pay while receiving short-term disability maternity benefits. For more information, refer to the Parental Pay Policy on **One.Walmart.com.

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

The taxation of benefits payable to you depends on whether you are enrolled in the short-term disability basic plan or enhanced plan. If you are enrolled in short-term disability basic plan, benefits payable to you are subject to taxes. This is because you do not make contributions to the short-term disability basic plan, and you do not pay any tax on the coverage that Walmart provides. If you are enrolled in short-term disability enhanced plan, only a portion of your benefits will be taxed, because both Walmart and you pay for the cost of the coverage through a combination of Walmart pretax and associate after-tax contributions. Walmart generally withholds federal, state, local, and Social Security taxes from the portion of your benefit that is taxable.

If you work in New York, please contact Lincoln for information regarding the taxation of your short-term disability plan basic or enhanced benefits. Associates in other states or localities with legally mandated benefits who are not eligible to participate in the short-term disability basic or enhanced plans should either contact Lincoln (if you work in Hawaii or New Jersey) or the state or locality in which you are located for information about the tax status of state or local benefits.

The Plan Administrator cannot guarantee the specific tax consequences that will result from your receipt of benefits under a Walmart short-term disability plan. The Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

RIGHT TO RECOVER OVERPAYMENT

The Plan has the right to recover from you, and you must repay, any amount overpaid to you for short-term disability benefits under a Walmart short-term disability plan. See **The Plan's right to recover overpayment** and **The Plan's right to salary/wage deduction** in the **Claims and appeals** chapter. If you do not repay overpaid amounts in a timely manner, the company will first deduct these amounts from future disability payments (if any). If there is a remaining amount due after any deductions from future disability payments, then the company may, in its discretion, either (i) treat overpaid amounts as taxable wages to you (reportable on your Form W-2), or (ii) deduct overpaid amounts from your paycheck, to the extent permitted by law.

When short-term disability benefit payments end

If you are receiving short-term disability benefits under a Walmart short-term disability plan, your benefit payments will end on the earliest of:

- The date you no longer meet the short-term disability plan's definition of disabled
- The date you fail to furnish the required proof of disability when requested to do so by Sedgwick or Lincoln
- The date you are no longer under the continuous care and treatment of a qualified doctor
- The date you refuse to be examined, if Sedgwick or Lincoln requires you to be examined
- The last day of the maximum period for which benefits are payable
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart, or
- The date of your death.

If your short-term disability benefits end and you do not return to work for any reason, you must request an extension of your leave of absence (refer to the **Resources** chart at the beginning of the chapter for contact information). Failure to do so may result in your employment being terminated.

Benefits provided under a state or locally mandated program may have different end dates from Walmart's short-term disability plan.

Returning to work

Sedgwick will contact you before your expected return-to-work date and advise you of steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

To ensure a smooth transition back to work and avoid a potential impact to your pay, you will need to contact Sedgwick up to four days prior to your actual return-to-work date. If your return-to-work date changes, you should notify Sedgwick immediately. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options, which include requesting an extension of your leave or voluntarily terminating your employment. Failure to request an extension may result in your employment being terminated.

If you return to work within 30 days of the end of your approved disability period, you will be reinstated to the disability coverage you had prior to your disability. If you do not return to work within 30 days of the end of your approved disability period, your coverage will lapse on the 31st day. However, your coverage will be reinstated if you return to active status within one year (you will not be required to satisfy the 12-month eligibility waiting period again).

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less and you are classified as a full-time associate on active status (with or without medical restrictions) and become disabled again from the same or a related condition that caused the first period of disability, as determined by Sedgwick or Lincoln, known as a "relapse/recurrent claim," your short-term disability benefits will pick up where they left off before you came back to work. There will be no additional waiting period of seven calendar days. The combined benefit duration for both periods of disability will not exceed 25 weeks.

If you have returned as a full-time associate and are on active status for more than 30 calendar days and then become disabled from the same or a related condition, it will be considered a new disability, and you may be able to receive up to 25 weeks of benefits following your completion of a new seven-calendar-day benefit waiting period.

If you return as a full-time associate and are on active status for any number of calendar days and then become disabled from a new and unrelated condition, it will be considered a new disability, and you may qualify for up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

If you go on a leave of absence or experience a temporary layoff

If you are not on active status due to a leave of absence or temporary layoff, your eligibility for short-term disability benefits will continue for 90 days from your last day of work. Your eligibility for short-term disability benefits ends on the 91st day after the beginning of your leave of absence or temporary layoff, but is reinstated to your prior coverage if you return to active work status within one year (you will not be required to satisfy the 12-month waiting period again). See **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits while on leave.

When coverage ends

Subject to the ability to have benefits reinstated in certain circumstances (as described under **Returning to work** above), your short-term disability basic plan and enhanced plan coverage ends on the earliest of:

- The date your employment terminates
- The last day of the pay period when your job status changes from an eligible job status
- The date of your death
- The 91st day of a leave of absence or layoff (unless you return to work)
- The 31st day following the end of your approved disability period (unless you return to work), or
- The date the short-term disability benefit is no longer offered by the company.

In addition, coverage under the short-term disability enhanced plan will end if you voluntarily drop your coverage. See the **Eligibility, enrollment, and effective dates** chapter for information.

If you leave the company and are rehired

If you are a full-time hourly associate, see the **If you leave the company and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

Salaried short-term disability plan

The information in this chapter describes short-term disability benefits that may be available to you if:

- You are an eligible salaried (management) associate (truck drivers: see next chapter), and
- You have met all requirements for coverage to be effective, including actively-at-work requirements.

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

Salaried short-term disability plan

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

RESOURCES		
Find What You Need	**Online**	**Other Resources**
To file a claim or get more information	**Go to One.Walmart.com/LOA > mySedgwick**	Call Sedgwick at **800-492-5678**
To file a state benefit claim if you work in any of the following areas:		
California (eCommerce associates)	Go to **edd.ca.gov**	Call **800-480-3287**
Connecticut	Go to **ctpaidleave.org**	Call **877-499-8606**
Massachusetts	Go to **paidleave.mass.gov**	Call **833-344-7365**
Washington, D.C.	Go to **dcpaidfamilyleave.dc.gov**	Call **202-899-3700**
Washington state	Go to **paidleave.wa.gov**	Call **833-717-2273**
Request an appeal of a denied short-term disability claim	**Go to One.Walmart.com/LOA > mySedgwick**	Call Sedgwick at **800-492-5678**

What you need to know about salaried short-term disability

- This chapter describes disability benefits available to you under the short-term disability plan.
- The salaried short-term disability plan replaces 100% of your base pay for up to six weeks and 75% of your base pay for up to 19 additional weeks. (Different rules may apply to work-related disabilities that qualify for workers' compensation through Walmart. See the chart titled **Your salaried short-term disability plan benefit** for more information.)
- If your disability is due to pregnancy, the short-term disability plan replaces 100% of your base pay for nine weeks. Additional benefits may be payable after the first nine weeks of benefits if you experience medical complications during pregnancy or post-partum. For details, see **Maternity benefit** later in this chapter.
- The salaried short-term disability plan is not a benefit covered by ERISA and is not part of the Associates' Health and Welfare Plan.
- The claims and appeals procedures described in this chapter apply to the salaried short-term disability benefit rather than the procedures in the **Claims and appeals** chapter.

Your short-term disability benefit

If you become disabled as defined in the **When you qualify for benefits** section later in this chapter and are eligible to receive short-term disability benefits, the salaried short-term disability plan generally pays 100% of your base pay for up to six weeks of an approved disability, after an initial waiting period of seven calendar days of continuous disability. (Disabilities that qualify for workers' compensation through Walmart are treated differently, as described in the chart titled **Your salaried short-term disability plan benefit**.) If you remain disabled and eligible for benefits after the first six weeks of disability payments, the salaried short-term disability plan will pay 75% of your base pay for up to 19 additional weeks.

If your disability is due to pregnancy, the salaried short-term disability plan pays a maternity benefit of 100% of your base pay for the first nine weeks, after an initial waiting period of seven calendar days. If you remain disabled and eligible for benefits after the first nine weeks of disability pay, the salaried short-term disability plan will pay 75% of your base pay for up to 16 additional weeks of benefit payments.

How salaried short-term disability is administered

Salaried short-term disability coverage is administered by Sedgwick Claims Management Services, Inc. (Sedgwick) and is provided by the company at no cost to you.

LEGALLY MANDATED PLANS

Short-term disability benefits provided by individual states and local governments generally have no impact on your eligibility for the Walmart salaried short-term disability plan, unless you are an eCommerce salaried associate who works in California or you work in Connecticut, Massachusetts, Washington, D.C., or Washington state. Rules applicable to these state and local plans can be found in the following chart.

LEGALLY MANDATED PLANS	
If you are an eCommerce salaried associate who works in California or a salaried associate who works in Connecticut, Massachusetts, Washington, D.C., or Washington state	You are eligible to participate in the Walmart salaried short-term disability plan to supplement your state benefits. The amount of the benefit under the salaried short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates that you are eligible to receive from the state or locality, regardless of whether you apply for that legally mandated benefit. If the benefit available to you under any state or locally mandated plan is less than the benefit available to you under the Walmart short-term disability plan, the combined total of the benefit available to you under the Walmart short-term disability plan and the benefit available to you under any state or locally mandated plan will not exceed the benefits that would have been available under the Walmart short-term disability plan if you had not worked in a state or locality with a legally mandated plan. You are responsible for providing your award letter from the state or locality to Sedgwick. If Sedgwick overestimated what your mandated benefit would be, meaning that you were paid less under the salaried short-term disability plan than you were entitled to, you will be paid the difference in a lump sum payment. If Sedgwick underestimated what your mandated benefit would be, meaning that you were paid more under the salaried short-term disability plan than you were entitled to, you must repay any amount overpaid to you. See the **Right to recover overpayment** section later in this chapter.

When you qualify for benefits

To be eligible to receive short-term disability benefits, you must meet the following requirements:

- Your coverage must be effective.
- Your disability must have occurred on or after the effective date of your coverage.
- You must be on active status at the time of your disability unless:
  - You are on leave of absence or layoff as described later in this chapter under **If you go on a leave of absence or experience a temporary layoff**, or
  - You are unable to work because you have experienced medical complications during pregnancy or post-partum and have exhausted the nine-week short-term disability plan maternity benefit, as described later in this chapter under **Maternity benefit**.
- Except as otherwise provided in the **Maternity benefit** section in this chapter, you must submit medical evidence provided by a qualified doctor that you are disabled as defined by the salaried short-term disability plan (for purposes of this chapter, the term "doctor" includes legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors [M.D.], osteopaths [D.O.], nurse practitioners, physician's assistants, psychologists, or other medical practitioners whose services would be eligible for reimbursement if submitted for reimbursement under the Associates' Medical Plan).
- You must receive approval by Sedgwick of your claim.

Sedgwick may require written proof of your disability, as defined later in this chapter, or additional information before making a decision on your claim. A statement by your doctor that you are unable to work does not by itself prove that you are disabled. Approval of a medical leave of absence also does not constitute approval for short-term disability benefits.

> If your disability is caused by a mental illness or substance use disorder, you are encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, licensed counselor, drug and alcohol counselor, or clinical social worker who specializes in mental health and/or substance use disorders, and is licensed pursuant to state law. See the **Resources for Living** chapter for information on resources that are available if you are experiencing the effects of a mental illness or substance use disorder.

Except as otherwise provided in the **Maternity benefit** section, for purposes of benefits provided under the short-term disability plan, "disabled" or "disability" means that (i) you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy, and (ii) you are under the continuous care of a qualified doctor and are following the course of treatment prescribed by your doctor.

Disability benefits are payable during a loss of license only while you are disabled and pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. Loss of license by itself is not sufficient for meeting the definition of disability. The determination of whether you are disabled is made by Sedgwick on the basis of objective medical evidence, which consists of facts and findings, including but not limited to X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician.

If Sedgwick requests that you be examined by an independent doctor, you must attend the exam to be considered for benefits. The company will pay the cost of any such examination.

The maximum length of any one period of disability during which disability benefits are paid, even if the disability is the result of more than one cause, is 25 weeks, after the initial waiting period of seven calendar days. See also **If you return to work and become disabled again**.

See the **Maternity benefit** section of this chapter for additional details regarding the maternity benefit.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that:

- Arose before your coverage became effective
- Is not under the care of and being treated by a qualified doctor
- Is caused by taking part in an insurrection, rebellion, or a riot, or civil disorder
- Resulted from your commission of or attempt to commit a crime (e.g., assault, battery, felony, or any illegal occupation or activity), or
- Resulted from doing any work for pay or profit (for example, an illness or injury that is related to work outside of Walmart).

Filing a claim

If you become disabled, file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption in your wages, or the denial of your claim. If you experience a disabling illness or injury, or are planning to begin maternity leave, follow these steps:

STEP 1: Notify Sedgwick to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury, or pregnancy. Sedgwick will send you an initial packet providing the information you will need and describing any actions you will need to take. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated. Report your disability online by going to **One.Walmart.com/LOA > mySedgwick**, or calling **800-492-5678**.

Processing of your claim cannot begin until you have stopped working. All claims for benefits under Walmart's salaried short-term disability plan must be submitted to Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

Associates who work in Connecticut, Massachusetts, Washington, D.C., and Washington state are advised to promptly apply to Sedgwick and to your state or locality for state-mandated state benefits. Refer to the **Resources** chart at the beginning of the chapter for contact information.

Note that associates in Washington, D.C. will generally not receive benefits for periods prior to the date of application for benefits, except in emergency situations.

STEP 2: Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide medical information, including:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, and
- Doctor visit notes.

You must sign a form authorizing your doctor to release this information. This release will be included in the initial packet that you receive from Sedgwick; however, if you are filing your claim online, an electronic signature is accepted.

STEP 3: Follow up with your doctor to ensure that information was forwarded to the disability administrator.

You may be required to provide written proof of your disability or additional medical information before your benefit payments begin.

> If you become disabled, file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption in your wages, or the denial of your claim.

Your pay after filing a claim

Sedgwick will send you an initial packet when you file your claim. You will have until the Medical Due Date, which is stated in your initial packet, to provide the required medical documentation. In order for your pay to continue during the initial waiting period of seven calendar days, you may use paid time off (PTO). Following your initial waiting period of seven calendar days, your pay will continue until your Medical Due Date; this pay is known as "provisional pay." Your pay will be suspended after your Medical Due Date if the required medical documentation has not been approved.

Be sure to provide the required medical documentation as soon as possible. If you do not meet the Medical Due Date deadline, your pay will be suspended effective the first day of the pay period in which it falls. If your claim is approved, the approval will be effective as of the date of your disability, and the provisional pay you received after your seven-day waiting period and while your claim was pending will count toward your disability benefit.

If your claim is denied before the Medical Due Date due to your medical circumstances not meeting the salaried short-term disability plan's definition of disability, your provisional pay will be stopped and Walmart will commence efforts to recover the amount paid to you for the period following your illness or injury.

You will not receive provisional pay during any period when a determination is being made regarding a relapse/recurrent claim (see **If you return to work and become disabled again** later in this chapter).

Benefits determination

Sedgwick makes a decision within 45 days of receiving your properly filed claim. The time for a decision may be extended for up to two additional 30-day periods. You will be notified in writing before any extension period that an extension is necessary due to matters beyond Sedgwick's control. Those matters must be identified and you must be given the date by which Sedgwick will make a decision. If your claim is extended due to your failure to submit information Sedgwick deems necessary to decide your claim, the time for decision will be suspended as of the date on which the notification of the extension is sent to you until the date Sedgwick receives your response. If Sedgwick approves your claim, the decision will contain information sufficient to inform you of that decision.

If Sedgwick denies your claim, you will be sent a written notification of the denial, which 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 appeal procedures and time limits applicable to such procedures, 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 submit a written or oral appeal to Sedgwick within 180 days of the denial. Your appeal should include any comments, documents, records, or any other information you would like considered.

For associates in states or localities with legally mandated plans, such as Connecticut, Massachusetts, Washington, D.C., and Washington state, you should submit your appeal directly to the state or local government. If you are appealing your Sedgwick claim, file your appeal with Sedgwick as noted below.

You 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.

Sedgwick 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 reason(s) 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 appeal procedures offered by the Plan.

VOLUNTARY SECOND APPEAL OF A SALARIED SHORT-TERM DISABILITY CLAIM

If your appeal is denied, you may make a voluntary second appeal of your denial orally or in writing to Sedgwick. You must submit your second appeal within 180 days of the receipt of the written notice of denial. You may submit any written comments, documents, records, and any other information relating to your claim. The same criteria and response times that applied to your first appeal, as described earlier, are generally applied to this voluntary second appeal.

All salaried short-term disability appeals (initial appeals and voluntary second appeals) should be sent to:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

When benefits begin

If your short-term disability claim is approved, the benefit will begin after a waiting period of seven calendar days, on the eighth calendar day after your disability begins. (There is no waiting period for work-related disabilities that qualify for workers' compensation through Walmart.)

For your pay to continue during the initial waiting period of seven calendar days, you may use paid time off. Short-term disability benefits begin on the eighth calendar day after your eligible disability begins. You should not use PTO beyond the initial seven-day waiting period while a claim decision is pending or for any period for which short-term disability benefits are approved (see **Your pay after filing a claim** earlier in this chapter for information regarding provisional pay that may apply after your initial waiting period of seven calendar days). If you are later found to be ineligible for short-term disability benefits, you may go back and use PTO for any time that was unpaid. Walmart and/or Sedgwick may seek repayment of any PTO used for days when disability benefits were received. Upon repayment, any PTO balance will be restored.

If you are receiving short-term disability at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information.

You do not accrue additional PTO while you are receiving short-term disability benefits.

Calculating your benefit

The amount of your short-term disability benefit is based on:

- Your base pay as of your last day worked, and
- The duration of your disability.

Base pay, for purposes of the salaried short-term disability benefit, is defined as follows:

ASSOCIATE TYPE	BASE PAY
Exempt associates	Gross biweekly salary
Non-exempt associates	Hourly rate multiplied by normal hours scheduled per pay period

If you become disabled and eligible to receive short-term disability benefits, the salaried short-term disability plan pays benefits as described below:

YOUR SALARIED SHORT-TERM DISABILITY PLAN BENEFIT		
Duration of your disability	**Your benefit is:**	
	If your disability does not qualify for workers' compensation through Walmart	**If you have a work-related disability that qualifies for workers' compensation through Walmart**
Up to 7 weeks	After an initial waiting period of 7 calendar days, 100% of your base pay. Benefits begin on the 8th calendar day. You may use PTO during your first 7 calendar days of continuous disability.	100% of your base pay, with no initial waiting period.
More than 7 weeks, up to 26 weeks	75% of your base pay. For example, if your biweekly base pay (as defined above) is $1,000, 75% of $1,000 is a $750 biweekly benefit. Short-term benefits are paid biweekly through your payroll check.	Workers' compensation benefits are payable at the applicable state rate; short-term disability benefits make up the difference up to 75% of your base pay. For example, if your base pay is $1,000 and workers' compensation pays 66% for your disability, or $660, short-term disability will pay an additional $90, for a total benefit of $750. (If the legally mandated workers' compensation rate exceeds 75% of your base pay, you will not receive any short-term disability benefit.)
If a benefit is payable for less than a week, your disability benefit will be based on your base pay divided by your regular work schedule for each day you are disabled. If you are able to return to work after a period of short-term disability and need to miss work periodically for reasons related to your disability, notify Sedgwick and your facility of your situation. Your treatment may be covered under your prior short-term disability claim for up to 12 months from the date you return to work from your short-term disability claim. Salaried short-term disability generally pays 100% of your base pay for the duration of your approved intermittent leave. You will not need to use PTO for the absences.		
NOTE: For associates who are eligible for legally mandated benefits (as noted in **Legally mandated plans** earlier in this chapter) as well as benefits under Walmart's salaried short-term disability plan, the amount of the benefit under Walmart's salaried short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates that they will receive.		

WORKERS' COMPENSATION AND YOUR SHORT-TERM DISABILITY BENEFITS

Workers' compensation and short-term disability benefits are made as separate payments, except in the states of Texas and Wyoming, where the entire benefit is included in the payment you receive from Walmart.

If you are receiving workers' compensation benefits for an unrelated injury or illness, any short-term disability benefit for which you are eligible will be reduced, or offset, by any workers' compensation benefits you are eligible to receive.

MATERNITY BENEFIT

Maternity benefits under the salaried short-term disability plan are as described here:

MATERNITY BENEFIT		
Duration of benefit	**Your benefit is:**	**If you are eligible for legally mandated benefits in California (for eCommerce salaried associates); Connecticut; Massachusetts; Washington, D.C.; and Washington state:**
Up to 9 weeks*	100% of your base pay after an initial waiting period of 7 calendar days.	Legally mandated benefits are payable at the applicable state or local government rate; the Walmart salaried short-term disability maternity benefit will make up the difference between the state or local government benefit and 100% of your base pay after an initial waiting period of 7 calendar days.
	Maternity benefits under the salaried short-term disability plan begin on the 8th calendar day after your eligible disability begins. You may use PTO during your first 7 calendar days of continuous disability. Benefits are paid biweekly through your payroll check.	
*You may also be eligible for parental pay and family care pay equal to 100% of your base pay. You cannot receive parental pay and family care pay benefits while receiving short-term disability maternity benefits. For more information, refer to the Parental Pay Policy and Family Care Pay Policy on **One.Walmart.com**.		
NOTE: For associates who are eligible for legally mandated benefits (as noted in **Legally mandated plans** earlier in this chapter) as well as benefits under the salaried short-term disability plan, the amount of the benefit under the salaried short-term disability plan will be reduced by the amount of the legally mandated benefit.		

See the **When you qualify for benefits** section for general requirements applicable to all disability benefits under the short-term disability plan, including the maternity benefit. There are some exceptions to those general rules that apply to the maternity benefit. Those exceptions are discussed in this section.

If your disability is due to pregnancy, the date of your disability is generally on or up to two weeks prior to your expected date of delivery. If you begin your short-term disability leave during this time frame, you will be deemed to meet the definition of disability. If you begin your leave more than two weeks prior to your expected delivery date, you will be required to provide objective medical evidence to demonstrate you are disabled, as defined in the **When you qualify for benefits** section. If you are disabled, as defined in that section, you will begin your short-term disability maternity benefit on the date you are determined to be disabled. In no event will the maternity benefit exceed nine weeks.

If you do not begin your short-term disability leave on your delivery date, you must meet the plan's definition of disabled, as defined in the **When you qualify for benefits** section. In that case, any disability benefit will be subject to rules applicable to non-maternity disability benefits. To the extent you are eligible for a disability benefit, that benefit would be determined under the rules applicable to non-maternity short-term disability. You will not be eligible for the maternity benefit described in this section.

If you experience medical complications during pregnancy or post-partum and continue to meet the definition of disability after the first nine weeks of maternity benefits, the short term disability plan will provide disability benefits of 75% of your base pay from week 10 up to 25 weeks of benefit payments.

NOTE: For associates in states or localities with legally mandated benefits, please refer to the **Legally mandated plans** chart earlier in this chapter for information about coordination of benefits.

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

Benefits payable to you under the salaried short-term disability plan are company-provided, at no cost to you. Because you do not make any contributions to the salaried short-term disability plan and you do not pay any tax on the coverage that Walmart provides, any benefits payable to you are subject to taxes. Walmart generally withholds federal, state, local, and Social Security taxes from the amount of your benefit payments.

Walmart cannot guarantee the specific tax consequences that will result from your receipt of benefits under Walmart's short-term disability plan. Walmart is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

RIGHT TO RECOVER OVERPAYMENT

The salaried short-term disability plan has the right to recover from you, and you must repay, any amount overpaid to you for short-term disability benefits under this plan. See **The Plan's right to recover overpayment** and **The Plan's right to salary/wage deduction** in the **Claims and appeals** chapter. If you do not repay overpaid amounts in a timely manner, the company will first deduct such amounts from future disability payments (if any). If there is a remaining amount due after any deductions from future disability payments, then the company may, in its discretion, either (i) treat overpaid amounts as taxable wages to you (reportable on your Form W-2), or (ii) deduct overpaid amounts from your paycheck, to the extent permitted by law.

When short-term disability benefit payments end

If you are receiving short-term disability benefit payments from the salaried short-term disability plan due to an approved disability, your benefit payments from the plan will end on the earliest of:

- The date you no longer meet the short-term disability plan's definition of disabled
- The date you fail to furnish the required proof of disability when requested to do so by Sedgwick
- The date you are no longer under the continuous care and treatment of a qualified doctor
- The date you refuse to be examined, if Sedgwick requires you to be examined
- The last day of the maximum period for which benefits are payable
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart
- The date your employment terminates, or
- The date of your death.

When your short-term disability benefits end and for any reason you do not return to work, you must request an extension of your leave (refer to the **Resources** chart at the beginning of the chapter for contact information). Failure to do so may result in your employment being terminated.

Returning to work

Sedgwick will contact you before your expected return-to-work date and advise you of steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

To ensure a smooth transition back to work and avoid a potential impact to your pay, you will need to contact Sedgwick up to four days prior to your actual return-to-work date. If your return-to-work date changes, you should notify Sedgwick immediately. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options, which include requesting an extension of your leave or voluntarily terminating your employment. Failure to request an extension may result in your employment being terminated.

If you return to work within 30 days of the end of your disability period, you will be reinstated to the disability coverage you had prior to your disability. If you do not return to work within 30 days of the end of your approved disability period, your coverage will lapse on the 31st day. However, your coverage will be reinstated if you return to active status within one year.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less and you are classified as a management associate on active status (with or without medical restrictions) and become disabled again from the same or a related condition that caused the first period of disability, as determined by Sedgwick, known as a "relapse/recurrent claim," your short-term disability benefits will pick up where they left off before you came back to work. There will be no additional waiting period of seven calendar days. The combined benefit duration for both periods of disability will not exceed 25 weeks.

If you have returned as a management associate and are on active status for more than 30 calendar days and then become disabled from the same or a related cause, it will be considered a new disability, and you may be able to receive up to 25 weeks of benefits, following your completion of a new seven-calendar-day waiting period.

If you return as a management associate and are on active status for any number of calendar days and then become disabled from a new and unrelated cause, it will be considered a new disability, and you may qualify for up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

Intermittent leave. If you are able to return to work after a period of short-term disability and need to miss work periodically for reasons related to your disability, notify Sedgwick and your facility of your situation. Your treatment may be covered under your prior short-term disability claim for up to 12 months from the date you return to work from your short-term disability claim. Salaried short-term disability generally pays 100% of your base pay for the duration of your approved intermittent leave. You will not need to use PTO for the absences.

If you go on a leave of absence or experience a temporary layoff

If you are not on active status due to a leave of absence or temporary layoff, your eligibility for short-term disability benefits will continue for 90 days from your last day of work. Your eligibility for short-term disability benefits ends on the 91st day after the beginning of your leave of absence or temporary layoff, but is reinstated if you return to work within one year. See **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits while on leave.

When coverage ends

Your short-term disability coverage ends on the earliest of:

- The date your employment terminates
- The last day of the pay period when your job status changes from an eligible job status
- The date of your death
- The 91st day of a leave of absence or layoff (unless you return to work)
- The 31st day following the end of your approved disability period (unless you return to work), or
- The date the benefit is no longer offered by the company.

If you leave the company and are rehired

If you leave the company and return to work for the company as a salaried associate, you will automatically be reenrolled in the salaried short-term disability plan.

Truck driver short-term disability plan

The information in this chapter describes short-term disability benefits that may be available to you if:

- You are a full-time truck driver associate, and
- You have met all requirements for coverage to be effective, including actively-at-work requirements.

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

Truck driver short-term disability plan

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

RESOURCES		
Find What You Need	**Online**	**Other Resources**
To file a claim or get more information	Go to **One.Walmart.com/LOA > mySedgwick**	Call Sedgwick at **800-492-5678**
To file a state benefit claim if you work in any of the following areas:		
Connecticut	Go to **paidleave.wa.gov**	Call **877-499-8606**
Massachusetts	Go to **paidleave.mass.gov**	Call **833-344-7365**
Washington, D.C.	Go to **dcpaidfamilyleave.dc.gov**	Call **202-899-3700**
Washington state	Go to **paidleave.wa.gov**	Call **833-717-2273**
Request an appeal of a denied short-term disability claim	Go to **One.Walmart.com/LOA > mySedgwick**	Call Sedgwick at **800-492-5678**

What you need to know about truck driver short-term disability

- This chapter describes disability benefits available to you under the short-term disability plan.
- The truck driver short-term disability plan replaces 75% of your average day's pay for up to 25 weeks, after an initial waiting period of seven calendar days. (Different rules may apply to work-related disabilities that qualify for workers' compensation through Walmart. See the chart titled **Your truck driver short-term disability plan benefit** for more information.)
- If your disability is due to pregnancy, the short-term disability plan replaces 100% of your average day's pay for nine weeks. Additional benefits may be payable after the first nine weeks of benefits if you experience medical complications during pregnancy or post-partum. For details, see **Maternity benefit** later in this chapter.
- The truck driver short-term disability plan is not a benefit covered by ERISA and is not part of the Associates' Health and Welfare Plan.
- The claims and appeals procedures described in this chapter apply to the truck driver short-term disability benefit rather than the procedures in the **Claims and appeals** chapter.

Your short-term disability benefit

If you become disabled as defined in the **When you qualify for benefits** section later in this chapter, and are eligible to receive short-term disability benefits, the truck driver short-term disability plan generally pays 75% of your average day's pay for up to 25 weeks of an approved disability, after an initial waiting period of seven calendar days of continuous disability. The waiting period begins on your next scheduled work day after your disability begins. (Disabilities that qualify for workers' compensation through Walmart are treated differently, as described in the chart titled **Your truck driver short-term disability plan benefit**.)

If your disability is due to pregnancy, the truck driver short-term disability plan pays a maternity benefit of 100% of your average day's pay for the first nine weeks, after an initial waiting period of seven calendar days. The waiting period begins on your next scheduled work day after your disability begins. If you remain disabled and eligible for benefits after the first nine weeks of maternity benefits, the truck driver short-term disability plan will pay 75% of your base pay for up to 16 additional weeks of benefit payments.

How truck driver short-term disability is administered

Truck driver short-term disability coverage is administered by Sedgwick Claims Management Services, Inc. (Sedgwick) and is provided by the company at no cost to you.

LEGALLY MANDATED PLANS

Short-term disability benefits provided by individual states and local governments generally have no impact on your eligibility for the truck driver short-term disability benefit plan through Walmart, unless you are an associate who works in Connecticut, Massachusetts, Washington, D.C., or Washington state. Rules applicable to these state and local plans can be found in the following chart.

LEGALLY MANDATED PLANS	
If you are an associate who works in Connecticut, Massachusetts, Washington, D.C., or Washington state	You are eligible to participate in the truck driver short-term disability plan to supplement your state benefits. The amount of the benefit under the truck driver short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates that you are eligible to receive from the state or locality, regardless of whether you apply for that legally mandated benefit. If the benefit available to you under any state or locally mandated plan is less than the benefit available to you under a Walmart short-term disability plan, the combined total of the benefit available to you under a Walmart short-term disability plan and the benefit available to you under any state or locally mandated plan will not exceed the benefits that would have been available under the short-term disability plan if you had not worked in a state with a legally mandated plan. You are responsible for providing your award letter from the state or locality to Sedgwick. If Sedgwick overestimated what your mandated benefit would be, meaning that you were paid less under the salaried short-term disability plan than you were entitled to, you will be paid the difference in a lump sum payment. If Sedgwick underestimated what your mandated benefit would be, meaning that you were paid more under the truck driver short-term disability plan than you were entitled to, you must repay any amount overpaid to you. See the **Right to recover overpayment** section later in this chapter.

When you qualify for benefits

To be eligible to receive short-term disability benefits, you must meet the following requirements:

- Your coverage must be effective.
- Your disability must have occurred on or after the effective date of your coverage.
- You must be on active status at the time of your disability unless:
  - You are on leave of absence or layoff as described later in this chapter under **If you go on a leave of absence or experience a temporary layoff**, or
  - You are unable to work because you have experienced medical complications during pregnancy or post-partum and have exhausted the nine-week short-term disability plan maternity benefit, as described later in this chapter under **Maternity benefit**.
- Except as otherwise provided in the **Maternity benefit** section, you must submit medical evidence provided by a qualified doctor that you are disabled as defined by the truck driver short-term disability plan (for purposes of this chapter, the term "doctor" includes legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors [M.D.], osteopaths [D.O.], nurse practitioners, physician's assistants, psychologists or other medical practitioners whose services would be eligible for reimbursement under the Associates' Medical Plan).
- You must receive approval by Sedgwick of your claim.

Sedgwick may require written proof of your disability, as defined later in this chapter, or additional information before making a decision on your claim. A statement by your doctor that you are unable to work does not by itself prove that you are disabled. Approval of a medical leave of absence also does not constitute approval for short-term disability benefits.

> If your disability is caused by a mental illness or substance use disorder, you are encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, licensed counselor, drug and alcohol counselor, or clinical social worker who specializes in mental health and/or substance use disorders, and is licensed pursuant to state law. See the **Resources for Living** chapter for information on resources that are available if you are experiencing the effects of a mental illness or substance use disorder.

Except as otherwise provided in the **Maternity benefit** section, for purposes of benefits provided under the short-term disability plan, "disabled" or "disability" means that (i) you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy, and (ii) you are under the continuous care of a qualified doctor and are following the course of treatment prescribed by your doctor. See the **Maternity benefit** section for exceptions to this general requirement for purposes of the maternity benefit.

Disability benefits are payable during a loss of license only while you are disabled and pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria, and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. Loss of license by itself is not sufficient for meeting the definition of disability. The determination of whether you are disabled is made by Sedgwick on the basis of objective medical evidence, which consists of facts and findings, including but not limited to X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician.

If Sedgwick requests that you be examined by an independent doctor, you must attend the exam to be considered for benefits. The company will pay the cost of any such examination.

The maximum length of any one period of disability during which disability benefits are paid, even if the disability is the result of more than one cause, is 25 weeks, after the initial waiting period of seven calendar days. See also **If you return to work and become disabled again**.

See the **Maternity benefit** section for additional details regarding the maternity benefit.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that:

- Arose before your coverage became effective
- Is not under the care of and being treated by a qualified doctor
- Is caused by taking part in an insurrection, rebellion, or a riot or civil disorder
- Resulted from your commission of or attempt to commit a crime (e.g., assault, battery, felony, or any illegal occupation or activity), or
- Resulted from doing any work for pay or profit (for example, an illness or injury that is related to work outside of Walmart).

Filing a claim

If you become disabled, file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption in your wages, or the denial of your claim. If you experience a disabling illness or injury, or are planning to begin maternity leave, follow these steps:

STEP 1: Notify Sedgwick to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury, or pregnancy. Sedgwick will send you an initial packet providing the information you will need and describing any actions you will need to take. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated. Report your disability online by going to **One.Walmart.com/LOA > mySedgwick**, or call **800-492-5678**.

Processing of your claim cannot begin until you have stopped working. All claims for benefits under Walmart's truck driver short-term disability plan must be submitted to Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

Associates who work in Connecticut, Massachusetts, Washington, D.C., and Washington state are advised to promptly apply to Sedgwick and to your state or locality for state-mandated state benefits. Refer to the **Resources** chart at the beginning of the chapter for contact information.

Note that associates in Washington, D.C. will generally not receive benefits for periods prior to the date of application for benefits, except in emergency situations.

STEP 2: Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide medical information, including:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, and
- Doctor visit notes.

You must sign a form authorizing your doctor to release this information. This release will be included in the initial packet that you receive from Sedgwick; however, if you are filing your claim online, an electronic signature is accepted.

STEP 3: Follow up with your doctor to ensure that information was forwarded to the disability administrator.

You may be required to provide written proof of your disability or additional medical information before your benefit payments begin.

> If you become disabled, file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption in your wages, or the denial of your claim.

Your pay after filing a claim

Sedgwick will send you an initial packet when you file your claim. You will have until the Medical Due Date, which is stated in your initial packet, to provide the required medical documentation. In order for your pay to continue during the initial waiting period of seven calendar days, you may use paid time off (PTO). Following your initial waiting period of seven calendar days, your pay will continue until your Medical Due Date; this pay is known as "provisional pay." Your pay will be suspended after your Medical Due Date if the required medical documentation has not been approved.

Be sure to provide the required medical documentation as soon as possible. If you do not meet the Medical Due Date deadline, your pay will be suspended effective the first day of the pay period in which it falls. If your claim is approved, the approval will be effective as of the date of your disability, and the provisional pay you received after your seven-day waiting period and while your claim was pending will count toward your disability benefit.

If your claim is denied before the Medical Due Date due to your medical circumstances not meeting the truck driver short-term disability plan's definition of disability, your provisional pay will be stopped and Walmart will commence efforts to recover the amount paid to you for the period following your illness or injury.

You will not receive provisional pay during any period when a determination is being made regarding a relapse/recurrent claim (see **If you return to work and become disabled again** later in this chapter).

Benefits determination

Sedgwick makes a decision within 45 days of receiving your properly filed claim. The time for a decision may be extended for up to two additional 30-day periods. You will be notified in writing before any extension period that an extension is necessary due to matters beyond Sedgwick's control. Those matters must be identified and you must be given the date by which Sedgwick will make a decision. If your claim is extended due to your failure to submit information Sedgwick deems necessary to decide your claim, the time for decision will be suspended as of the date on which the notification of the extension is sent to you until the date Sedgwick receives your response. If Sedgwick approves your claim, the decision will contain information sufficient to inform you of that decision.

If Sedgwick denies your claim, you will be sent a written notification of the denial, which 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 appeal procedures and time limits applicable to such procedures, 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 submit a written or oral appeal to Sedgwick within 180 days of the denial. Your appeal should include any comments, documents, records, or any other information you would like considered.

For associates in states or localities with legally mandated plans, such as Connecticut, Massachusetts, Washington, D.C., and Washington state, you should submit your appeal directly to the state or local government. If you are appealing your Sedgwick claim, file your appeal with Sedgwick as noted below.

Sedgwick 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 reason(s) 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 appeal procedures offered by the Plan.

VOLUNTARY SECOND APPEAL OF A TRUCK DRIVER SHORT-TERM DISABILITY CLAIM

If your appeal is denied, you may make a voluntary second appeal of your denial orally or in writing to Sedgwick. You must submit your second appeal within 180 days of the receipt of the written notice of denial. You may submit any written comments, documents, records, and any other information relating to your claim. The same criteria and response times that applied to your first appeal, as described earlier, are generally applied to this voluntary second appeal.

All truck driver short-term disability appeals (initial appeals and voluntary second appeals) should be sent to:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

When benefits begin

If your short-term disability claim is approved, the benefit will begin after a waiting period of seven calendar days. The waiting period begins on your next scheduled work day after your disability begins. (Work-related disabilities that qualify for workers' compensation through Walmart may have different waiting periods under state law.)

For your pay to continue during the initial waiting period of seven calendar days, you may use paid time off. Short-term disability benefits begin on the eighth calendar day after your eligible disability begins. You should not use PTO beyond the initial seven-day waiting period while a claim decision is pending or for any period for which short-term disability benefits are approved (see **Your pay after filing a claim** earlier in this chapter for information regarding provisional pay that may apply after your initial waiting period of seven calendar days). If you are later found to be ineligible for short-term disability benefits, you may go back and use PTO for any time that was unpaid. Walmart and/or Sedgwick may seek repayment of any PTO used for days when disability benefits were received. Upon repayment, any PTO balance will be restored.

If you are receiving short-term disability at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information.

You do not accrue additional PTO while you are receiving short-term disability benefits.

Calculating your benefit

The amount of your short-term disability benefit is based on:

- Your average day's pay as of your last day worked.
- The duration of your disability.

If you become disabled and are eligible to receive short-term disability benefits, the truck driver short-term disability plan replaces 75% of your average day's pay as of your last day before your disability for up to 25 weeks, after an initial waiting period of seven calendar days. There is no maximum weekly benefit under the truck driver short-term disability plan.

If you become disabled and are eligible to receive short-term disability benefits, the truck-driver short-term disability plan pays benefits as described below.

YOUR TRUCK DRIVER SHORT-TERM DISABILITY PLAN BENEFIT		
Duration of your disability	**Your benefit is:**	
	If your disability does not qualify for workers' compensation through Walmart	**If you have a work-related disability that qualifies for workers' compensation through Walmart**
Up to 26 weeks	After an initial waiting period of 7 calendar days, 75% of your average day's pay. The waiting period begins on your next scheduled workday after your total disability begins. You may use PTO during your first 7 calendar days of continuous disability. For example, if your average day's pay over the week totals $1,000, 75% of $1,000 is a $750 weekly benefit. Short-term benefits are paid biweekly through your payroll check.	75% of your average day's pay. The short-term disability benefit will pay 75% during the state workers' compensation waiting period, then workers' compensation will pay according to the state's compensation rate. The short-term disability benefit will "top off" this pay to 75%. If the state compensation rate is greater than 75%, you will not receive additional benefits from Sedgwick. For example, if your workers' compensation benefit or anticipated benefit is 66%, the short-term disability benefit will provide 9% of your wages. Short-term disability benefits are paid biweekly through your payroll check, while workers' compensation is paid through a separate check except in the states of Texas and Wyoming, where the entire benefit is included in the payment you receive from Walmart.
If a benefit is payable for less than a week, your disability benefit will be based on 75% of your average day's pay multiplied by your regular work days scheduled for each day you are disabled. If you are able to return to work after a period of short-term disability and need to miss work periodically for reasons related to your disability, notify Sedgwick and your facility of your situation. Your treatment may be covered under your prior short-term disability claim for up to 12 months from the date you return to work from your short-term disability claim. Truck driver short-term disability generally pays 100% of your average day's pay for the duration of your approved intermittent leave. You will not need to use PTO for the absences.		
NOTE: For associates who are eligible for legally mandated benefits (as noted in **Legally mandated plans** earlier in this chapter) as well as benefits under the truck driver short-term disability plan, the amount of the benefit under the truck driver short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates that they will receive.		

WORKERS' COMPENSATION AND YOUR SHORT-TERM DISABILITY BENEFITS

Workers' compensation and short-term disability benefits are made as separate payments except in the states of Texas and Wyoming, where the entire benefit is included in the payment you receive from Walmart.

If you are receiving workers' compensation benefits for an unrelated injury or illness, any short-term disability benefit for which you are eligible will be reduced, or offset, by any workers' compensation benefits you are eligible to receive.

MATERNITY BENEFIT

Maternity benefits under the truck driver short-term disability plan are as described here:

MATERNITY BENEFIT		
Duration of benefit	**Your benefit is:**	**If you are eligible for legally mandated benefits in Connecticut; Massachusetts; Washington, D.C.; and Washington state:**
Up to 9 weeks*	100% of your average day's pay after an initial waiting period of 7 calendar days	Legally mandated benefits are payable at the applicable state or local government rate; the Walmart truck driver short-term disability maternity benefit will make up the difference between the state or local government benefit and 100% of your average day's pay after an initial waiting period of 7 calendar days.
	Maternity benefits under the truck driver short-term disability plan begin on the 8th calendar day after your eligible disability begins. You may use PTO during your first 7 calendar days of continuous disability. Benefits are paid biweekly through your payroll check.	
*You may also be eligible for additional parental and family care pay equal to 100% of your average day's pay. You cannot receive parental pay and family care pay benefits while receiving short-term disability maternity benefits. For more information, refer to the Parental Pay Policy and Family Care Pay Policy on **One.Walmart.com**.		
NOTE: For associates who are eligible for legally mandated benefits (as noted in **Legally mandated plans** earlier in this chapter) as well as benefits under the truck driver short-term disability plan, the amount of the benefit under the truck driver short-term disability plan will be reduced by the amount of the legally mandated benefit.		

See the **When you qualify for benefits** section for general requirements applicable to all disability benefits under the short-term disability plan, including the maternity benefit. There are some exceptions to those general rules that apply to the maternity benefit. Those exceptions are discussed in this section.

If your disability is due to pregnancy, the date of your disability is generally on or up to two weeks prior to your expected date of delivery. If you begin your short-term disability leave during this time frame, you will be deemed to meet the definition of disability. If you begin your leave more than two weeks prior to your expected delivery date, you will be required to provide objective medical evidence to demonstrate you are disabled, as defined in the **When you qualify for benefits** section. If you are disabled, as defined in that section, you will begin your short-term disability maternity benefit on the date you are determined to be disabled. In no event will the maternity benefit exceed nine weeks.

If you do not begin your short-term disability leave on your delivery date, you must meet the plan's definition of disabled, as defined in the **When you qualify for benefits** section. In that case, any disability benefit will be subject to rules applicable to non-maternity disability benefits.

If you experience medical complications during pregnancy or post-partum and continue to meet the definition of disability after the first nine weeks of maternity benefits, the short-term disability plan will provide disability benefits of 75% of your average day's pay from week 10 up to 25 weeks of benefit payments.

NOTE: For associates in states or localities with legally mandated benefits, please refer to the **Legally mandated plans** chart earlier in this chapter for coordination of benefits.

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

Benefits payable to you under the truck driver short-term disability plan are company-provided at no cost to you. Because you do not make any contributions to the truck driver short-term disability plan, and you do not pay any tax on the coverage that Walmart provides, any benefits payable to you are subject to taxes. Walmart generally withholds federal, state, local, and Social Security taxes from the amount of your benefit payments.

Walmart cannot guarantee the specific tax consequences that will result from your receipt of benefits under the truck driver short-term disability plan. Walmart is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

RIGHT TO RECOVER OVERPAYMENT

The truck driver short-term disability plan has the right to recover from you, and you must repay, any amount overpaid to you for short-term disability benefits under this plan. See **The Plan's right to recover overpayment** and **The Plan's right to salary/wage deduction** in the **Claims and appeals** chapter. If you do not repay overpaid amounts in a timely manner, the company will first deduct such amounts from future disability payments (if any). If there is a remaining amount due after any deductions from future disability payments, then the company may, in its discretion, either (i) treat overpaid amounts as taxable wages to you (reportable on your Form W-2), or (ii) deduct overpaid amounts from your paycheck, to the extent permitted by law.

When short-term disability benefit payments end

If you are receiving short-term disability benefit payments from the truck driver short-term disability plan due to an approved disability, your benefit payments from the plan will end on the earliest of:

- The date you no longer meet the short-term disability plan's definition of disabled
- The date you fail to furnish the required proof of disability when requested to do so by Sedgwick
- The date you are no longer under the continuous care and treatment of a qualified doctor
- The date you refuse to be examined if Sedgwick requires you to be examined
- The last day of the maximum period for which benefits are payable
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart
- The date your employment terminates, or
- The date of your death.

When your short-term disability benefits end and for any reason you do not return to work, you must request an extension of your leave (refer to the **Resources** chart at the beginning of the chapter for contact information). Failure to do so may result in your employment being terminated.

Returning to work

Sedgwick will contact you before your expected return-to-work date and advise you of steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return- to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

To ensure a smooth transition back to work and avoid a potential impact to your pay, you will need to contact Sedgwick up to four days prior to your actual return-to-work date. If your return-to-work date changes, you should notify Sedgwick immediately. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options, which include requesting an extension of your leave or voluntarily terminating your employment. Failure to request an extension may result in your employment being terminated.

If you return to work within 30 days of the end of your approved disability period, you will be reinstated to the disability coverage you had prior to your disability. If you do not return to work within 30 days of the end of your approved disability period, your coverage will lapse on the 31st day. However, your coverage will be reinstated if you return to active status within one year.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less and you are classified as a full-time driver on active status (with or without medical restrictions) and become disabled again from the same or a related condition that caused the first period of disability, as determined by Sedgwick, known as a "relapse/recurrent claim," your short-term disability benefits will pick up where they left off before you came back to work. There will be no additional waiting period of seven calendar days. The combined benefit duration for both periods of disability will not exceed 25 weeks.

If you have returned as a full-time driver and are on active status for more than 30 calendar days and then become disabled from the same or a related cause, it will be considered a new disability, and you may be able to receive up to 25 weeks of benefits, following your completion of a new seven calendar day waiting period.

If you return as a full-time driver and are on active status for any number of calendar days and then become disabled from a new and unrelated cause, it will be considered a new disability, and you may qualify for up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

Intermittent leave. If you are able to return to work after a period of short-term disability and need to miss work periodically for reasons related to your disability, notify Sedgwick and your facility of your situation. Your treatment may be covered under your prior short-term disability claim for up to 12 months from the date you return to work from your short-term disability claim. Truck driver short-term disability generally pays 100% of your average day's pay for the duration of your approved intermittent leave. You will not need to use PTO for the absences.

If you go on a leave of absence or experience a temporary layoff

If you are not on active status due to a leave of absence or temporary layoff, your eligibility for short-term disability benefits will continue for 90 days from your last day of work. Your eligibility for short-term disability benefits ends on the 91st day after the beginning of your leave of absence or temporary layoff, but is reinstated if you return to work within one year. See **Keeping your premiums current in the Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits while on leave.

When coverage ends

Your short-term disability coverage ends on the earliest of:

- The date your employment terminates
- The last day of the pay period when your job status changes from an eligible job status
- The date of your death
- The 91st day of a leave of absence or layoff (unless you return to work)
- The 31st day following the end of your approved disability period (unless you return to work), or
- The date the benefit is no longer offered by the company.

If you leave the company and are rehired

If you leave the company and return to work for the company as a full-time truck driver, you will automatically be reenrolled in the truck driver short-term disability plan.

Full-time hourly and salaried long-term disability

The information in this chapter describes long-term disability benefits that may be available to you if:

- You are an eligible full-time hourly or salaried (management) associate (truck drivers: see next chapter)
- You have met all requirements for coverage to be effective, including actively-at-work requirements, and
- You have enrolled in a timely manner.

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

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the 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.

Full-time hourly and salaried 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.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get more details or file a claim	Go to **One.Walmart.com/LOA > mySedgwick**	Call Lincoln at **877-353-6404**

What you need to know about full-time hourly and salaried long-term disability

- This chapter describes long-term disability benefits available to you under one of two plan options:
  - The **long-term disability (LTD) plan** replaces 50% of your average monthly wage.
  - The **LTD enhanced plan** replaces 60% of your average monthly wage.
- If you enroll in either plan after your initial eligibility 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 before you can be approved for coverage.

The LTD plans

If you become disabled, as defined in the **When you qualify for LTD benefits** section, the LTD plan provides a benefit of 50% of your average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive, after your benefit waiting period.

If you become disabled, as defined in the **When you qualify for LTD benefits** section, the LTD enhanced plan provides a benefit of 60% of your average monthly wage up to a maximum monthly benefit of $18,000, minus the amount of certain other benefits or income you are eligible to receive, after your benefit waiting period.

Both plans are insured by Lincoln. For information about your 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 reduce LTD benefits** later in this chapter.

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.

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. If you have no earnings in a pay period, no premiums are due for that pay period. If while receiving LTD benefits you receive any other earnings, including bonuses, through the Walmart payroll systems, 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. However, if you are employed as a pilot, copilot, or crewmember of an aircraft, "disability" or "disabled" means that, as a result of an injury or sickness, you are unable to perform the material and substantial duties of your own occupation under the applicable Federal Aviation Administration fitness standards.

In determining whether you are disabled, for persons other than pilots or copilots, Lincoln does not consider employment factors, including interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing, or loss of professional or occupational license or certification.

To qualify for 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.
- You must be actively at work at the time of your disability. You will be considered actively at work if you are performing services at the company's usual place of business or a location designated by the company or if you were actually at work on the day immediately preceding:
  - A weekend or holiday (except where one or both of these days are scheduled work days)
  - Paid time off (PTO)
  - Any non-scheduled work day, or
  - An approved leave of absence.

If your LTD coverage was subject to Proof of Good Health and approved by Lincoln, Lincoln has the right to reexamine your Proof of Good Health questionnaire within the first two years from the date LTD coverage became effective. If material facts about you are found to have been stated inaccurately, the true circumstances will be used to determine if your coverage should be in effect and for what amount, and your premium may be adjusted.

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

If you are on an approved short-term disability claim and are enrolled in LTD benefits, your claim will be automatically transitioned from Sedgwick to Lincoln. You may also call Lincoln at **877-353-6404** as soon as you know you will need to use your LTD benefit. Lincoln will provide you with additional information on how to complete your claim.

Associates receiving workers' compensation benefits 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 **877-353-6404** 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 benefit waiting period: 26 weeks or the end of your short-term disability benefits, whichever is longer.

IF YOU RETURN TO WORK DURING YOUR WAITING PERIOD AND BECOME DISABLED AGAIN

If you cease to be disabled and return to work full-time for a total of the specified number of calendar days (as defined below) or less during a 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 hourly pharmacists (other than hourly pharmacists working in California), and (ii) 180 days for salaried associates, salaried pharmacists, hourly pharmacists working in California, management, and pilots.

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	Your earnings since date of hire ÷ number of months worked For example, the average monthly wage for an associate with earnings of $21,000 for seven months of work is $3,000 ($21,000 ÷ 7).

Earnings used to determine average monthly wage include:

- Regular earnings for the 26 pay periods prior to your last day worked
- Overtime
- Regularly scheduled target incentive bonuses that you and associates in similarly situated job types or job levels are eligible to earn
- Paid time off and similar pay that replaces regular earnings (e.g., bereavement , jury duty, and sick time)

Any pay periods in which you have no earnings are excluded, decreasing the number of pay periods used for the calculation.

Earnings used to determine average monthly wage exclude commissions or any other extra compensation or fringe benefits not listed above.

If you have been employed less than 12 months, an annualized average of 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 reduce 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.

PTO AND YOUR LTD BENEFIT

Paid time off (PTO) may not be used while receiving LTD benefits. If you are receiving LTD benefits at the end of the PTO plan year, refer to your location's PTO policy for payout and/or carryover information. You do not accrue additional PTO while receiving LTD benefits.

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 REDUCE 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 benefits under any other governmental benefit act or law
- Settlement or judgment, less associated costs of a lawsuit that represents or compensates for your loss of earnings or bodily function.

If any of the other benefits that reduce your 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 **877-353-6404**.

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.

If you are required to pursue Social Security disability benefits and you do not apply, or you do not provide proof of application or appeal, your LTD benefits will be reduced by the amount you are estimated to receive from Social Security disability.

If you qualify for Social Security disability or retirement benefits while you are receiving benefits under 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 average monthly wage.

If you accept a new position and perform all of the material and substantial duties on a full-time basis, you are not partially disabled.

Lincoln offers a work incentive benefit for the first 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 average monthly wage. Your monthly benefit will be reduced by the excess amount so that the monthly benefit plus your earnings do not exceed 100% of your average monthly wage.

After the first 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 average monthly wage*
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

*"Indexed average monthly wage" means your average monthly wage increased annually by 7% or the percentage change in the Consumer Price Index, whichever is less.

IF YOU PASS AWAY WHILE RECEIVING 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 average monthly wage
- The date you no longer meet the plan's definition of disabled
- The last day of the maximum period for which benefits are payable (see charts below), 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/successive claim," the successive 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.

If you go on a leave of absence or experience a 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 a 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 leave of absence or temporary layoff begins, but is reinstated if you return to active work status within one year. See **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits coverage while on leave.

When coverage ends

Your LTD coverage ends:

- On the date you voluntarily drop coverage (as described below)
- At termination of your employment, unless you have been absent due to disability during the 26-week benefit waiting period and any period during which premium payments are waived
- On the last day of the pay period 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 a leave of absence
- When the benefit is no longer offered by the company, or
- On the date of your death.

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

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave the company and are rehired

If you are a full-time hourly or management associate (excluding full-time truck drivers), see the **If you leave the company and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

Truck driver long-term disability

The information in this chapter describes long-term disability benefits that may be available to you if:

- You are a full-time truck driver
- You have met all requirements for coverage to be effective, including actively-at-work requirements, and
- You have enrolled in a timely manner.

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

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by The Lincoln National Life Insurance Company (Lincoln) regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Truck driver long-term disability

If a disability keeps you off the road and unable to work, this plan works with other benefits you get to replace part of your paycheck. There are two long-term disability (LTD) plans for truck drivers that pay different levels of benefits.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get more details or file a claim	Go to **One.Walmart.com/LOA > mySedgwick**	Call Lincoln at **877-353-6404**

What you need to know about truck driver long-term disability

- Walmart offers truck drivers an LTD plan and also an LTD enhanced plan. Each plan offers a choice of full-duration coverage or five-year coverage.
- The truck driver LTD plans work with certain other benefits you receive while disabled to replace 50% of your average monthly wage if you select the truck driver LTD plan or 60% of your average monthly wage if you select the truck driver LTD enhanced plan.
- If you enroll in either plan after your initial enrollment period, you will have to submit Proof of Good Health, and you may be required to undergo a medical exam at your own expense before you can be approved for coverage.

The truck driver LTD plans

You are eligible to enroll in truck driver LTD coverage if you are a full-time truck driver. You can choose between two coverage plans, each of which is available in two options:

- **LTD plan**
  - Five-year coverage
  - Full-duration coverage
- **LTD enhanced plan**
  - Five-year coverage
  - Full-duration coverage

The options under the truck driver LTD plan and LTD enhanced plan pay benefits as described in the following chart.

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

TRUCK DRIVER LTD		
	LTD PLAN	**LTD ENHANCED PLAN**
Five-year coverage	Pays 50% of average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive*	Pays 60% of average monthly wage up to a maximum monthly benefit of $18,000, minus the amount of certain other benefits or income you are eligible to receive*
	Both plans pay benefits for 60 months, unless the amount of time shown in the **Maximum duration of truck driver LTD benefits** chart (later in this chapter) will result in a benefits duration of less than 60 months, in which case the monthly benefit will be payable for the lesser period.	
	LTD PLAN	**LTD ENHANCED PLAN**
Full-duration coverage	Pays 50% of average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive*	Pays 60% of average monthly wage up to a maximum monthly benefit of $18,000, minus the amount of certain other benefits or income you are eligible to receive*
	Both plan options pay benefits for the amount of time shown in the **Maximum duration of truck driver LTD benefits** chart (later in this chapter).	
*See **Calculating your benefit** and **Other benefits or income that reduces truck driver LTD benefits** (later in this chapter) for more information.		

If you enroll during your initial enrollment period, your coverage will be effective on your date of hire.

If you enroll at any time after your initial enrollment period, you will be considered a late enrollee and required to submit Proof of Good Health. You may be required to undergo a medical exam at your own expense before you can be approved for coverage.

If you enroll in the five-year coverage option and subsequently decide to enroll in the full-duration coverage option, or if you enroll in the truck driver LTD plan and subsequently decide to enroll in the truck driver LTD enhanced plan, you will be considered a late enrollee and required to provide Proof of Good Health before you can be approved for coverage.

See the **Eligibility, enrollment, and effective dates** chapter for more details about when coverage is effective.

THE COST OF TRUCK DRIVER LTD COVERAGE

Your cost for truck driver long-term disability coverage is based on your biweekly earnings and the type of truck driver LTD coverage you select. Premiums are deducted from all wages, including bonuses. 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. If you have no earnings in a pay period, no premiums are due for that pay period. If while receiving LTD benefits you receive any other earnings, including bonuses, through the Walmart payroll systems, your premiums for all benefits will be withheld from those payments. To review how to maintain coverage for other benefits, see **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

When you qualify for truck driver LTD benefits

Under the terms of the truck driver LTD plans, “disability” or “disabled” means that, due to an injury or sickness, during the benefit waiting period and for the next 24 months of disability, you are unable to perform the material and substantial duties of your own occupation, or you lose medical certification in accordance with the Federal Motor Carrier Safety Regulations. After 24 months of benefit payments, “disability” or “disabled” means that you are unable to perform, with reasonable continuity, the material and substantial duties of any occupation for which you are reasonably fitted by training, education, experience, age, and physical or mental capacity.

In determining whether you are disabled, Lincoln does not consider employment factors, including interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing, or loss of professional or occupational license or certification for reasons other than a covered injury or sickness.

To qualify for truck driver 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.
- You must be actively at work at the time of your disability. You will be considered actively at work if you are performing services at the company's usual place of business or a location designated by the company or if you were actually at work on the day immediately preceding:
  - A weekend or holiday (except where one or both of these days are scheduled work days)
  - Paid time off (PTO)
  - Any non-scheduled work day, or
  - An approved leave of absence

If your LTD coverage was subject to Proof of Good Health and approved by Lincoln, Lincoln has the right to reexamine your Proof of Good Health questionnaire within the first two years from the date LTD coverage became effective. If material facts about you are found to have been stated inaccurately, the true circumstances will be used to determine if your coverage should be in effect and for what amount, and your premium may be adjusted.

PRE-EXISTING CONDITION EXCLUSION

You will not receive truck driver 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 five-year duration coverage to the full-duration coverage under either of the truck driver LTD plans, or if you change from the truck driver LTD plan to the truck driver LTD enhanced plan, the pre-existing condition exclusion will apply to the additional duration or level of benefits, as applicable. In this scenario, if you had satisfied the pre-existing condition requirement of the five-year duration coverage option or the truck driver LTD plan and then suffer a disability before you satisfy the pre-existing condition exclusion of the full-duration coverage option or truck driver LTD enhanced plan, you will only receive benefits under the five-year duration coverage plan or truck driver LTD plan, as applicable.

Filing a truck driver LTD claim

If you are on an approved short-term disability claim and are enrolled in LTD benefits, your claim will be automatically transitioned from Sedgwick to Lincoln. You may also call Lincoln at **877-353-6404** as soon as you know you will need to use your truck driver LTD benefit. Lincoln will provide you with additional information on how to complete your claim.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

When benefits are not paid

Benefits are not paid for any truck driver 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 truck driver LTD benefits begin

If you are approved by Lincoln for truck driver LTD benefits, they will begin after your benefit waiting period: 26 weeks or the end of your short-term disability benefits, whichever is longer.

IF YOU RETURN TO WORK DURING YOUR WAITING PERIOD AND BECOME DISABLED AGAIN

If you cease to be disabled and return to work for a total of 60 calendar days or less during a waiting period, the waiting period will be suspended and you must meet the balance of the waiting period if you become disabled again. If you return to work for a total of more than 60 calendar days while satisfying your benefit waiting period, you must satisfy an entirely new benefit waiting period if you again become disabled before you are eligible to receive LTD benefits.

Calculating your benefit

The amount of your truck driver LTD is based on:

- Your average monthly wage, and
- Which truck driver LTD plan you're enrolled in.

AVERAGE MONTHLY WAGE	
Length of employment	**How average monthly wage is determined**
Employed 12 months or more	Your activity pay, mileage rate, and bonuses paid in the 26 pay periods prior to your last day worked ÷ 12
Employed less than 12 months	Your activity pay, mileage rate, and bonuses since date of hire ÷ the number of months worked

Note that any pay periods in which you have no earnings are excluded, decreasing the number of pay periods used for the calculation.

Your truck driver long-term disability benefit is shown below:

YOUR TRUCK DRIVER LONG-TERM DISABILITY BENEFIT	
If you are enrolled	**Your coverage is**
In the truck driver five-year coverage LTD plan or the truck driver full-duration coverage 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 truck driver five-year coverage LTD enhanced plan or the truck driver full-duration coverage 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 truck driver long-term disability benefits** for more information.	

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

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

Lincoln has the right to recover from you any amount that is overpaid to you for truck driver LTD benefits under the truck driver LTD plan or the truck driver LTD enhanced plan.

PTO AND YOUR LTD BENEFIT

Paid time off (PTO) may not be used while receiving LTD benefits. If you are receiving LTD benefits at the end of the PTO plan year, refer to your location's PTO policy for payout and/or carryover information. You do not accrue additional PTO while receiving LTD benefits.

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 truck driver LTD plans are not subject to income taxes.

OTHER BENEFITS OR INCOME THAT REDUCES TRUCK DRIVER LTD BENEFITS

Your truck driver 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 truck driver 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 that are granted after the date of disability (including benefits your family receives or is eligible to receive due to your eligibility for retirement benefits)
- Workers' compensation
- Company-related group insurance plans providing disability benefits
- Company-paid or partially paid individual policies providing disability benefits to the extent such benefits, plus your truck driver 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 benefits under any other governmental benefit act or law
- Settlement or judgment, less associated costs of a lawsuit, that represents or compensates for your loss of earnings or bodily function.

If any of the other benefits that reduce your 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 truck driver LTD policy by calling Lincoln at **877-353-6404**.

EXAMPLE: REDUCTION OF TRUCK DRIVER LTD BENEFIT		
	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 benefits	- $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 truck driver LTD policy terms may require you to apply for Social Security disability benefits. If the Social Security Administration denies you benefits, you will be required to follow the Social Security Administration's appeal process.

If you are required to pursue Social Security disability benefits and you do not apply, or you do not provide proof of application or appeal, your LTD benefits will be reduced by the amount you are estimated to receive from Social Security disability.

If you qualify for Social Security disability or retirement benefits while you are receiving benefits under any of the truck driver LTD plan options 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 truck driver LTD plans, "partial disability" and "partially disabled" mean that, as a result of sickness or injury, you are able to:

- Perform one or more, but not all, of the material and substantial duties of your own or any occupation on a full-time or part-time basis, or
- Perform all of the material and substantial duties of your own occupation or any occupation on a part-time basis, and
- Earn between 20% and 80% of your indexed average monthly wage.

If you accept a new position and perform all of the material and substantial duties on a full-time basis, you are not partially disabled.

Lincoln offers a work incentive benefit for the first 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 average monthly wage.

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 average monthly wage*
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

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

IF YOU PASS AWAY WHILE RECEIVING TRUCK DRIVER LTD BENEFITS

Coverage under the truck driver LTD plans ends upon your death. However, if you pass away while receiving truck driver 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 truck driver LTD benefit payments end

Truck driver 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 average monthly wage
- The date you no longer meet the plan's definition of disabled
- The last day of the maximum period for which benefits are payable (see charts on the right), or
- The date of your death.

FIVE-YEAR COVERAGE

Five-year coverage pays benefits for 60 months unless the amount of time shown in the **Maximum duration of truck driver LTD benefits** chart on right will result in a benefits duration of less than 60 months, in which case the monthly benefit will be payable for the lesser period.

FULL-DURATION COVERAGE

Full-duration coverage pays benefits for the amount of time shown in the **Maximum duration of truck driver LTD benefits** chart on the right.

MAXIMUM DURATION OF TRUCK DRIVER 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 truck driver LTD benefits for more than 24 months for the following disabilities, you must be confined in a hospital or other place licensed to provide medical care:

- Mental illness (excluding demonstrable, structural brain damage)
- Any condition that results from mental illness
- Alcoholism, 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/successive claim," the successive disability will be part of the same disability. Your LTD benefits will pick up where they left off before you came back to work. No additional waiting period will be required. The combined benefit duration for both periods of disability will not exceed the maximum duration listed in the chart on the previous page.

If you return to work as an active full-time associate for six months or more, any recurrence of a disability will be treated as a new disability. A new benefit waiting period must be completed.

If you go on a leave of absence or experience a temporary layoff

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

When coverage ends

Your truck driver LTD coverage ends:

- On the date you voluntarily drop coverage (as described in the next column)
- 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 a leave of absence
- When the benefit is no longer offered by the company, or
- On the date of your death.

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

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave the company and are rehired

If you are a full-time truck driver, see the **If you leave the company and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

Company-paid life insurance

The information in this chapter describes company-paid life insurance benefits that may be available to you if:

- You are a full-time hourly or salaried (management) associate, and
- You have met all requirements for coverage to be effective, including actively-at-work requirements.

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

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the 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 • Request an accelerated benefit • Get details about continuing your insurance		Call Prudential at **877-740-2116**
File a claim		Call Prudential at **877-740-2116**

What you need to know about company-paid life insurance

- If you are an eligible associate, Walmart provides life insurance coverage at no cost to you. No enrollment is necessary, and Proof of Good Health is not required.
- Your coverage amount is equal to your annualized rate of pay, including overtime and bonuses, during the one-year period prior to your 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.
- The Certificate of Insurance is available online at **One.Walmart.com** or at **Prudential.com/Walmart**. The certificate provides detailed information about company-paid life insurance, in addition to the highlights available in this chapter.

Company-paid life insurance

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

If your death occurs outside a 100-mile radius of your home, there is a benefit for expenses incurred to return your body to either a preferred location within the United States or to your residence at the time of death. The benefit includes expenses for embalming, cremation, coffin, and transportation of your remains. The benefit is the lesser of the cost to return your remains or $10,000.

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. No paper forms 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. No paper forms are accepted.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to surviving family members in the following order:

- Spouse or partner of the deceased; if not surviving, then
- Children in equal shares; if not surviving, then
- Parents in equal shares; if not surviving, then
- Siblings in equal shares; if not surviving, then
- Your estate.

Be sure to keep your beneficiary information up to date. Proceeds will go to whoever is listed 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**. No paper forms are accepted.

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 to you 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 the **Continuing your company-paid life insurance after you leave Walmart or lose coverage** section in this chapter for details on conversion.

Under the policy, you are considered terminally ill if death is expected within 12 months and a doctor can certify the illness or injury as terminal.

There may be circumstances in which the accelerated benefit is not paid. Contact Prudential at **877-740-2116** for details.

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

Filing a 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 **877-740-2116**.

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.

No benefits are paid if you die before your coverage effective date.

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.

EstateGuidance®

EstateGuidance offers you the convenience of online will preparation from your personal computer at no cost to you. Wills ensure that your assets will be distributed in accordance with your wishes and allow you to name a guardian of your minor children. To complete the online will questionnaire, log on to **willguidance.com**, password: **Walmart**.

NOTE: Your will does not override the beneficiary designation on a life insurance policy or retirement account (such as a 401(k) plan). For this reason, be sure to review your beneficiary designations, particularly after you have created a will, to make sure your designations are consistent and fully in line with your wishes. If the beneficiary(ies) you have listed with Walmart differs from the beneficiary(ies) named in your will, the list that Walmart has prevails.

Continuing your company-paid life insurance after you leave Walmart or lose coverage

In most circumstances, you have two options to continue your company-paid life insurance if your group life coverage ends. The first option, called **portability**, allows you to continue all or a portion of your coverage through a group term policy with Prudential. The second option, called **conversion**, allows you to convert all or a portion of your coverage to a Prudential individual policy.

You must apply for portability or conversion within 31 days of the date your company-paid coverage ends. If you die within 31 days of a qualifying loss of coverage and before electing portability or conversion of your life insurance coverage, Prudential will pay a death benefit to your beneficiary. The benefit will be paid based on the amount of coverage in effect prior to the qualifying loss of coverage, even if you did not apply for portability or conversion of your coverage.

Portability enables you to maintain similar term life insurance with Prudential after your employment ends if certain conditions are met. Proof of Good Health is required to "port" your coverage. If you do not pass or do not submit Proof of Good Health, you will be eligible to convert your company-paid life insurance to an individual policy, as described below.

You can apply for term life coverage under the portability feature if you meet all of these conditions:

- Your company-paid life coverage ends for any reason other than:
  - you leave 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.

If you are a resident of Minnesota, you have a continuation right instead of a conversion right when you lose coverage due to a reduction in your hours or termination of employment (other than for gross misconduct). You may elect to continue coverage at your expense until you obtain coverage under another group life insurance policy; however, the maximum period that coverage may be continued is 18 months. If you continue coverage, at the expiration of the continuation period you may convert your life insurance coverage to an individual policy, as described above.

To request information on portability or conversion, call Prudential at **877-740-2116**.

If you leave the company and are rehired

If you are a full-time hourly or management associate (including full-time truck drivers but not part-time truck drivers), see the **If you leave the company and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

Company-paid life insurance

Optional associate life insurance

The information in this chapter describes optional associate life insurance benefits that may be available to you if:

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

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

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the 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 • Request an accelerated benefit • Get details about continuing your insurance		Call Prudential at **877-740-2116**
File a claim		Call Prudential at **877-740-2116**

What you need to know about optional associate life insurance

- Depending on the amount of coverage you choose and when you enroll, you may be required to provide Proof of Good Health.
- An early payout due to terminal illness is available.
- Coverage is provided through The Prudential Insurance Company of America (Prudential).
- This policy is term life insurance. It has no cash value.
- The Certificate of Insurance available online at **One.Walmart.com** or at **Prudential.com/Walmart**. The certificate provides detailed information about company-paid life insurance, in addition to the highlights available in this chapter.

Optional associate life insurance

Optional associate life insurance protects your family if you die while coverage is in effect. If you become terminally ill, a benefit may be payable to you while you are still living.

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

HOURLY ASSOCIATES AND PART-TIME TRUCK DRIVERS		MANAGEMENT ASSOCIATES	
$25,000	$100,000	$25,000	$200,000
$50,000	$150,000	$50,000	$300,000
$75,000	$200,000	$75,000	$500,000
		$100,000	$750,000
		$150,000	$1,000,000

For details about eligible job classifications, see the **Enrollment and effective dates by job classification** section in the **Eligibility, enrollment, and effective dates** chapter.

If you die, your beneficiary(ies) may receive a lump sum payment for the coverage amount you select.

The cost of optional associate life insurance is based on the coverage amount you select, your age, and whether you are eligible for tobacco-free rates. Premiums from optional associate life coverage do not subsidize coverage under company-paid life insurance.

PROOF OF GOOD HEALTH

Proof of Good Health is 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.

If Proof of Good Health is required, coverage will not be effective until Prudential approves. See the **Eligibility, enrollment, and effective dates** chapter for details.

Naming a beneficiary

To ensure that your life insurance benefit is paid according to your wishes, you must name a beneficiary(ies) to receive your optional associate life insurance benefit if you die. You may do this by going to **One.Walmart.com**. No paper forms 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**. No paper forms are accepted.

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:

- Spouse or partner of the deceased; if not surviving, then
- Children in equal shares; if not surviving, then
- Parents in equal shares; if not surviving, then
- Siblings in equal shares; if not surviving, then
- Your estate.

Early payout due to terminal illness

If you are terminally ill, you may elect to receive an "accelerated benefit" while you are still living of up to 50% of the coverage amount your beneficiary(ies) would have received upon your death, up to a $250,000 maximum. Payment is made to you in a lump sum. Upon your death, your beneficiary(ies) receives the total amount of coverage in effect at your death minus the amount of early payouts you received before your death.

If you terminate from 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 or lose coverage** section later in this chapter for details on conversion.

Under the policy, you are considered terminally ill if death is expected within 12 months and a doctor can certify the illness or injury as terminal.

There may be circumstances in which the accelerated benefit is not paid. Contact Prudential at **877-740-2116** for details.

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

Filing 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

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. Your beneficiary has the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For more details, contact Prudential at **877-740-2116**.

When benefits are not paid

No benefits are paid to your beneficiary(ies) if you die as a result of suicide while sane or insane during the first two years of coverage. If you increase your coverage and you die as a result of suicide within two years of the date you increase your coverage, your beneficiary(ies) will receive the prior coverage amount.

If your beneficiary(ies) files a claim within the first two years of your approval date, Prudential has the right to reexamine your Proof of Good Health questionnaire. If material facts about you are found to have been stated inaccurately, the true circumstances will be used to determine what amount of coverage should have been in effect, if any, and:

- The claim may be denied, and
- Premiums paid may be refunded.

If you die before your coverage effective date, no benefits will be paid.

Break in coverage

There may be occasions in which you must make special arrangements to pay 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 **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

When coverage ends

Your optional associate life insurance coverage ends:

- On the date you voluntarily drop coverage (as described below)
- At termination of your employment
- On the last day of coverage for which 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), or
- When the benefit is no longer offered by the company.

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

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

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

Continuing your optional associate life insurance after you leave Walmart or lose coverage

In most circumstances, you have two options to continue your optional associate life insurance if your group life coverage ends. The first option, called **portability**, allows you to continue all or a portion of your current coverage through a group term policy with Prudential. The second option, called **conversion**, allows you to convert all or a portion of your coverage to a Prudential individual policy.

You must apply for portability or conversion within 31 days of the date your coverage ends. If you die within 31 days of a qualifying loss of coverage and before electing portability or conversion of your life insurance coverage, Prudential will pay a death benefit to your beneficiary. The benefit will be paid based on the amount of coverage in effect prior to the qualifying loss of coverage, even if you did not apply for portability or conversion of your coverage.

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 be no more than the lesser of the amount of coverage you elected under the plan or not more than five times your annual earnings; provided, however, the amount will not be less than $20,000.

Conversion is a required Plan provision that allows you to convert your life insurance coverage to an individual policy if coverage would end due to your termination of employment or transfer from an eligible class. Proof of Good Health is not required. Rates are based on your age and amount converted. You must apply for the individual contract and pay the first premium by the later of:

- the 31st day after you cease to be insured, or
- the 15th day after you have been given written notice of the conversion privilege.

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

If you are a resident of Minnesota, you have a continuation right instead of a conversion right when you lose coverage due to a reduction in your hours or termination of employment (other than for gross misconduct). You may elect to continue coverage at your expense until you obtain coverage under another group life plan; however, the maximum period that coverage may be continued is 18 months. If you continue coverage, at the expiration of the

continuation period you may convert your life insurance coverage to an individual policy, up to the amount of coverage in effect at that time. You have 31 days from the date continuation coverage would end to request to convert your coverage to an individual policy.

To request information on portability or conversion, call Prudential at **877-740-2116**.

If you leave the company and are rehired

If you are a part-time or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave the company and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

Optional dependent life insurance

The information in this chapter describes optional dependent life insurance benefits that may be available to you if:

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

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

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the 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 **877-740-2116**
File a claim		Call Prudential at **877-740-2116**

What you need to know about optional dependent life insurance

- Full-time hourly and management associates can enroll their spouse/partners and/or their children; part-time hourly associates and part-time truck drivers can enroll their children but not their spouse/partners.
- 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.
- Your dependent is not eligible for coverage while on active duty in the armed forces of any country.
- Coverage is provided through the Prudential Insurance Company of America (Prudential).
- This policy is term life insurance. It has no cash value.
- The Certificate of Insurance is available online at **One.Walmart.com** or at **Prudential.com/Walmart**. The certificate provides detailed information about company-paid life insurance, in addition to the highlights available in this chapter.

Optional dependent life insurance

Optional dependent life insurance pays you a financial benefit if you are an enrolled associate and your dependent dies while coverage is in effect.

When you enroll in optional dependent life insurance, if your covered spouse/partner and/or 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	

*Not available for part-time hourly associates, temporary associates, or part-time truck drivers

Depending on the coverage amount you choose and when you enroll, your spouse/partner may be required to provide Proof of Good Health.

You (the associate) are automatically assigned as the primary beneficiary of your dependent's life insurance coverage. If you and your covered dependent or dependents die at the same time, benefits are paid to your dependent's estate or, at Prudential's option, to a surviving relative of the dependent.

The cost of optional dependent life insurance for your spouse/partner is based on the coverage amount you select, your (the associate's) age, and whether your spouse/partner is eligible for the tobacco-free rates. The cost of coverage for your children is based on the coverage amount you select. Premiums from optional dependent life coverage do not subsidize coverage under company-paid life insurance.

Your dependent is not eligible for coverage while on active duty in the armed forces of any country.

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

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

PROOF OF GOOD HEALTH

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

- 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.

Proof of Good Health is not required for children.

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.

If Proof of Good Health is required, coverage will not be effective until Prudential approves. See the **Eligibility, enrollment, and effective dates** chapter for details.

Additional benefits

Benefits also are payable under the following circumstances:

- If a dependent child is born alive and dies within 60 days of birth and was eligible but not enrolled in optional dependent life insurance prior to the loss—with a live birth certificate and a death certificate—Prudential will pay a $5,000 benefit only.
- If a dependent child is stillborn, Prudential will pay a $5,000 benefit to associates who have met the eligibility waiting period for dependent life insurance. See the **Eligibility, enrollment, and effective dates** chapter for details. A stillborn child is defined as an eligible associate's natural-born child whose death occurs before expulsion, extraction, or delivery and whose fetal weight is 350 grams or more; or, if fetal weight is unknown, whose duration in utero was 20 or more complete weeks of gestation. If both the mother and father of the stillborn child work at Walmart, each associate is eligible to submit a claim for this benefit separately, for a total of $10,000.

Filing 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 **877-740-2116**.

When benefits are not paid

No benefits are paid to you if your spouse/partner dies as a result of suicide while sane or insane during the first two years of coverage. If you increase your spouse/partner's coverage and your spouse/partner dies as a result of suicide within two years of the increase in coverage, you will receive the prior coverage amount.

If you file a claim for your spouse/partner within the first two years of your approval date, Prudential has the right to reexamine your spouse/partner's Proof of Good Health questionnaire. If material facts about your spouse/partner are found to have been stated inaccurately, the true circumstances will be used to determine what amount of coverage should have been in effect, if any, and:

- The claim may be denied, and
- Premiums paid may be refunded.

Except as otherwise provided, if your dependent dies before the coverage effective date, no benefits will be paid.

Break in coverage

There may be occasions in which you must make special arrangements to pay 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 **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

When coverage ends

Your optional dependent life insurance coverage ends:

- On the date you voluntarily drop coverage (as described below)
- At termination of your employment
- On the last day of coverage for which 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, enrollment, and effective dates** chapter). However, if your spouse/partner becomes ineligible because your job status changes to part-time hourly associate, temporary associate, or part-time truck driver, coverage for your spouse/partner will end on the last day of the pay period when your job status changes
- 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.

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

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

Continuing spouse/partner coverage after you leave Walmart or lose coverage

If you are a full-time or management associate and carry optional dependent life insurance for your spouse 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. These options are not available to part-time hourly associates, temporary associates, or part-time truck drivers.

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.

If you are a resident of Minnesota, you have a continuation right instead of a conversion right when you lose coverage due to a reduction in your hours or termination of employment (other than for gross misconduct). You may elect to continue coverage at your expense until you obtain coverage under another group life insurance policy; however, the maximum period that coverage may be continued is 18 months. If you continue coverage, at the expiration of the continuation period, you may convert your life insurance coverage to an individual policy, up to the amount of coverage in effect at that time. You have 31 days from the date continuation coverage would end to request to convert your coverage to an individual policy. In addition,

if you lose coverage for any reason other than a reduction in your hours or termination of employment (other than for gross misconduct), you may convert up to the amount of coverage that was in force under the plan.

To request information on portability or conversion, call Prudential at **877-740-2116**.

If you leave the company and are rehired

If you are a part-time or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave the company and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

Business travel accident insurance

The information in this chapter describes business travel accident insurance benefits that may be available to you if:

- You are an eligible associate, and
- You have met all requirements for coverage to be effective, including actively-at-work requirements.

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

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policies issued by the applicable insurers under this chapter regarding the calculation of benefits and limitations under the policies, the terms of the policies will govern. You may obtain a copy of these policies by contacting the Plan.

Business travel accident insurance

When you're traveling on authorized company business, this insurance protects you and your loved ones financially if you have an accident resulting in certain types of injury or death.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Change your beneficiary designation	Go to **One.Walmart.com**	Beneficiary changes cannot be made over the phone
Get more details		Call Prudential at **877-740-2116**
File a business travel accident insurance claim		Call Prudential at **877-740-2116**
Get more details about international business travel medical insurance through GeoBlue	Go to **geo-blue.com**	Call GeoBlue at **888-412-6403** Outside the U.S. call **610-254-5830**

What you need to know about business travel accident insurance

- Walmart provides all associates with business travel accident insurance. There is no cost to you and no enrollment is necessary.
- Business travel accident insurance pays a benefit for loss of life, limb, sight, speech and hearing, or paralysis, due to an accident you are involved in while traveling on authorized company business.
- Your coverage amount for accidents while traveling is three times your base annual earnings to a maximum of $1 million.
- This company-paid insurance is provided through The Prudential Insurance Company of America (Prudential).
- International business travel medical insurance is available for eligible business travelers through 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. If you experience a covered injury resulting in loss or death while traveling on authorized company business, a lump-sum benefit is payable to you or your beneficiary(ies) of up to three times your base annual earnings, with a maximum of $1 million and minimum of $200,000 (unless otherwise specified).

Base annual earnings is defined as follows:

- **For hourly associates:** Annualized hourly rate as shown in the Walmart payroll system as of date of loss or death.
- **For management associates and officers:** Base salary as shown in the Walmart payroll system as of date of loss or death.
- **For truck drivers:** Annualized average day's pay as of date of loss or death, as determined by Logistics Finance.

Note that any bonus you may receive is not included in base annual earnings.

Naming a beneficiary

To ensure that your business travel accident insurance benefit is paid according to your wishes, you must name a beneficiary(ies). You may do this by going to **One.Walmart.com**. No paper forms accepted. You (the associate) or your beneficiary will receive any benefits payable for the injuries listed in **When benefits are paid** later in this chapter.

You can name anyone you wish. 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**. No paper forms are accepted.

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**. No paper forms are accepted.

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 **877-740-2116**.

When benefits are paid

Benefits are paid if you sustain an accidental injury while traveling on authorized company business or due to a felonious assault while you are working; your injuries are the direct and sole cause of a covered loss; and you properly provide proof of the accidental loss and covered loss to Prudential.

Traveling for business includes travel using a common carrier or any means of transportation owned and operated by 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 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

Any coverage that was in effect (or the most similar coverage offered under the Plan) on your termination date will be reinstated when you return to work.

International business travel medical insurance

International business travel medical insurance is available through a policy with 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.

You are not eligible to make health savings account contributions for any month in which you are traveling on Walmart business outside the U.S. and are covered under the GeoBlue policy. If you have medical coverage under the Saver Plan, you are encouraged to consult with your tax advisor if you have questions about the amount to reduce your HSA contributions based on your individual circumstances.

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**. Outside the U.S. call collect: **610-254-5830**.

Accident insurance

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

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

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

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Allstate Benefits 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. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company, the underwriting company and subsidiary of The Allstate Corporation.

Accident insurance

This insurance helps you if you're in an accident away from work. If the accident is covered, this can help you pay for things like immediate care treatment, hospitalization, physical therapy, transportation, and lodging. Benefits are paid directly to you unless you want to have them paid to the provider.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get detailed information	Go to **One.Walmart.com** or **AllstateBenefits.com/Walmart**	Call Allstate Benefits at **800-514-9525**

What you need to know about accident insurance

- You may purchase accident insurance to assist you and your family in the event you or your covered dependent has a covered accident that requires medical care.
- Accident insurance pays a set benefit in a lump sum based on the nature of the accident and the care required.
- Proof of Good Health is not required for any level of coverage.
- Coverage is provided through Allstate Benefits. The Certificate of Insurance available at **One.Walmart.com** or **AllstateBenefits.com/Walmart** provides detailed information about accident insurance, in addition to the highlights available in this chapter.

Accident insurance

Accident insurance provides benefits to you if you or any covered dependent receives covered treatment related to an off-the-job accident. The benefits under this policy are not reduced by any other benefits you may receive.

CHOOSING A COVERAGE TIER

When you enroll for accident insurance, you also select the eligible family members you wish to cover:

- Associate only
- Associate + spouse/partner (except for part-time hourly associates, temporary associates, and part-time truck drivers)
- Associate + child(ren), or
- Associate + family (except for part-time hourly associates, temporary associates, and part-time truck drivers).

If you have associate-only or associate + spouse/partner coverage and you (or your spouse/partner) give birth to a child, your newborn child will be automatically covered for 60 days after birth. You must change your tier to associate + child(ren) or associate + family if you wish to continue covering your child after 60 days. See the **Eligibility, enrollment, and effective dates** chapter for information on when and how you may change your election.

The cost for coverage is based on the eligible dependents you choose to cover.

Any injury incurred while you are an active member of the military, naval, or air forces of any country or combination of countries is not covered. Upon notice and proof of service in such forces, Allstate will return the pro-rata portion of the premium paid for any period of such service.

Accident insurance benefits

Accident insurance pays a benefit if you or a covered dependent sustains an injury caused by an off-the-job accident, which results in any of the losses listed in the chart on the following page.

Injuries must be diagnosed by a physician. An accident generally is a covered accident if it occurs while you or your covered dependent is not working at any job for pay or benefits and is the result of a sudden, unforeseen, and unexpected event that occurs without the covered individual's consent and results in injury to you or your covered dependent. Certain accidents are not covered. See **When benefits are not paid** later in this chapter for more information.

Benefits are payable subject to terms of the Certificate of Insurance available at **One.Walmart.com** or **AllstateBenefits.com/Walmart**. You can also call Allstate Benefits at **800-514-9525** for a copy and it will be provided at no cost to you. Coverage must be effective before the occurrence of an accident for the accident to be covered. No benefit is payable for any accident that occurs before your effective date of coverage. If you should die before your effective date, no accident insurance benefit will be paid to your beneficiary(ies).

Accident insurance pays benefits described in the following chart for injuries resulting from a covered accident and related services, subject to the terms of the Certificate of Insurance.

SERVICE/INJURY	BENEFIT AMOUNT	LIMITATIONS
Ambulance	$400 for ground ambulance or $4,000 for air ambulance if covered individual requires ambulance transportation to a hospital or emergency center as a result of a covered accident	Transportation must occur within 72 hours of covered accident.
Appliance to aid personal locomotion or mobility	$200 if covered individual, as a result of a covered accident and on the advice of a physician, requires use of a medical appliance	Covered medical appliances are: crutches, wheelchair, leg brace, back brace, walker, and CAM boot walker. Payable once per covered individual, per covered accident.
Blood, plasma, and/or platelets	$100 if a covered individual, as a result of a covered accident, requires blood, plasma, and/or platelets	Not payable for immunoglobulins. Payable once per covered individual, per covered accident.
Burns	$100–$10,000 depending on degree of burn and size of affected area, when a covered individual sustains a burn as a result of a covered accident.	If proof of loss does not specify size of burn, the lowest benefit amount will be paid. Treatment by a physician must occur within 72 hours of the covered accident. Injuries due to sunburn are not covered.
Coma	$10,000 if a covered individual is in a coma as a result of a covered accident	Coma must persist at least seven consecutive days and require intubation for respiratory assistance. Medically induced comas are excluded.
Concussions (brain)	$50 if a covered individual sustains a concussion as a result of a covered accident	
Dislocation	$188–$3,750, depending on joint dislocated, when a covered individual sustains a dislocation as a result of a covered accident	Payable for only the first dislocation of a joint. The benefit amount is reduced if a covered dislocation is reduced by a physician. Payable for up to two covered dislocations per covered individual, per accident.
Emergency dental services	$50 for broken teeth resulting in extractions and $150 for broken teeth repaired with crowns	Payable once per covered individual, per covered accident.
Eye injury	$250 for surgical repair; $50 for removal of foreign body	For services performed by a physician.
Family lodging for confinement at a non-local hospital	$100 per night for one hotel/motel room for an immediate family member of covered individual	Payable for up to 30 days per covered accident, and only during the days the covered individual is confined to the non-local hospital.
Follow-up treatment (not covered under physical therapy)	$50 per follow-up visit for required follow-up treatment after receiving emergency treatment for which a benefit is paid under immediate care benefit	Follow-up treatment must be administered by a physician in a physician's office or in a hospital and must begin within 30 days of the initial covered treatment. Payable for one follow-up treatment per day for a maximum of six treatments per covered individual, per covered accident. Not payable for treatments for which the physical therapy benefit is paid.
Fractures	$375–$3,750, depending on location of fracture when fracture is corrected by open or closed repair; 25% for chip fractures or other fractures not corrected by open or closed repair	Payable for no more than two fractures per covered individual, per covered accident.
Hospital confinement	Daily benefit of $300 for a continuous hospital confinement of at least 18 hours, up to 365 days per covered accident	Hospitalization must begin within 30 days of covered accident. Not payable on same day rehabilitation benefit is paid. Paid in addition to the initial hospitalization benefit.
Immediate care (physician fees, X-rays, and emergency department)	$170 for a covered person's required medical treatment as a result of a covered accident	Payable for physician fees, X-rays, and emergency room services. Treatment must be received within 30 days of covered accident. Payable only once for any and all treatment occurring within 24-hour period, per covered individual, per covered accident.

(Continued on the next page)

SERVICE/INJURY	BENEFIT AMOUNT	LIMITATIONS
Initial hospitalization	$1,500 payable the first time a covered individual is hospitalized for at least 24 hours; $2,250 if admitted directly to a hospital intensive care unit	Hospitalization must begin within 30 days of the covered accident. Payable only once per continuous hospitalization per calendar year, per covered individual.
Intensive care unit (ICU) confinement	$900 per day, up to 15 days for any one accident	Confinement must begin within 30 days of covered accident. Paid in addition to initial hospitalization benefit.
Lacerations	$25–$400, depending on the size of the laceration	Treatment must occur within 72 hours of the covered accident. If proof of loss does not specify size of laceration, the lowest benefit amount will be paid.
Major diagnostic exams	$400 for one of the following: CT scan, MRI, or EEG	Must be performed in a hospital, physician's office, or ambulatory surgical center. One payment per covered individual, per calendar year.
Physical therapy (not covered by follow-up treatment)	$50 per day for physical therapy received as a result of a covered accident	Therapy must be prescribed by a physician and begin within 30 days of covered accident or discharge from hospital and be received within six months of covered accident or discharge. Payable for one treatment per day, up to 10 treatments per covered accident, per covered individual. Not payable for treatments for which the follow-up treatment benefit is paid.
Post-traumatic stress disorder	$100 per day for PTSD counseling	Payable only once per day, per covered individual, up to six days per calendar year.
Prosthesis	$1,000 for a prosthetic device required as a result of a covered accident	Not payable for hearing aids, wigs, or dental aids (including false teeth). Payable once per covered individual, per covered accident.
Rehabilitation unit confinement (after hospitalization)	$100 per day if covered individual is confined to rehabilitation unit as a result of a covered accident	Must have been confined to a hospital immediately prior to being transferred to the rehabilitation unit. Payable for each day a room charge is incurred, up to 30 days per covered individual, per continuous period of confinement; maximum of 60 days. Not payable for days in which hospital confinement benefit is paid.
Skin grafts	50% of benefit amount under the burns benefit if a covered individual receives one or more skin grafts for a covered burn.	Paid in addition to the burns benefit.
Step-down ICU confinement	$200 per day for confinement of at least 18 hours	Payable per covered person, per covered accident, in addition to any hospital confinement benefit. Payable for up to 15 days per covered individual, per covered accident.
Surgical procedures	$350–$1,400, depending on surgical procedure	Two or more surgical procedures performed through the same incision or entry point are considered one operation. Must be performed within one year of covered accident. Requires general anesthesia and must not be covered by any other specific surgery benefit listed. Payable once per 24 hours even though more than one surgery or procedure may be performed.
Transportation for treatment at a non-local hospital	$400 per round trip for treatment at a non-local hospital as a result of a covered accident; additional $400 per round trip for one parent or legal guardian if dependent child is receiving treatment	Physician must prescribe the treatment. Payable for up to three round trips per calendar year per covered individual. Not payable for ambulance transportation.

Naming a beneficiary

If you die while covered under accident insurance, your beneficiary(ies) will receive any benefits due at the time of your death. You must name a beneficiary(ies) to receive your accident insurance benefit if you die. You may do this by going to **One.Walmart.com**. All changes must be made at **One.Walmart.com**. Paper forms are not 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.

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.

You can name a minor as a beneficiary; however, Allstate Benefits may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult an attorney or an estate planner before naming a minor as a beneficiary.

You (the associate) are automatically assigned as the primary beneficiary of your covered dependent's accident coverage. If you and your dependent die at the same time, benefits will be paid as if you had not named a beneficiary. See **If you do not name a beneficiary** below.

CHANGING YOUR BENEFICIARY

You can change your beneficiary(ies) at any time on **One.Walmart.com**. All changes must be made at **One.Walmart.com**. Paper forms are not accepted.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or the beneficiary you named does not survive you, payment of any benefits due at your death will be paid in the following order:

- Your spouse/partner; if not surviving, then
- Your children, in equal shares; if not surviving, then
- Your parents, in equal shares; if not surviving, then
- Your siblings, in equal shares; if not surviving, then
- Your estate.

> Be sure to keep your beneficiary information up to date. Proceeds go to whoever is listed on your beneficiary form with the company, regardless of your current relationship with that person, unless state law says otherwise. All beneficiary changes must be completed on **One.Walmart.com**. Paper forms are not accepted.

Filing a claim

Within 60 days of the occurrence or commencement of any covered accident, or as soon as reasonably possible, send a notice of claim to:

Allstate Benefits
Attn. Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488

You may also provide notice of claim as follows:

Online: **AllstateBenefits.com/mybenefits**
By phone: **800-514-9525**
By fax: **877-423-8804**

Provide the following information for the covered person:

- Name
- Social Security number, and
- Date the covered accident occurred.

You may request a claim form from Allstate Benefits or visit **One.Walmart.com** or **AllstateBenefits.com/Walmart** to obtain a copy. If you do not receive a claim form within 15 days of your request, you may send a notice of the claim to Allstate Benefits by providing Allstate Benefits with a statement of the nature and extent of the loss.

You will be required to provide written proof of your claim to Allstate. Generally, you should provide written proof related to your claim within 90 days of the service or loss, or as soon as reasonably possible after the loss if it is not possible to provide it within 90 days. In any event, you generally must provide any required proof of the claim to Allstate within 15 months, or your claim will be denied.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You or your beneficiary has the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

When benefits are not paid

No benefit will be paid for an accident that occurs as a result of:

- An injury that occurs as the result of an on-the-job accident
- An injury that occurs prior to the coverage effective date
- Any act of war, whether or not declared, or participation in a riot, insurrection, or rebellion
- Suicide, or any attempt at suicide, whether sane or insane
- Any injury sustained while under the influence of alcohol or any narcotic, unless administered upon the advice of a physician
- Dental or plastic surgery for cosmetic purposes, except when such surgery is required to treat an injury or correct a disorder of normal bodily function that was caused by an injury
- Committing or attempting to commit an assault or felony, or
- Any injury incurred while a covered individual is an active member of the military, naval, or air forces of any country or combination of countries.

Break in coverage

There may be occasions in which you must make special arrangements to pay your accident 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 **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

When coverage ends

Your accident insurance coverage ends on the earliest of the following:

- On the date you voluntarily drop coverage (as described below)
- On the date you terminate employment
- On the last day through which required premiums were paid, if you fail to pay your premiums within 30 days of the date they were due
- On your date of death
- On the last day of an approved leave of absence (unless you return to work), or
- When accident insurance is no longer offered by the company.

Accident insurance coverage for your spouse/partner ends:

- On the date your accident insurance coverage ends
- On the last day of the pay period when your job status changes to part-time, temporary, or part-time truck driver
- On the date you and your spouse are legally separated
- On the date you and your spouse are divorced or your partnership terminates, or
- On your spouse/partner's death.

Accident insurance coverage for your dependent child(ren) ends on the earliest of the following:

- On the date your accident insurance coverage ends
- On the date your dependent child loses eligibility, or
- On your dependent child's death.

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

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

CONTINUATION OF COVERAGE AT TERMINATION

If your coverage under accident insurance terminates as described above (except due to nonpayment of premiums or death), you and your covered dependents may continue accident insurance coverage directly from Allstate Benefits through portability coverage. The benefits, terms, and conditions of the portability coverage will be the same as those provided under the accident insurance available under the Plan at the time of termination. To receive portability coverage, you must notify Allstate Benefits that you wish to continue coverage and send the first premium within 60 days of the date your coverage under critical illness insurance terminates.

Portability coverage will be effective on the day after coverage under the Plan terminates and will end on the earliest of the following:

- The date you again are eligible for accident insurance under the Plan.
- The last day through which required premiums were paid, if you fail to pay your premiums within 30 days of the date they were due.
- For your covered dependents, on the date your coverage terminates or the date the dependent ceases to be an eligible dependent.

Any eligible dependent covered under accident insurance at the time such coverage terminates as a result of reaching the maximum age for eligibility may also receive portability coverage under the terms described above. Contact Allstate Benefits at **800-514-9525** for information.

The premiums for portability coverage are due in advance of each month's coverage, on the first day of the calendar month. The premiums are set at the same rate in effect under critical illness insurance for active associates with the same coverage.

For more information, please contact Allstate Benefits at **800-514-9525**.

If you leave the company and are rehired

If you are a part-time or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave the company and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

Accidental death and dismemberment (AD&D) insurance

The information in this chapter describes accidental death and dismemberment benefits that may be available to you if:

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

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

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the 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 **877-740-2116**
File a claim		Call Prudential at **877-740-2116**

What you need to know about AD&D insurance

- Proof of Good Health is not required for AD&D insurance, regardless of the coverage amount you choose.
- If you have a covered loss, AD&D insurance pays a lump sum benefit based on the nature of the loss and the coverage amount you select. Additional benefits may be payable depending on the circumstances of the covered loss.
- Coverage is provided through The Prudential Insurance Company of America (Prudential).
- The Certificate of Insurance is available at **One.Walmart.com** or at **Prudential.com/Walmart**. The certificate provides detailed information about company-paid life insurance, in addition to the highlights available in this chapter.

AD&D insurance

AD&D insurance pays a lump sum benefit to you or your beneficiary(ies) if you or a covered dependent experiences a covered loss. The amount of your benefit depends on the type of loss you experience, as described later in this chapter.

You have two AD&D coverage decisions. You choose whom you want to cover and your coverage amount.

You can choose to cover:

- Associate only
- Associate + dependents

If you are a part-time hourly associate, temporary associate, or part-time truck driver and you choose associate + dependents coverage, you can cover your dependent children but not your spouse/partner.

The coverage amount for your dependents will be a percentage of the coverage amount you choose for yourself (see **AD&D coverage amount** later in this chapter). The amounts available for you to choose as your associate coverage amount are:

- $25,000
- $50,000
- $75,000
- $100,000
- $150,000
- $200,000

Management associates may also choose the following additional coverage amounts:

- $300,000
- $500,000
- $750,000
- $1,000,000

The cost of AD&D insurance is based on the coverage amount you select and whether you choose associate-only or associate + dependents coverage.

Naming a beneficiary

To ensure that your AD&D benefit is paid according to your wishes, you must name a beneficiary(ies). You may do this by going to **One.Walmart.com**. All changes must be made at **One.Walmart.com**. Paper forms are not 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** below.

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**. All changes must be made at **One.Walmart.com**. Paper forms are not accepted.

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.

AD&D coverage amount

When you enroll in AD&D insurance, the coverage amount you select is the amount that applies to you, the associate. If you enroll in associate + dependent(s) coverage, the coverage amount for your dependent(s) is a percentage of your associate coverage amount. The coverage amount for your dependent(s) depends on the type of dependents you are covering. See the **Full benefit amount** chart below for information on the coverage amount for your family members.

When AD&D benefits are paid

If you have chosen associate + dependent(s) coverage and you or your dependent sustains an accidental injury that is the direct and sole cause of a covered loss, AD&D benefits are paid when proof of the accidental injury and covered loss have been properly provided to Prudential.

Prudential deems a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements.

"Direct and sole cause" means the covered loss occurs within 12 months of the date of the accidental injury and is a direct result of the accidental injury, independent of other causes.

COVERED LOSSES PAID AT FULL BENEFIT

The following covered losses resulting from an accident are payable at the full benefit:

- Loss of life: It will be presumed that you have suffered a loss of life if your body is not found within one year of disappearance, stranding, sinking, or wrecking of any vehicle in which you were an occupant.
- Loss of both hands above the wrists; both feet above the ankles; total and permanent loss of sight in both eyes; loss of speech and hearing in both ears that lasts for at least six consecutive months following the accident.
- Loss of one hand and one foot: Severance at or above the wrist and ankle joints.
- Loss of one arm or one leg: Severance at or above the elbow or above the knee.
- Loss of one hand or foot and sight in one eye: Severance at or above the wrist or ankle joint, with total and permanent loss of sight in one eye.
- Quadriplegia: Total paralysis of both upper and lower limbs.
- Paraplegia: Total paralysis of both lower limbs.
- Hemiplegia: Total paralysis of upper and lower limbs on one side of the body.

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

50% OF FULL BENEFIT

The following covered losses resulting from an accident are payable at 50% of full benefit:

- Brain damage: Brain damage means permanent and irreversible physical damage to the brain, causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of more than five consecutive days within 30 days of the accident, and continue for 12 consecutive months.
- Loss of hand or foot: Severance at or above the wrist or ankle.
- Loss of sight in one eye: Total and permanent loss of sight in one eye.
- Loss of speech or hearing in both ears: Total and permanent loss of speech or hearing (i.e., continuing for at least six consecutive months following the accident).

25% OF FULL BENEFIT

The following covered losses resulting from an accident are payable at 25% of full benefit:

- Loss of hearing in one ear: Total and permanent loss of hearing (i.e., continuing for at least six consecutive months following the accident).
- Loss of thumb and index finger of the same hand: Severance at or above the point at which they are attached to the hand.
- Uniplegia: Total paralysis of one limb.

"Paralysis" means loss of use, without severance, of a limb. A doctor must determine that the loss is complete and not reversible. "Severance" means complete separation and dismemberment of the limb from the body.

COMA BENEFIT

If you or a covered dependent is comatose or becomes comatose within 365 days as the result of an accident, a coma benefit equal to 1% of your full benefit amount is paid for 11 consecutive months to you, your spouse/partner, your children, or a legal guardian. The benefit is payable after 31 consecutive days of being comatose. If you or a covered dependent remains comatose beyond 11 months, the full sum of the coverage, less any AD&D benefit already paid, is made to you or your designated beneficiary.

"Coma" means a profound state of unconsciousness from which the comatose person cannot be aroused, even by powerful stimulation, as determined by the person's doctor. Such state must begin within 365 days of the accidental injury and continue for 31 consecutive days and is total, continuous, and permanent at the end of the 31-day period.

The maximum amount that AD&D insurance will pay for all covered losses of an individual resulting from a covered accident is the full benefit amount.

Additional AD&D benefits

Additional benefits may be payable by the Plan:

- Seat belt benefit: If you and/or your covered dependents suffer a loss of life as a result of a covered accident that occurs while wearing a seat belt, an additional benefit may be payable.
- Safe motorcycle rider benefit: If you and/or your covered dependents suffer a loss of life as a result of a covered accident that occurs while wearing a helmet, an additional benefit may be payable.
- Tuition reimbursement benefit (full-time hourly and management associates only): If you (the associate) suffer a loss of life, a spouse/partner education benefit may be payable.
- Tuition reimbursement and childcare benefit: If you (the associate) or your covered spouse/partner suffers a loss of life, a childcare benefit and/or child education benefit may be payable.
- Home alteration and vehicle modification benefit: If you or your covered dependents suffer a covered loss that requires home alteration or vehicle modification, an additional benefit may be payable.
- COBRA monthly medical premium benefit: If you (the associate) suffer a covered accidental bodily injury which results in your death or a termination after a leave of absence, an additional benefit may be payable to assist with the continuation of medical benefits under the Associates' Medical Plan.
- Monthly rehabilitation benefit: If you or your covered dependents suffer a covered accidental bodily injury that requires medically necessary rehabilitation, an additional benefit may be payable.
- Common accident benefit: If you (the associate) 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.
Tuition reimbursement for spouse/partner	An amount equal to the least of: • The actual tuition charged for the program; • 10% of your (the associate's) amount of insurance; and • $25,000	Payable for up to 4 years. Must be enrolled in a professional or trade program within 30 months after the date of your death. *Full-time hourly and management associates only.*
Tuition reimbursement for child	An amount equal to the least of: • The actual annual tuition, exclusive of room and board, charged by the school; • 10% of the amount of insurance on the person incurring the loss; and • $25,000	Payable annually for up to 4 consecutive years, but not beyond the date the child reaches age 26. Child must be enrolled as a full-time student on the date of your death; or, if in the 12th grade on the date of death, becomes a full-time student within 365 days after the date of your death.
Childcare benefit	An amount equal to the least of: • The actual cost charged by a childcare center per year; • 10% of the amount of insurance on the person incurring the loss; and • $12,500	Payable annually for up to 5 consecutive years, but not beyond the date the child reaches age 13. Child must be enrolled on the date of your death or within 90 days after the date of your death.
Home alteration and vehicle modification benefit	An amount equal to the least of: • The actual cost charged for the alteration or modification; • 10% of the amount of insurance on the person incurring the loss; and • $10,000	Payable for an amount no greater than $10,000.
Medical premium benefit for associate (COBRA)	An amount equal to the least of: • The amount of the medical premium; • 5% of your (the associate's) amount of insurance; and • $500	Payable monthly until the first of these occurs: • Your continued enrollment in the AMP ends • You become covered under any other group medical plan • The benefit has been paid for 36 consecutive months
Medical premium benefit for dependent (COBRA)	An amount equal to the lesser of: • The actual amount of the medical premium; and • $10,000	Payable yearly until the first of these occurs: • Your dependent's continued enrollment in the AMP ends • Your dependent becomes covered under any other group medical plan • The benefit has been paid for 3 consecutive years. *A benefit for spouse/partner premiums is 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 **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

When coverage ends

Your AD&D coverage ends:

- On the date you voluntarily drop coverage (as described on the following page)
- At termination of your employment
- On the last day of coverage for which 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, temporary associate, or part-time truck driver, your coverage for your spouse/partner will end on the last day of the pay period when your job status changes.

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

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave the company and are rehired

If you are a part-time or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave the company and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits, of terminating employment with the company and then returning to work.

Critical illness insurance

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

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

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

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Allstate Benefits 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. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company, the underwriting company and subsidiary of The Allstate Corporation.

Critical illness insurance

If you enroll yourself and your eligible dependents in critical illness insurance, you or your beneficiary will be eligible for a direct lump-sum cash benefit to help pay for expenses related to covered critical illnesses.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get detailed information	Go to **One.Walmart.com** or **AllstateBenefits.com/Walmart**	Call Allstate Benefits at **800-514-9525**

What you need to know about critical illness insurance

- You may purchase critical illness insurance to assist you and your family in the event you or your covered dependent is diagnosed with certain serious illnesses.
- You may elect coverage amounts of $5,000, $10,000, $15,000, or $20,000.
- If you or a covered dependent is diagnosed with a covered critical illness, critical illness insurance pays a percentage of the coverage amount in a lump sum, based on the nature of the condition.
- Proof of Good Health is not required for any level of coverage.
- The Certificate of Insurance available online at **One.Walmart.com** or **AllstateBenefits.com/Walmart** provides detailed information about critical illness insurance, in addition to the highlights available in this chapter.

Critical illness insurance

Critical illness insurance provides a direct benefit if you or any covered dependents are diagnosed with a covered illness or disease. The policy pays benefits regardless of, and in addition to, any other insurance you may have.

Coverage is available in $5,000 increments up to a maximum of $20,000 with no Proof of Good Health required.

CHOOSING A COVERAGE TIER

When you enroll for critical illness insurance, you may also select the eligible family members you wish to cover:

- Associate only
- Associate + spouse/partner (except for part-time hourly associates, temporary associates, and part-time truck drivers)
- Associate + child(ren), or
- Associate + family (except for part-time hourly associates, temporary associates, and part-time truck drivers).

If you have associate-only or associate + spouse/partner coverage and you (or your spouse/partner) give birth to a child, your newborn child will be automatically covered for 60 days after birth. You must change your election to associate + child(ren) or associate + family if you wish to continue covering your child after 60 days. See the **Eligibility, enrollment, and effective dates** chapter for information on when and how you may change your election.

The cost for coverage is based on the coverage amounts you choose, the eligible dependents you choose to cover, your age, and whether you (and/or your covered spouse/partner) are eligible for tobacco-free rates.

Critical illness benefits

Benefits are payable if you are diagnosed with one of the conditions listed below, subject to terms of the Certificate of Insurance available at **One.Walmart.com** or **AllstateBenefits.com/Walmart**. You can also call Allstate Benefits at **800-514-9525** for a copy. Coverage must be effective before the date of diagnosis for an illness or disease to be covered under the policy.

No benefit is payable for any disease diagnosed before the effective date of coverage. If you die before your effective date, no critical illness insurance benefit will be paid to your beneficiary(ies).

Benefits of 100% of the coverage amount you elect will be paid upon the occurrence of the following critical illnesses, subject to complete details in the Certificate of Insurance:

- Invasive cancer
- Alzheimer's disease (requires loss of three activities of daily living)
- Coronary artery bypass surgery (excludes balloon angioplasty, laser embolectomy, atherectomy, stent placement, and other non-surgical procedures)
- End-stage renal failure
- Heart attack
- Stroke
- Parkinson's disease (requires loss of two activities of daily living)
- Total and irreversible loss of hearing in both ears continuing for six consecutive months following the illness that caused it and that cannot be corrected by the use of any hearing aid or device
- Permanent and uncorrectable loss of sight in one or both eyes due to sickness
- Quadriplegia
- Paraplegia
- Loss of at least one foot, hand, arm, or leg
- Benign brain tumor, other than tumors of the skull, pituitary adenomas, or germinomas, resulting in persistent neurological deficits
- Coma (not medically induced) lasting at least seven consecutive days due to underlying illness or traumatic brain injury
- Sickle cell anemia
- Systemic lupus
- Tuberculosis, or
- Major organ transplant or placement on the National Transplant List as an active or an inactive candidate for a major organ transplant (see note below).

If you undergo a major organ transplant, as specified in the major organ transplant rider found in the Certificate of Insurance, you will receive 100% of the coverage amount you elect. If you are enrolled in the Saver Plan, you are not eligible for the major organ transplant rider included in critical illness insurance.

The following benefits are payable at less than 100% of the coverage amount you elect:

- Carcinoma in situ: 25% of coverage amount
- Complete loss of one or more fingers and/or one or more toes: 25% of coverage amount
- Transient ischemic attacks (TIAs): 25% of coverage amount
- Aneurysm (ruptured or dissecting): 25% of coverage amount
- Specified diseases: 50% of coverage amount
  - Addison's disease
  - Amyotrophic lateral sclerosis (Lou Gehrig's disease)
  - Cerebrospinal meningitis (bacterial)
  - Cerebral palsy
  - Cystic fibrosis

- Diphtheria
- Encephalitis
- Huntington's chorea
- Legionnaires' disease (confirmation by culture or sputum)
- Malaria
- Multiple sclerosis
- Muscular dystrophy
- Myasthenia gravis
- Necrotizing fasciitis
- Osteomyelitis
- Poliomyelitis
- Rabies
- Systemic sclerosis (scleroderma), or
- Tetanus.

All of the benefits described above will be paid once, under the Initial Critical Illness benefit.

The following Recurrence of Critical Illness benefits are paid for a second diagnosis:*

- Benign brain tumor
- Invasive cancer
- Carcinoma in situ
- Ruptured or dissecting aneurysm
- Coma
- Rabies
- Coronary artery bypass surgery
- Stroke
- Heart attack

*The Recurrence of Critical Illness benefits will be paid a second time at 100% of the coverage amount if:

- The recurrence happens at least 181 days after the initial occurrence.
- For a recurrence of the same type of cancer, you must be symptom-free and treatment-free for 181 days after the initial occurrence. (Maintenance medications and follow-up visits do not count as treatment.)

Other benefits payable include:

- Ambulance: $400 for ground ambulance or $4,000 for air ambulance if a covered individual requires ambulance transportation to a hospital or emergency center due to a covered illness.
- Post-traumatic stress disorder (PTSD): $100 for each day a covered individual receives counseling for PTSD; payable once per day per covered individual and limited to six days per calendar year.
- Skin cancer benefit: $500 upon positive diagnosis of skin cancer (basal cell carcinoma and squamous cell carcinoma) by a licensed Doctor of Medicine certified by the American Board of Pathology to practice pathological anatomy, or an osteopathic pathologist, based on microscopic examination of skin biopsy samples). This benefit is not paid for malignant melanoma (which is covered under the invasive cancer benefit). It also does not include any conditions which may be considered precancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; nonmalignant melanoma; moles; or similar diseases or lesions. Payable only once per covered individual each calendar year.
- National Cancer Institute (NCI) evaluation or Walmart Centers of Excellence evaluation: when evaluated for determining the appropriate treatment of a previously diagnosed covered illness, $500 for evaluation; $250 for transportation and lodging if the NCI center or Walmart Centers of Excellence facility is more than 100 miles from your home. Payable once for each initial occurrence or recurrence of a covered illness.
- Lodging benefit: $60 per day when a covered individual receives treatment for a covered illness on an outpatient basis at a treatment facility more than 100 miles from the covered individual's home. This benefit is limited to 60 days per calendar year and is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment.
- Transportation benefit: $0.50 per mile for personal vehicle, up to $1,500, or up to $1,500 round-trip transportation for coach fare on a common carrier. Transportation must be required for treatment of a covered critical illness at a hospital (inpatient or outpatient), radiation therapy center, chemotherapy or oncology clinic, or any other specialized freestanding treatment facility. If the treatment is for a covered child and common carrier travel is necessary, the benefit will be paid for up to two adults to accompany the child. This benefit will not be paid if the covered individual lives within 100 miles of the treatment facility.

Naming a beneficiary

If you die while covered under critical illness insurance, your beneficiary(ies) will receive any benefits due at the time of your death. You must name a beneficiary(ies) to receive your critical illness insurance benefit if you die. Do this by going to **One.Walmart.com**. Note that only beneficiary designations made online are accepted. Paper forms are not accepted.

You can name anyone you wish. If the beneficiary(ies) you list with the company differs from the beneficiary(ies) named in your will, the list that the company has prevails.

The following information is needed for each beneficiary you name:

- 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 a total 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.

You can name a minor as a beneficiary; however, Allstate Benefits may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult an attorney or an estate planner before naming a minor as a beneficiary.

You (the associate) are automatically assigned as the primary beneficiary of your covered dependent's critical illness coverage. If you and your dependent die at the same time, benefits will be paid as if you had not named a beneficiary. See **If you do not name a beneficiary** below.

CHANGING YOUR BENEFICIARY

You can change your beneficiary(ies) at any time on **One.Walmart.com**. All changes must be made at **One.Walmart.com**. Paper forms are not accepted.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or the beneficiary you named does not survive you, payment of any benefits due at your death will be paid in the following order:

- Your spouse/partner; if not surviving, then
- Your children, in equal shares; if not surviving, then
- Your parents, in equal shares; if not surviving, then
- Your siblings, in equal shares; if not surviving, then
- Your estate.

Be sure to keep your beneficiary information up to date. Proceeds go to whoever is listed on your beneficiary form with the company, regardless of your current relationship with that person, unless state law says otherwise. All beneficiary changes must be completed on **One.Walmart.com**. Paper forms are not accepted.

Filing a claim

Within 60 days of the occurrence or commencement of any covered critical illness, or as soon as reasonably possible, send a notice of claim to:

Allstate Benefits
Attn: Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488

You may also provide notice of claim as follows:

Online: **AllstateBenefits.com/mybenefits**
By phone: **800-514-9525**
By fax: **877-423-8804**

Be sure to provide the following information for the covered person:

- Name
- Social Security number, and
- Date the covered illness began.

You may request a claim form from Allstate Benefits or visit **One.Walmart.com** or **AllstateBenefits.com/Walmart** to obtain a copy. If you do not receive a claim form within 15 days of your request, you may send a notice of the claim to Allstate Benefits by providing Allstate Benefits with a statement of the nature and extent of the loss.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You or your beneficiary has the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

When benefits are not paid

No benefit will be paid for any critical illness due to or resulting directly or indirectly from:

- A critical illness that occurred prior to the coverage effective date
- Any act of war, whether or not declared, or participation in a riot, insurrection, or rebellion
- Intentionally self-inflicted injuries
- Engaging in an illegal occupation or committing or attempting to commit a felony
- Attempted suicide, while sane or insane
- Being under the influence of narcotics or any other controlled chemical substance, unless administered upon the advice of a physician

- Participation in any form of aeronautics, except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports, or
- Alcohol abuse or alcoholism, drug addiction, or dependence upon any controlled substance.

Break in coverage

There may be occasions in which you must make special arrangements to pay your critical illness 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 **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

When coverage ends

Your critical illness insurance coverage ends on the earliest of the following:

- On the date you voluntarily drop coverage (as described on this page)
- On the date you terminate your employment
- On the last day through which required premiums were paid, if you fail to pay your premiums within 30 days of the date they were due
- On your date of death
- On the last day of an approved leave of absence (unless you return to work), or
- When critical illness insurance is no longer offered by the company.

Critical illness insurance coverage for your spouse/partner ends on the earliest of the following:

- On the date your insurance coverage ends
- On the last day of the pay period when your job status changes to part-time, temporary, or part-time truck driver
- On the date you and your spouse are legally separated
- On the date you and your spouse are divorced or your partnership ends, or
- On your spouse/partner's death.

Critical illness insurance coverage for your dependent child(ren) ends on the earliest of the following:

- On the date your insurance coverage ends
- On the date your dependent child loses eligibility, or
- On your dependent child's death.

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

- **After an election change event**: coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

CONTINUATION OF COVERAGE AT TERMINATION

If your coverage under critical illness insurance terminates as described above (except due to nonpayment of premiums or death), you and your covered dependents may continue critical illness insurance coverage directly from Allstate Benefits through portability coverage. The benefits, terms, and conditions of the portability coverage will be the same as those provided under the critical illness insurance available under the Plan at the time of termination. To receive portability coverage, you must notify Allstate Benefits that you wish to continue coverage and send the first premium within 60 days of the date your coverage under critical illness insurance terminates.

Portability coverage will be effective on the day after coverage under the Plan terminates and will end on the earliest of the following:

- The date you again are eligible for critical illness insurance under the Plan.
- The last day through which required premiums were paid, if you fail to pay your premiums within 30 days of the date they were due.
- For your covered dependents, on the date your coverage terminates or the date the dependent cases to be an eligible dependent.

Any eligible dependent covered under critical illness insurance at the time such coverage terminates as a result of reaching the maximum age for eligibility may also receive portability coverage under the terms described above. Contact Allstate Benefits at **800-514-9525** for information.

The premiums for portability coverage are due in advance of each month's coverage, on the first day of the calendar month. The premiums are set at the same rate in effect under critical illness insurance for active associates with the same coverage.

For more information, please contact Allstate Benefits at **800-514-9525**.

If you leave the company and are rehired

If you are a part-time or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave the company and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

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 determination regarding your enrollment or eligibility status or a claim for the following benefits that has been partially or fully denied: medical, pharmacy, dental, vision, HMO and PPO Plan options, disability, and life, AD&D, critical illness or accident insurance.

RESOURCES	
Find What You Need	
Submit a claim for benefits	For medical, pharmacy, dental, and vision claims, see your plan ID card for the claims address or call your health care advisor at the number on your plan ID card. Submit Centers of Excellence claims to the administrator as shown in the **Centers of Excellence** chart later in the chapter. Submit all other claims to the Plan's third-party administrators or insurer, if applicable, as shown later in this chapter.
Appeal a denied claim	Submit appeals to the addresses and within the deadlines provided in this chapter. Your initial denial letter will also specify where and when to file an appeal.
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: **WageWorks (COBRA Appeals)** **P.O. Box 226591** **Dallas, Texas 75222-6591**
Designate an authorized representative to submit appeals on your behalf	Call the number on your plan ID card or call People Services at **800-421-1362**.

What you need to know about claims and appeals

- You have the right to appeal an adverse enrollment or eligibility decision affecting your coverage.
- You have the right to appeal an adverse preauthorization decision regarding your requested benefits.
- 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 by completing the Plan's authorized representative form.
- After a final decision of an appeal of a medical, pharmacy, or Centers of Excellence claim is made, you may have the right to request an independent external review of the decision if the claim is denied based on medical judgment or based on a determination that the claim is not subject to surprise billing protections.
- Decisions regarding enrollment, eligibility status, and questions related to eligibility waiting periods are not eligible for external review, but are eligible for voluntary review under the Plan. In addition, for the medical, dental, and vision plans, appeals denied for nonmedical administrative reasons (e.g., because you exceeded the Plan's visit limits) are eligible for voluntary review under the Plan.
- You have the right to bring legal action if a claim is denied on appeal, but only after you have exhausted the Plan's claims and appeals procedures.

Deadlines to file a claim or bring legal action

You must submit your claim to the Plan within 18 months. Unless otherwise specified in the chapter describing the applicable benefit, or in this chapter, initial claims for benefits under the Plan must be filed within 18 months from the date of service or other date on which the right to make a claim first arises. Since procedures for filing a claim or an appeal are different for different benefit plans and third-party administrators, be sure to review the relevant section of this chapter for detailed information.

You must meet all claim and appeal deadlines and "exhaust" your administrative remedies before you may take other legal action. You must complete the required claims and appeals process described in this **Claims and appeals** chapter before you may bring legal action or, for certain medical, pharmacy, dental, or Centers of Excellence claims, pursue external review. You may not file a lawsuit for benefits if the initial claim or appeal is not made within the time periods set forth in the procedures described in this chapter. You can appoint another party to file a claim or appeal on your behalf by completing the Plan's authorized representative form.

You have limited time to file a lawsuit claiming benefits. If you have completed all required claims and 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). You may not file suit after the end of that 180-day period. If you request a voluntary review or, if applicable, an external review, the time taken by the voluntary review or external review is not counted against the 180 days you have to file a lawsuit. However, you are not required to request a voluntary review 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, such as the right to pursue an appeal, the right to request copies of certain Plan-related documents, the right to pursue any type of litigation on your behalf, including but not limited to litigation for payment of benefits, the right to pursue litigation for breach of fiduciary duty, the right to pursue litigation seeking equitable relief, or the right to pursue litigation to recover any statutory penalties, or your rights to any payments under this Plan. However, the Plan may choose to remit benefit payments directly to health care providers with respect to covered services, but only as a convenience to you and only if you authorize the Plan to do so. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to exercise legal rights or pursue appeals or legal causes of action on behalf of (or in place of) you or your covered dependents under any circumstances.

Appealing an enrollment or eligibility status decision

This section describes the appeal process that applies to enrollment and eligibility determinations, including whether you have met applicable waiting periods for coverage to be effective. See the **Special appeal procedures for Centers of Excellence** section of this chapter for specific details about requesting a waiver of the 12-month waiting period for transplant services. The AMP does not permit waiver of the 12-month waiting period applicable to weight loss surgery.

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 Total Rewards Benefits, attention Internal Appeals, at the address in the **Resources** chart at the beginning of this chapter.

COBRA participants should send the appeal, in writing, to WageWorks at the address in the **Resources** chart at the beginning of this chapter.

Your appeal will be handled within 60 days from the date it is received (30 days for COBRA appeals), unless an extension is required.

The 60-day period may be extended if it is determined that an extension is necessary due to matters beyond the Plan's control. You will be notified prior to the end of the 60-day period if an extension or additional information is required.

Appeals of enrollment or eligibility decisions are not eligible for external review but are eligible for voluntary review. See the **Voluntary review** section later in this chapter.

Medical, pharmacy, Centers of Excellence, dental, and vision benefits claims process

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

- Medical, pharmacy, and Centers of Excellence benefits except for HMO plan and PPO Plan options; see **HMO plan options' claims and appeals procedures** and **PPO Plan option's claims and appeals procedures** later in this chapter
- Dental benefits (through Delta Dental)
- Vision benefits (through VSP), and
- A rescission of coverage, which is a cancellation of coverage that has a retroactive effect, 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 ("TPA") of a scheduled medical service before you receive treatment, and the medical service is not required to be preauthorized, the TPA's response is nonbinding on the Plan and not subject to appeal. However, if the Plan terms or policies, as applied by your TPA, require

you or your provider to preauthorize services and your request for preauthorization is denied, that decision is subject to appeal. See **The medical plan** chapter for more information on voluntary prenotification and required preauthorization provisions. Contact your TPA if you have questions about whether a service requires preauthorization.

Refer to the respective chapters in this *Associate Benefits Book* for additional information on filing your initial claim. In many cases, initial claims will be submitted on your behalf by your health care provider. Initial claims will be determined by the TPA listed in the chart below. These TPAs have been delegated authority to make claim determinations. In some cases, the TPA may contract with a third party to make claim determinations.

TIME PERIODS FOR CLAIM DETERMINATIONS

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

Pre-service claims. See the **Preauthorization** section of **The medical plan** chapter for services that require preauthorization. You should also check with your TPA to determine whether a service requires preauthorization. If a specific service requires preauthorization, you or your provider must file a claim for approval of that service 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 time frames applicable to urgent care claims. 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."

CLAIMS ADMINISTRATION: ROUTINE MEDICAL, PHARMACY, DENTAL, AND VISION	
Medical • For Centers of Excellence claims other than family building, see below • Includes services at a Centers of Excellence facility that are not covered under the Centers of Excellence program and transplant claims not required to be performed at Mayo Clinic	**Your third-party administrator** **Premier, Contribution, and Saver Plan and family building benefits under the Centers of Excellence program** (see your plan ID card) • Aetna Life Insurance Company (Aetna)* • BlueAdvantage Administrators of Arkansas (BlueAdvantage)* • UMR **Local Plan options** • Mercy Arkansas Local Plan—HealthSCOPE Benefits • Banner Local Plan—Aetna *If your TPA is Aetna or BlueAdvantage and your work location is in AL, AK, AZ, CO, IL, IN, IA, KY, MN, MO, NC, SC, TN, VA, WV, or WI, pre-service claims may be determined by Included Health or a third party on behalf of Included Health. However, you should still contact your TPA for any pre-service ("preauthorization") requests.
Pharmacy	OptumRx
Dental	Delta Dental
Vision	VSP
CLAIMS ADMINISTRATION: CENTERS OF EXCELLENCE **NOTE:** If you are enrolled in a local plan, please call your health care advisor to be directed to the appropriate administrator.	
Heart surgery	Contigo Health
Cancer medical record review	HealthSCOPE Benefits
Outpatient kidney dialysis or ESRD medical record review	HealthSCOPE Benefits
Family-building treatment and services	Your third-party administrator
Hip and knee replacement	Contigo Health
Spine surgery	Contigo Health
Transplant	HealthSCOPE Benefits
Weight loss surgery	Contigo Health

The chart titled **Claims process and timing** on the following page shows deadlines for 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 circumstances, and in no case later than 72 hours after receipt of the claim. Notice will be provided regardless of whether the claim is approved or denied. You may receive notice orally, in which case a written notice will be provided within three days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information. If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request.
Pre-service claims A claim for services that have not yet been rendered and for which the Plan requires preauthorization.	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 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.

NOTICE OF CLAIM DENIAL

If your claim is denied, the denial notice will include the following information:

- The specific reasons for the denial
- Reference to Plan provisions on which the denial was based
- Information regarding time limits for appeal
- A description of any additional information necessary to consider your claim and why such information is necessary
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitation, an explanation of this rule (or a statement that it is available upon request), and
- Notice regarding your right to bring legal action following a denial on appeal.

For medical, pharmacy, Centers of Excellence, and vision benefits, the denial also will include:

- Information sufficient to identify the claim involved, including, as applicable, the date of service, health care provider, and claim amount
  - Upon written request, the Plan will provide you with the diagnosis and treatment codes (and their corresponding meanings) associated with any denied claim or appeal.
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal, and

- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist you with the internal and external appeals process.

SOME TYPES OF PAYMENT DISPUTES ARE NOT CLAIM "DENIALS"

Not every situation in which there is a payment dispute between the Plan and your health care provider will be considered a claim for benefits under these claims procedures that results in a denial notice or a right to appeal. If a decision is limited to a question about the amount owed by the Plan to a provider and does not affect the amount you may owe to the provider, the dispute generally will not fall under these procedures. This may occur, for example, when a network provider disputes the negotiated amount paid by the TPA or when a non-network provider disputes a payment from the TPA with respect to a service for which the provider is prohibited under state or federal law from billing you for the balance of unpaid amounts. The provider may separately dispute this payment to the TPA or Plan, but it is not a claim for your Plan benefits under these procedures.

Internal appeal process

APPEALING A CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If a claim submitted by you (or on your behalf) has been denied, you may request an appeal of the decision. In order for your appeal to be considered, it must:

- Be in writing
- Be sent to the correct address (see **Contact information for appeals** on the right)
- Be submitted within 365 days of the date of the initial denial (for medical, Centers of Excellence, and dental claims) or 180 days (for pharmacy and vision claims), and
- Contain any additional information/documentation you would like considered.

If your appeal involves an urgent claim, please contact your TPA for information about how to file your appeal orally.

Aetna, OptumRx, and VSP allow two appeals (i.e., two levels of review). The second appeal must be submitted within 60 days of the date of the first appeal denial. All other TPAs have one level of appeal.

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

Your claim denial notice will provide specific information about appealing a denied claim.

CONTACT INFORMATION FOR APPEALS

MEDICAL SERVICES (Including services performed at a Centers of Excellence facility but not covered under the Centers of Excellence program) *If you are unable to locate the address for appeals in the claim denial notice, call your TPA at the number listed below. Refer to your plan ID card for the name of your TPA.*	
Aetna	**855-548-2387** **800-525-6257** (Chicago metro & south FL) **833-554-1544** (AZ, TN, MN, CO) **800-626-9170** (GA, OH)
BlueAdvantage	**866-823-3790**
UMR	**855-870-9177**
HealthSCOPE Benefits	**800-804-1272**
UnitedHealthcare (claims with a date of service on or before Dec. 31, 2021)	**888-285-9255**
CENTERS OF EXCELLENCE SERVICES *Note that there is a special claims and appeals process for certain Centers of Excellence benefits. See details later in this chapter.*	
Contigo Health • Heart surgery • Spine surgery • Hip and knee replacement • Weight loss surgery	**Contigo Health** **Centers of Excellence: Walmart** **Attn: Appeals Coordinator** **300 Executive Pkwy Ste 100** **Hudson, Ohio 44236**
HealthSCOPE Benefits • Weight loss surgery at Mercy AR Local Plan • Cancer records review • Kidney/ESRD records review • Mayo Clinic transplant appeals	**HealthSCOPE Benefits** **Attn: Appeals Coordinator** **27 Corporate Hill Drive** **Little Rock, Arkansas 72205**
Your third-party administrator • Family-building treatment and services	See your plan ID card
PHARMACY	
OptumRx	**OptumRx** **Attn: Appeals Coordinator** **P.O. Box 25184** **Santa Ana, California 92799**
DENTAL	
Delta Dental of Arkansas	**Delta Dental of Arkansas** **Appeals Committee** **P.O. Box 15965** **Little Rock, Arkansas 72231-5965**
VISION	
VSP	**VSP** **Member Appeals** **3333 Quality Drive** **Rancho Cordova, California 95670**

NOTE: Certain types of benefits offered through the Centers of Excellence, including transplants, spine surgery, and hip and knee replacement, are subject to special appeal procedures, as described later in this chapter. If you are appealing a decision related to a benefit offered through a Centers of Excellence facility, please consult those procedures.

Your appeal will be conducted without regard to your initial determination, by someone other than the party who decided your initial claim. No deference will be afforded to the initial determination, meaning the appeal will be an independent determination regarding the claim. You will have the opportunity to submit written comments, documents or other information in support of your appeal. You have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. The TPA, on behalf of the Plan, will provide you with any new or additional evidence or rationale considered in connection with your claim sufficiently in advance of the appeals determination date to give you a reasonable opportunity to respond.

If your claim involves a medical judgment question, the Plan will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the Plan will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

A final decision on appeal will be made within the time periods specified in 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 circumstances, but not later than 72 hours after receipt of the claim (36 hours for each of two Aetna or Optum appeals).
Pre-service claims	You will be notified of the determination within a reasonable period of time, taking into account the medical circumstances, but no later than 30 days from the date your request is received (15 days for each of two Aetna or Optum appeals).
Post-service claims	You will be notified of the determination within a reasonable period of time, but no later than 60 days from the date your request is received (30 days for each of two Aetna, Optum, or VSP appeals).

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

- The specific reasons for the denial
- Reference to Plan provisions on which the denial was based
- A statement describing your right to request copies, free of charge, of all documents, records, or other information relevant to your claim
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on a medical necessity or similar limitation, an explanation of this rule (or a statement that it is available upon request)
- A description of any voluntary review procedures available, and
- Notice regarding your right to bring legal action following a denial on appeal.

For medical, pharmacy, and Centers of Excellence benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider, and claim amount (if applicable)
  - Upon written request, the Plan will provide you with the diagnosis and treatment codes (and their corresponding meanings) associated with any denied claim or appeal.
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal, and
- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist you with the internal and external appeals process.

Special appeal procedures for Centers of Excellence

Benefits for transplants, spine surgery, hip and knee replacement under the Centers of Excellence program, or to waive the 12-month waiting period (where applicable) are subject to special claim and appeal procedures. Those special procedures are described below. Please review these procedures carefully if you are filing an exception request or appealing a claim denial related to one of these benefits.

TRANSPLANT BENEFITS: REQUESTING A WAIVER OF THE 12-MONTH WAITING PERIOD

NOTE: As stated in the **Centers of Excellence** and **When limited benefits apply to the AMP** sections of **The medical plan** chapter, cornea and intestinal transplant services are not covered under the Centers of Excellence program but

may be covered services under otherwise applicable AMP terms. For all transplant services (those covered under the Centers of Excellence program and those covered under otherwise applicable AMP terms), you must be enrolled in the AMP for at least 12 months before being eligible for benefits. With respect to the 12-month waiting period only, the procedures for requesting a waiver of the waiting period described in this section apply to all transplant services, including cornea and intestinal, notwithstanding the fact that cornea and intestinal transplant services are not covered under the Centers of Excellence program.

If the treating physician certifies that, absent the transplant, the individual's death is imminent within 48 hours, the otherwise applicable 12-month waiting period for transplant benefits may be waived. To request this waiver, you must file a preauthorization request.

Send your request and supporting documentation to:

By email: **ghappeal@wal-mart.com**
By fax: **888-715-4154**
By mail: **Walmart Total Rewards Benefits**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Your request will be treated as an urgent or pre-service claim. See the **Appeal process and timing** chart earlier in this chapter for details on the time frames under which the Plan Administrator will notify you of its determination in response to your request.

TRANSPLANT SERVICES: REQUESTING NETWORK EXCEPTION FOR COVERAGE OUTSIDE THE CENTERS OF EXCELLENCE PROGRAM

As described in **The medical plan** chapter, all eligible transplant recipients under the Centers of Excellence program must undergo a pre-transplant evaluation at Mayo Clinic. Mayo Clinic will make a recommendation regarding transplant services at Mayo Clinic. You may request an exception to have a transplant performed at a facility other than a Mayo Clinic. If the exception is granted, the AMP would pay for covered transplant services under otherwise applicable terms. This section describes the procedures you must follow to request an exception to have the AMP pay for covered transplant services at a facility other than Mayo Clinic under otherwise applicable terms.

Pre-service exception request to have transplant at a facility other than Mayo Clinic

You may file a pre-service exception request (a "pre-service" claim) to receive a transplant at a facility other than Mayo Clinic and have the AMP pay benefits for covered services under otherwise applicable terms if there is significant risk that travel to Mayo Clinic could result in death, or where Mayo Clinic determines that it will not recommend and perform a transplant because it is not an appropriate medical course of treatment or you are not an appropriate candidate.

Send your written pre-service exception request to:

By email: **ghappeal@wal-mart.com**
By fax: **888-715-4154**
By mail: **Walmart Total Rewards Benefits**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Your request will be considered by an Independent Review Organization appointed by the Plan Administrator. The Independent Review Organization will not include any associate of Walmart, Mayo Clinic, or a TPA of the Plan. The Independent Review Organization will review any relevant medical files reviewed or generated by Mayo Clinic, as well as any additional materials you submit, and will consider various factors, including your condition, alternative courses of treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit of the transplant.

If you are filing a pre-service exception request for services at a facility other than Mayo Clinic because there is significant risk that travel to Mayo Clinic could result in death, you should file as soon as possible. If you are filing a pre-service exception request because Mayo Clinic has determined that the transplant is not an appropriate medical course of treatment, your request must be received by the Plan within 120 calendar days of Mayo Clinic's initial denial of transplant treatment.

If the request is urgent, the Independent Review Organization will make its determination within 72 hours after receipt of the request (otherwise, the Independent Review Organization will make its determination within 15 days of receipt of the request). If the urgent pre-service exception request is determined to be incomplete, you will receive a notice within 24 hours of receipt of the request, and you will have 48 hours to provide additional information.

For non-urgent requests, the deadline to decide the request may be extended 15 days, and the Independent Review Organization will send a notice explaining the extension, if one is necessary. If an extension is necessary to request additional information, the extension notice will describe the required information and you will be given at least 45 days to submit the information. The Independent Review Organization will make a determination within 15 days of the date the Independent Review Organization receives your information, or, if earlier, the deadline to submit your information.

Internal appeal of denial of a pre-service exception request to have transplant at a facility other than Mayo Clinic

If your pre-service exception request is denied, you will have 180 days to appeal the denial and request that an Independent Review Organization conduct an internal review of the denial. The denial notice will provide information about how to request an appeal.

Or, you can send your appeal to:

By email: **ghappeal@wal-mart.com**
By fax: **888-715-4154**
By mail: **Walmart Total Rewards Benefits**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

The appeal will be decided by the Independent Review Organization. The Independent Review Organization will not include any associate of Walmart, Mayo Clinic, or a TPA of the Plan. Your appeal will be conducted without regard to the initial determination, by someone other than the party who decided your initial pre-service exception request. No deference will be afforded to the initial determination, meaning the appeal will be an independent determination regarding the initial request. You will have the opportunity to submit written comments, documents or other information in support of your appeal. You have the right to request copies, free of charge, of all documents, records or other information relevant to your request.

The Independent Review Organization will decide a request for an urgent appeal within 72 hours and a non-urgent appeal within 30 days after receipt.

If your internal appeal is denied, you then may appeal under the external appeal process described later in this chapter if the denial was based on medical judgment.

Cornea and intestinal transplants will be decided under the regular medical claims and appeals procedures outlined earlier in this chapter.

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

SPINE SURGERY AND HIP AND KNEE REPLACEMENT: REQUESTING NETWORK EXCEPTION FOR COVERAGE OUTSIDE THE CENTERS OF EXCELLENCE PROGRAM

As described in **The medical plan** chapter, spine surgery and hip and knee replacements that are eligible to be performed at a Centers of Excellence facility must be preauthorized by the administrator of the program and performed at a Centers of Excellence facility in order for covered services to be paid under the Centers of Excellence benefit. You may request an exception to have a procedure performed at a facility other than a Centers of Excellence facility. If the exception is granted, the AMP would pay for covered services under otherwise applicable terms. This section describes the procedures to request an exception to have the AMP pay for covered services performed at a facility other than a Centers of Excellence facility under otherwise applicable terms.

Pre-service exception request to receive services from a non-Centers of Excellence facility

You may file a pre-service exception request (a "pre-service" claim) for the AMP to pay benefits for covered services received from a non-Centers of Excellence facility under otherwise applicable terms if there is significant risk that travel could result in paralysis or death, or where a Centers of Excellence facility determines that the procedure is not the appropriate medical course of treatment or that you are not an appropriate candidate for surgery.

Send your written request for a pre-service exception request for spine surgery or hip or knee replacement to:

Centers of Excellence: Walmart
Attn: Appeals Coordinator
300 Executive Pkwy Ste 100
Hudson, Ohio 44236

Your pre-service exception requests will be considered by Contigo Health, the administrator of the Centers of Excellence for spine surgery and hip and knee replacement. Contigo Health will utilize an Independent Review Organization which will not include any associate of Walmart, the Centers of Excellence facility for spine surgery or hip or knee replacement, or a TPA of the Plan. The Independent Review Organization will review any relevant medical files that were reviewed or generated by the Centers of Excellence facility, as well as any additional materials you submit, and will consider various factors, including your condition, alternative courses of treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit the surgical procedure would have.

If you are filing a pre-service exception request for services at a non-Centers of Excellence facility because there is significant risk that travel could result in paralysis or death, you should file as soon as possible. If you are filing a pre-service exception request because a Centers of Excellence facility determined that the surgery is not an appropriate medical course of treatment, your claim must be received by the Plan within 120 calendar days of the initial denial by the Centers of Excellence facility.

If the pre-service exception request is urgent, the Independent Review Organization designated by Contigo Health will make its determination within 72 hours after receipt of the request (otherwise, the Independent Review

Organization will make its determination within 15 days of receipt of the request). If the urgent pre-service exception request is determined to be incomplete, you will receive a notice within 24 hours of receipt of the request, and you will have 48 hours to provide additional information.

For non-urgent requests, the deadline to decide the request may be extended 15 days, and Contigo Health will send a notice explaining the extension, if one is necessary. If an extension is necessary to request additional information, the extension notice will describe the required information and you will be given at least 45 days to submit the information. The Independent Review Organization will make a determination within 15 days from the date Contigo Health receives your information, or, if earlier, the deadline to submit your information.

Post-service exception request to receive services from a non-Centers of Excellence facility

If you have already received surgical treatment because your circumstances called for immediate surgery, without which you would likely have suffered paralysis or loss of life, you may request that the AMP pay benefits for covered services received from a non-Centers of Excellence facility under otherwise applicable terms (a "post-service" claim).

Send your written request for a post-service exception request for spine surgery or hip or knee replacement to:

By email: **ghappeal@wal-mart.com**
By fax: **888-715-4154**
By mail: **Walmart Total Rewards Benefits**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Your post-service exception request will be considered by an Independent Review Organization appointed by the Plan Administrator. The Independent Review Organization will not include any associate of Walmart, the Centers of Excellence facility for spine surgery or hip or knee replacement, or a TPA of the Plan. The Independent Review Organization will review any relevant medical files that were reviewed or generated by the Centers of Excellence facility, as well as any additional materials you submit, and will consider various factors, including your condition, alternative courses of treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit the surgical procedure would have.

You must file your exception request within 120 calendar days of the date of service.

If you file a post-service exception request, the Independent Review Organization will make its determination within 30 days of receipt of the post-service request. The deadline to decide the request may be extended 15 days, and the Independent Review Organization will send a notice explaining the extension, if one is necessary. If an extension is necessary to request additional information, the extension notice will describe the required information and you will be given at least 45 days to submit the information. The Independent Review Organization will make a determination within 15 days from the date the Independent Review Organization receives your information, or, if earlier, the deadline to submit your information.

Internal appeal of denial of a pre-service or post-service exception request to receive services from a non-Centers of Excellence facility

If your request is denied (whether it is a pre-service claim considered by Contigo Health or a post-service claim considered by an Independent Review Organization), you will have 180 days to appeal the denial and request that an Independent Review Organization conduct an internal review of the denial. The denial notice will provide information about how to request an appeal.

Or, you can send your appeal to:

By email: **ghappeal@wal-mart.com**
By fax: **888-715-4154**
By mail: **Walmart Total Rewards Benefits**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

The appeal will be decided by the Independent Review Organization. The Independent Review Organization will not include any associate of Walmart, the Centers of Excellence facility for spine surgery or hip or knee replacement or a TPA of the Plan. Your appeal will be conducted without regard to the initial determination, by someone other than the party who decided your initial exception request. No deference will be afforded to the initial determination, meaning the appeal will be an independent determination regarding the initial request. You will have the opportunity to submit written comments, documents or other information in support of your appeal. You have the right to request copies, free of charge, of all documents, records or other information relevant to your request.

The Independent Review Organization will decide a request for an urgent appeal of a pre-service exception request within 72 hours after receipt, a non-urgent appeal of a pre-service exception request within 30 days after receipt, and an appeal of a post-service exception request within 60 days of receipt.

If your internal appeal is denied, you then may appeal under the external appeal process described later in this chapter if the denial was based on medical judgment.

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

Voluntary review

In situations described below, you may request a voluntary review of an appeal that has been denied. Voluntary review is optional. *You are not required to request a voluntary review to be treated as exhausting your administrative remedies.*

REQUESTING A VOLUNTARY REVIEW OF A DENIED APPEAL: ENROLLMENT OR ELIGIBILITY STATUS DETERMINATIONS (INCLUDING COBRA)

If you have additional information that was not in your appeal, you may ask for a voluntary review of the decision on your appeal within 180 days 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 enrollment or eligibility status to:

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

Or fax to **888-715-4154**

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

REQUESTING A VOLUNTARY REVIEW OF AN APPEAL DENIED FOR ADMINISTRATIVE REASONS: MEDICAL, DENTAL, AND VISION APPEALS

You may request a voluntary review of the decision on your appeal of a denied medical, dental, or vision benefit claim if your appeal was denied for an administrative reason, such as if you exceeded the number of allowed visits, rather than for a medical judgment reason. You must file your request within 180 days 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

Or fax to **888-715-4154**

External appeal process for medical, pharmacy, or Centers of Excellence benefits

If your internal appeal for medical, pharmacy, or Centers of Excellence benefits under the Plan is denied based on medical judgment or based on a determination that the claim is not subject to surprise billing protections, you may have the right to further appeal your claim in an independent external review process. The denial notice will contain information on the external appeal process.

Your external appeal will be conducted by an Independent Review Organization not affiliated with the Plan. If this Independent Review Organization overturns the Plan's decision, the Independent Review Organization's decision will be binding on the Plan and will be implemented immediately, although the Plan may seek further review by a court in appropriate cases. Your internal appeal denial notice will include information about your right to file a request for an external review as well as contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Send a written request for an external medical appeal (including an exception request related to Centers of Excellence benefits) to:

Walmart Total Rewards Benefits
Attn: External Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500
800-421-1362

Or fax to **888-715-4154**

Send a written request for an external pharmacy appeal to:

OptumRx
Attn: Appeals Coordinator
P.O. Box 25184
Santa Ana, California 92799

Other rights related to medical, pharmacy, Centers of Excellence, dental, vision, and short-term disability benefits

THE PLAN'S RIGHT TO REQUEST MEDICAL RECORDS

The Plan has the right to request medical records for any covered individual.

THE PLAN'S RIGHT TO RECOVER OVERPAYMENT

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for an ineligible charge or that another plan or insurance was considered primary or that any other circumstances have occurred that resulted in the Plan paying greater benefits than permitted or required under the Plan terms, the Plan has the right to recover the overpayment. The Plan (or the third-party administrator or other service provider acting on behalf of the Plan) will try to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek recovery of an overpayment from any participant, beneficiary, or dependent. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan's collection effort is not successful. The Plan may also bring a lawsuit to enforce its rights to recover overpayments.

If an overpayment is made to a provider, the Plan (or any third-party administrator acting on behalf of the Plan) may reduce, offset, or deny benefits, in the amount of the overpayment, for otherwise covered services for current or future claims with the provider on behalf of any participant, beneficiary, or dependent in the Plan. If a provider to whom an overpayment was made has patients who are participants in other health and welfare plans administered by the third-party administrator, the third-party administrator may reduce or offset payments otherwise owed to the provider from such other health plans by the amount of the overpayment.

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 claims, including claims of medical providers. The Plan (or the applicable third-party administrator) may reduce or deny benefits for otherwise covered services for all current or future claims with the provider made on your behalf or a participant in any other health and welfare plan administered by the third-party administrator based on the results of an audit. The Plan may also reduce or deny benefits for otherwise covered services for all current or future claims you file.

THE PLAN'S RIGHT TO SALARY/WAGE DEDUCTION

To the extent that the Plan may recover from you or your dependents all or part of benefits previously paid, such as for benefits that are overpaid or for which you were not entitled under the Plan terms, 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, enrollment, and effective dates** chapter, including the applicable payroll deductions.

The Plan's subrogation and reimbursement rights

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 uninsured/underinsured motorist coverage
  - Business medical and/or liability insurance coverage or payments, and
  - Attorney fees.

The Plan's lien exists at the time the Plan pays any benefits to or for the benefit of a covered person. If a covered person files a petition for bankruptcy, the covered person agrees that the Plan's lien existed prior to the creation of the bankruptcy estate.

Also note that:

- "Covered person" means any participant (as defined by ERISA) or dependent of a participant who is entitled to benefits under the Plan
- The Plan has first priority with respect to its right to reduction, reimbursement, and subrogation
- The Plan has the right to recover interest on the amount paid by the Plan because of the accident
- The Plan has the right to 100% reimbursement in a lump sum
- The Plan is not subject to any state laws or equitable doctrine, including the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of a covered person's attorney's fees and costs
- The Plan is not responsible for the covered person's attorney's fees, expenses, or costs
- The right of reduction, reimbursement, and subrogation is based on the Plan language in effect at the time of judgment, payment, or settlement
- The Plan's right to reduction, reimbursement, and subrogation applies to any funds recovered from another party, by or on behalf of the estate of any covered person, 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.

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, 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 to guarantee reimbursement to the Plan from third-party benefits. Failure to comply will entitle the Plan to withhold benefits due to you 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 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 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.

A claimant may also designate an authorized representative to submit claims for benefits or appeals on their behalf.

For an initial claim for benefits to be considered, it must:

- Be in writing
- Be sent to the correct address
- Be submitted within 12 months 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 your claim for benefits and an explanation of why such material or information is necessary
- A statement that the claimant has the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making the Plan's determination
- A description of the Plan's appeal procedures and the time limits for appeal, 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 the 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.

Send a written request for an appeal to:

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

Or fax to **888-715-4154**

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 your appeal.

If the claim for benefits is denied on appeal, the Plan will provide a denial notice that includes:

- The specific reason(s) for the denial
- Specific reference to provisions of the Plan on which the denial was based
- A statement describing the claimant's right to request copies, free of charge, of all documents, records, or other information relevant to the claim for benefits
- A statement that the claimant has the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- A description of available voluntary review procedures, if any, 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 a claimant can request the Plan not to reduce benefits using the Plan's rights of reduction and recovery is to file a claim for benefits, following the process described above. A claimant must complete the required claims and appeals process described in these claims procedures before bringing any legal action. A claimant may not file a lawsuit for benefits if the initial claim for benefits or appeal is not made within the time periods set forth in these claims procedures. A claimant must file any lawsuit for benefits within 180 days after the decision on appeal. You may not file suit after that 180-day period expires.

HMO plan options' claims and appeals procedures

In some locations, Walmart offers health insurance coverage through a health maintenance organization (HMO) as part of the Associates' Health and Welfare Plan. If you participate in an HMO, the HMO will provide a benefit booklet that, together with this document, will serve as the Summary Plan Description for the HMO coverage and will describe its claims and appeals procedures. Contact your HMO for additional information.

PPO Plan option's claims and appeals procedures

In some locations, Walmart offers the PPO Plan as part of the Associates' Health and Welfare Plan. If you participate in the PPO Plan, Aetna, the PPO Plan option's third-party administrator, will provide a booklet that, together with this document, will serve as the Summary Plan Description for the PPO Plan coverage and describe its claims and appeals procedures. Contact Aetna for additional information.

Accident and critical illness insurance claims process

Accident and critical illness insurance claims must be submitted within 60 days after the occurrence or commencement of any covered accident or critical illness, or as soon as reasonably possible, to:

Allstate Benefits
Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488

You may also provide notice of claim as follows:
Online: **allstatebenefits.com/mybenefits**
By phone: **800-514-9525**
By fax: **877-423-8804**

Be sure to provide the following information for the covered person:

- Name
- Walmart identification number (WIN), and
- Date the covered illness or accident occurred or commenced.

You may request a claim form from Allstate Benefits or visit **One.Walmart.com** or **AllstateBenefits.com/Walmart** to obtain a copy. If you do not receive a claim form within 15 days of your request, you may send a notice of the claim to Allstate Benefits by providing Allstate Benefits with a statement of the nature and extent of the loss.

Allstate Benefits has the right to recover any overpayments due to fraud or an error they make in processing a claim. You or your beneficiary will be required to reimburse

Allstate Benefits in full. Allstate Benefits will work with you or your beneficiary to develop a reasonable method of repayment if you or your beneficiary is financially unable to repay Allstate Benefits in a lump sum.

ACCIDENT INSURANCE

When you submit a claim to Allstate Benefits, the claim determination will be made within a reasonable time period, but no later than 90 days after Allstate Benefits receives the claim. If Allstate Benefits determines that an extension is necessary due to special circumstances, this time may be extended an additional 90 days. In that case, you will receive written notice of the extension before the end of the 30-day period indicating the circumstances requiring the extension and the date by which Allstate Benefits expects to render a determination.

If your claim is denied, you will receive a denial notice that will consist of a written explanation, which will include:

- The specific reasons for the denial
- Reference to specific Plan provisions on which the denial was based
- A description of additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary, and
- Information about the claims review procedures and the time limits for appeal, including a statement that you have a right to file a lawsuit following a denial on appeal.

Written proof must be given to Allstate Benefits within 90 days of the covered accident. If it is not possible to provide written proof within that time period, Allstate will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to Allstate Benefits no later than 15 months from the time specified, unless the covered person is legally incapacitated.

Your beneficiary must reasonably cooperate during any investigation and/or determination of a claim. This includes the authorization for the release of medical records and other information.

Allstate Benefits has the right, at their own expense, to have any covered person examined by a physician of their choosing, as often as may be reasonably required while a claim is pending. Allstate Benefits may also have an autopsy performed while a claim is pending, where permitted by law.

APPEALING AN ACCIDENT INSURANCE CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

You may appeal any denial of a claim for benefits by filing a written request with:

Allstate Benefits
P.O. Box 41488
Jacksonville, Florida 32203-1488

Your appeal must be filed within 60 days of receipt of the written notice of denial of a claim. You may also submit with your appeal any comments, documents, records, and issues that you believe support your claim, even if you have not previously submitted such documentation. You may request, free of charge, all documents that are relevant (as defined by ERISA) to your claim. You may have representation throughout the review procedure.

A final decision on appeal will be made within a reasonable period of time, but no later than 60 days after receipt of your written appeal. If Allstate Benefits determines that an extension is necessary due to special circumstances, this time may be extended an additional 60 days. In that case, you will receive written notice of the extension before the end of the 60-day period indicating the circumstances requiring the extension and the date by which Allstate Benefits expects to render a determination.

If your appeal is denied, you will receive a written notice of the denial that will include:

- The specific reasons for the denial
- Reference to specific Plan provisions on which the denial was based
- A statement that you have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits
- A description of any voluntary review procedures offered by the Plan and your right to obtain information about such procedures, and
- A statement regarding your right to bring an action under section 502(a) of ERISA.

If your claim is denied, you have the right to bring action in federal court in accordance with ERISA Section 502(a), but only after you have followed the Plan's claims and appeals procedures. See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

CRITICAL ILLNESS INSURANCE

When you submit a claim to Allstate Benefits, the claim determination will be made within a reasonable time period, but no later than 30 days after Allstate Benefits receives the claim. If Allstate Benefits determines that an extension is necessary due to matters beyond their control, this time may be extended an additional 15 days. In that case, you will receive written notice of the extension before the end of the 30-day period indicating the circumstances requiring the extension and the date by which Allstate Benefits 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. Allstate

Benefits will then make their determination within 15 days from the date they receive the information, or, if earlier, the deadline to submit the information.

If your claim is denied, your denial will consist of a written explanation, which will include:

- The specific reasons for the denial
- Reference to specific Plan provisions on which the denial was based
- A description of additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary
- A description of the claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following a denial of your claim on review;
- A disclosure of any internal rule, guideline, or protocol relied on in denying the claim or a statement that you have the right to obtain, upon request and free of charge, such information, and
- If your denial is based on medical necessity or experimental treatment or similar limitations, an explanation of the scientific or clinical judgment for the determination or a statement that you have the right to obtain, upon request and free of charge, such information.

Written proof must be given to Allstate Benefits within 90 days of each covered critical illness. If it is not possible to provide written proof within that time period, Allstate will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to Allstate Benefits no later than 15 months from the time specified, unless the covered person is legally incapacitated.

Your beneficiary must reasonably cooperate during any investigation and/or determination of a claim. This includes the authorization for the release of medical records and other information.

Allstate Benefits has the right, at their own expense, to have any covered person examined by a physician of their choosing, as often as may be reasonably required while a claim is pending. Allstate Benefits may also have an autopsy performed while a claim is pending, where permitted by law.

APPEALING A CRITICAL ILLNESS INSURANCE CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

You may appeal any denial of a claim for critical illness benefits by filing a written request with:

Allstate Benefits
Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488
Attention: Appeals

Your appeal must be filed within 180 days of receipt of the written notice of denial of a claim. You may also submit with your appeal any comments, documents, records, and issues that you believe support your claim, even if you have not previously submitted such documentation. You may request, free of charge, all documents that are relevant (as defined by ERISA) to your claim. The appeal will be conducted by a person different from the person who made the initial decision. No deference will be given to the initial determination. You may have representation throughout the review procedure.

If the claim involves a medical judgment question, Allstate Benefits 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, Allstate Benefits will provide you with the identification of any medical expert whose advice was obtained in connection with the appeal.

A final decision on appeal will be made within a reasonable period of time, but no later than 60 days after receipt of your written appeal.

If your appeal is denied, you will receive a written notice of the denial that will include:

- The specific reasons for the denial
- Reference to specific Plan provisions on which the denial was based
- A statement that you have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits
- A description of any voluntary review procedures offered by the Plan and your right to obtain information about such procedures
- A disclosure of any internal rule, guideline, or protocol relied on in denying the claim or a statement that you have the right to obtain, upon request and free of charge, such information
- If your denial is based on medical necessity or experimental treatment or similar limitations, an explanation of the scientific or clinical judgment for the determination or a statement that you have the right to obtain, upon request and free of charge, such information, and
- A statement regarding your right to bring an action under section 502(a) of ERISA.

If your claim is denied, you have the right to bring action in federal court in accordance with ERISA Section 502(a), but only after you have followed the Plan's claims and appeals procedures. See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

Company-paid life insurance, optional associate and dependent life insurance, business travel accident insurance, and AD&D claims process

Claims for company-paid life, optional associate and dependent life, business travel accident, and AD&D insurance can be initiated by calling Prudential at **877-740-2116**. See the applicable chapter for information that must be provided to Prudential when filing a claim. Claims for benefits insured by Prudential may also be submitted by sending the claim to:

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

Claims for benefits under life insurance coverage must be filed within 90 days after the date of loss.

Claims for benefits under business travel accident insurance coverage must be filed within 365 days after the date of loss.

Claims for benefits under accidental death and dismemberment insurance coverage must be filed within 90 days after the date of loss.

LIFE, BUSINESS TRAVEL ACCIDENT, OR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

When you submit a life insurance claim to Prudential, a claim determination will be made within 45 days. This period may be extended for an additional 30 days if an extension if necessary due to matters beyond the control of Prudential. A written notice of the extension, the reason for the extension, and the date by which Prudential expects to decide on your claim, will be furnished to you within the initial 45-day period if an additional extension of time is needed. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of Prudential. A written notice of the additional extension, the reason for the additional extension, and the date by which Prudential expects to decide the claim will be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

- The specific reason(s) for the denial
- Reference to the specific plan provisions on which the benefit determination was based
- A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary
- A description of Prudential's appeals procedures and applicable time limits, and
- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

APPEALING A LIFE, BUSINESS TRAVEL ACCIDENT, OR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

You may appeal any denial of a claim for benefits by filing a written request with:

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

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential will make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension,

the reason for the extension, and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

- The specific reason(s) for the adverse determination
- Reference to the specific plan provisions on which the determination was based
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents, and other information relevant to your benefit claim upon request
- A description of Prudential's review procedures and applicable time limits
- A statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- A statement describing any appeals procedures offered by the plan.

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

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

VOLUNTARY SECOND APPEAL OF LIFE, BUSINESS TRAVEL ACCIDENT, OR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE CLAIMS

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. *You are not required to request a voluntary review to be treated as exhausting your administrative remedies.* See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

You may submit with your second appeal any written comments, documents, records, and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential will make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension, and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Claims and appeals process for disability coverage claims

NOTE: This section describes the claims and appeals process for the full-time hourly short-term disability plan (basic and enhanced), the full-time hourly and salaried long-term disability plan, and the truck driver long-term disability plan. For claims and appeals information for the short-term disability plans for salaried associates and truck drivers, refer to the respective chapters.

FILING A CLAIM

All requests of leaves of absence are administered by Sedgwick unless indicated otherwise. Notify Sedgwick to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury, or pregnancy. You may do this by visiting **One.Walmart.com > mySedgwick**, or by calling **800-492-5678**.

You may also submit short-term disability claims by mail to:

Sedgwick Claims Management Services, Inc.
P.O. Box 14748
Lexington, Kentucky 40512-4748

For associates in states or localities with legally mandated benefits, you should submit your claim directly to the state or local government. If you are appealing a Sedgwick-managed claim, file your appeal with Sedgwick, as described

above. For information, including filing timelines, call the appropriate phone number listed in the **Resources** chart at the beginning of the **Full-time hourly short-term disability** chapter.

Claims under the full-time hourly and salaried long-term disability plan and truck driver long-term disability plan should be submitted to:

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

If you elected long-term disability or truck driver long-term disability and were required to submit Proof of Good Health but your proof was not approved, you may submit an appeal in writing to Lincoln Financial Group. Contact Lincoln Financial Group for specific procedures regarding the appeal of a Proof of Good Health decision, including timing requirements. Submit your appeal via email at **EOIQuestions@lfg.co**, or by U.S. mail to:

Lincoln Financial Group
ATTN: Medical Underwriting
P.O. Box 2870
Omaha, NE 68103-2870

FILING DEADLINES

Claims for short-term disability benefits in Hawaii, New Jersey, and New York must be submitted to Sedgwick within 30 days of the date your disability begins. Sedgwick will notify Lincoln of your disability claim.

For all other states (with the exception of California and Rhode Island, as noted below), you must submit your short-term disability claim to Sedgwick within 90 days of the date your disability begins in order to assure consideration for benefits. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

If you are on an approved short-term disability claim and are enrolled in a long-term disability plan, your claim will automatically be transitioned to Lincoln for consideration.

If you work in Connecticut, Massachusetts, Washington, D.C., or Washington state, you should promptly apply to Sedgwick and to your state or locality for state-mandated benefits. Note that associates in Washington, D.C. will generally not receive benefits for periods prior to the date of the application for benefits, except in emergency situations.

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 Plan provisions on which the decision is based
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by you to the Plan of health care professionals treating you and vocational professionals evaluated by you
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the benefit determination, and
  - A disability determination regarding you made by the Social Security Administration and presented by you to the Plan.
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits
- A description of the review procedures and time limits applicable to such procedures, and
- 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.

APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for disability benefits is denied and you would like to appeal, you must submit a written or oral appeal to Sedgwick or Lincoln (as applicable) within 180 days of the denial.

For associates in states or localities with legally mandated plans, such as California, Connecticut, Massachusetts, Rhode Island, Washington, D.C., and Washington state, you should submit your appeal directly to the state or local government. For information, including filing timelines, call the appropriate phone number listed in the **Resources** chart at the beginning of the **Full-time hourly short-term disability** chapter.

Your appeal will be conducted without regard to your initial determination by someone other than the party who decided your initial claim or a subordinate of the individual who decided your initial claim. No deference will be afforded to the initial determination. You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You have the right to request copies, free of charge, of all documents, records, or other information relevant to your claim. The third-party administrator, on behalf of the Plan, will provide you with any new or additional evidence or rationale considered in connection with your claim sufficiently in advance of the appeals determination date to give you a reasonable opportunity to respond.

If your claim involves a medical judgment question, third-party administrator, on behalf of the Plan, will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the third-party administrator, on behalf of the Plan, will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

Sedgwick or Lincoln (as applicable) will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if it is determined that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification of the denial that will include:

- The specific reasons for the adverse determination
- Reference to the specific Plan provisions on which the determination was based
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the benefit determination, and
  - A disability determination regarding you made by the Social Security Administration and presented by you to the Plan.
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits, and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA (including a description of any contractual limitation period that applies and the date on which the contractual limitation period expires).

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

See **Appealing an enrollment or eligibility status decision** earlier in this chapter for information on appealing eligibility determinations.

All other appeals under the short-term disability plan for full-time hourly associates for all states except California, Hawaii, New Jersey, New York, and Rhode Island should be submitted to:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

For associates in states with legally mandated benefits, you should submit your appeal directly to the state or local government. If you are appealing your Sedgwick-managed claim, file your appeal with Sedgwick as described above.

For salaried associates and truck drivers, see the **Salaried short-term disability plan** chapter or the **Truck driver short-term disability plan** chapter, as appropriate, for detailed information on the appeals process for those plans.

Appeals for short-term disability benefits in Hawaii, New Jersey, and New York, and long-term disability appeals, should be sent to:

Group Benefits Claims Appeal Unit
Lincoln Financial Group
Group — Charlotte WM
Attn: Appeal Review Unit
P.O. Box 2578
Omaha, Nebraska 68172-9688

VOLUNTARY SECOND APPEAL OF A CLAIM FOR BENEFITS UNDER THE FULL-TIME HOURLY SHORT-TERM DISABILITY PLAN

If you are a full-time hourly associate whose short-term disability coverage is administered through Sedgwick and your appeal is denied, you may make a voluntary second appeal of your denial orally or in writing to Sedgwick. You must submit your second appeal within 180 days of the receipt of the written notice of denial. You may submit any written comments, documents, records, and any other information relating to your claim. The same criteria and response times that applied to your first appeal, as described earlier, are generally applied to this voluntary second appeal.

Voluntary second appeals for short-term disability benefits should be sent to:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

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

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 People Services 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 2023 *Associate Benefits Book* contains separate chapters that, taken together, constitute the Summary Plan Description (SPD) for the Walmart Inc. Associates' Health and Welfare Plan (the Plan). Specifically, the SPD for the Plan includes the following chapters:

- Eligibility, enrollment, and effective dates
- Eligibility, enrollment, and effective dates for associates in Hawaii
- The medical plan
- The pharmacy benefit
- The dental plan
- The vision plan
- Resources for Living
- COBRA
- Short-term disability for full-time hourly associates
- Long-term disability
- Truck driver long-term disability
- Company-paid life insurance
- Optional associate life insurance
- Optional dependent life insurance
- Business travel accident insurance
- Accident insurance
- Accidental death and dismemberment (AD&D) insurance
- Critical illness insurance
- Claims and appeals

In this **Legal information** chapter of the SPD, you will find important administrative information and facts about your rights as a participant in the Plan.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Contact the Plan Administrator		Write to: **Plan Administrator** **Senior Vice President, U.S. Benefits** **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 **AHWPrivacy@walmart.com**	Call People Services at **800-421-1362**
Answers to questions about Medicare Part D	Visit **medicare.gov**	**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 Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.
- The HIPAA privacy notice in this chapter describes how medical information about you may be used and disclosed and how you can get access to this information.
- The **Medicare and your prescription drug coverage** section in this chapter explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll.
- The Medicaid/Children's Health Insurance Program (CHIP) notice explains special enrollment and premium assistance rights for individuals eligible for these programs.

Associates' Health and Welfare Plan

Walmart Inc. maintains the Plan for the exclusive benefit of its eligible associates and their eligible family members. The Plan provides health and welfare benefits through the following component benefit programs:

- Self-funded medical benefits, including pharmacy*
- Medical insurance (including HMOs)**
- Self-funded dental benefits
- Vision insurance
- Resources for Living
- Self-funded short-term disability benefits
- Long-term disability insurance
- Company-paid life insurance
- Optional associate life insurance
- Optional dependent life insurance
- Business travel accident insurance
- Accident insurance
- Accidental death and dismemberment insurance
- Critical illness insurance

Each component benefit program (except for medical insurance) is summarized in the respective chapter of this SPD. Medical insurance (including HMOs) is summarized in a certificate of insurance booklet issued by an insurance company, a summary prepared specifically for that component benefit program. These summaries are also part of the Plan's SPD.

The terms and conditions of the Plan are set forth in this SPD, in the Associates' Health and Welfare Plan Wrap Document (Wrap Document), and in the insurance policies and other welfare program documents incorporated into the Wrap Document. The Wrap Document, together with this book and the other incorporated documents, constitutes the written instrument under which the Plan is established and maintained. An amendment to an incorporated document, including this SPD, is considered an amendment to the Plan.

*Self-funded medical benefits include the following plan options: Premier Plan, Contribution Plan, Saver Plan, and Local Plans.
**Medical insurance includes the following plan options: PPO Plan, HMOs.

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, vision, employee assistance program, short-term disability, long-term disability insurance, company-paid life insurance, optional associate and dependent life insurance, business travel accident insurance, accident insurance, accidental death and dismemberment (AD&D), and critical illness insurance.

Type of Administration: The Plan is administered by the Plan Administrator. The Plan Administrator has 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 that administer claims and appeals for the respective benefits.

The Plan Administrator (or its delegates, including third-party administrators and insurers deciding claims and appeals) has complete discretion to interpret and construe the provisions of the Plan, 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 insured medical, vision, company-paid life, optional associate life, optional dependent life, business travel accident, long-term disability, accident, AD&D, and critical illness insurance): For each of the insured component benefit programs, the applicable insurance company is a named fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the insurance contract.

Plan Trustee:
J. P. Morgan
4 New York Plaza, 15th Floor
New York, New York 10004-2413

Agent for Service of Legal Process:
Corporation Trust Company
1209 Orange Street Corporation Trust Center
Wilmington, Delaware 19801

Legal process may also be served on the Plan Administrator or Trustee.

Plan Year: January 1 through December 31

Plan funding

Walmart Inc. may fund Plan benefits out of its general assets or through contributions made to the Walmart Inc. Associates' Health and Welfare Trust. Contributions also may be required by associates, in an amount determined by Walmart Inc. in its sole discretion. All assets of the Plan, including associate contributions and any dividends or earnings of the Plan, shall be available to pay any benefits provided under the Plan or expenses of the Plan, including insurance premiums.

Plan amendment or termination

Walmart reserves the right within its sole discretion to amend or terminate any benefit or provision under the Plan, at any time and for any reason, as it relates to any current, past, or future participant or beneficiary under the Plan.

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, a representative in the benefits call center, or a third-party administrator. Only written statements by the Plan Administrator shall bind the Plan.

Your rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified facilities, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You have the right to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights. (See the **COBRA** chapter for more information.)

You should be provided a certificate of creditable coverage, free of charge, from the Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage.

The Plan's medical benefit component does not have a 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 Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, can fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request materials from the Plan and do not receive them within 30 days, you can file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up

to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

- If you have a claim for benefits that is denied or ignored, in whole or in part, you can file suit in a state or federal court. Generally, you must complete the appeals process before filing a lawsuit against the Plan. However, you should consult with your own legal counsel in determining when it is proper to file a lawsuit against the Plan.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you can file suit in a federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you can seek assistance from the U.S. Department of Labor, or you can file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U. S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

You can also obtain certain publications about your rights under ERISA by calling the Employee Benefits Security Administration publications hotline at **866-444-3272** or by going to **dol.gov/ebsa**.

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"

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 One.Walmart.com.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. You have certain rights under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA governs when and how your medical health information held by the AMP, dental plan, 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.

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. **To the Plans' Sponsor.** The Plans may use or disclose your PHI to Walmart, the Plan Sponsor. The Plans' Sponsor will only use your PHI as necessary to administer the Plans. The law only permits the Plans to disclose your PHI to Walmart, in its role as the Plans' Sponsor, if Walmart certifies, among other things, that it will only use or disclose your PHI as permitted by the Plan, will restrict access to your PHI to those Walmart employees whose job it is to administer the Plan, and will not use PHI for any employment-related actions.
5. **For Health-Related Programs and Services.** The Plans may contact you about information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.
6. **To Individuals Involved in Your Care or Payment for Your Care.** The Plans may disclose your PHI to a third party involved in your health care, including a family member, close friend, or a person you identified to the 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. **To Law Enforcement.** The Plans may release your PHI if asked to do so by a law enforcement official in certain circumstances, including but not limited to the following:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe might have resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena, or similar legal process
   - To identify/locate a suspect, material witness, fugitive, or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime or the description, identity, or location of the person who committed the crime), and
   - In cases where a law enforcement agency has requested PHI for purposes of identifying or locating an individual, HIPAA permits that if certain specific situations are met, the Plans must disclose to the law enforcement agency limited information such as name, address, Social Security number, ABO blood type, type of injury, date and time of treatment or death, and distinguishing physical characteristics.
6. **To Avert a Serious Threat to Health or Safety.** The Plans may use or disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. **For Military Functions.** The Plans may use or disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans), and if required to assure the proper execution of a military mission if the appropriate military authority has published the required information in the Federal Register.
8. **For National Security.** The Plans may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials, or foreign heads of state or to conduct investigations.
9. **Inmates.** The Plans may disclose your 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 in the next column 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' Medical Plan (the AMP) and your prescription drug coverage option under Medicare. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium. For purposes of the *Associate Benefits Book*, any of the Medicare drug plans covered under this notice are considered Part D plans.
- The AMP has determined that the prescription drug coverage offered under all self-funded options of the AMP, is on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered creditable coverage. If you enroll in one of these options, you may keep your current coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

You should also know that if you are enrolled in an AMP option and drop or lose your AMP coverage and do not join a Medicare drug plan within 63 continuous days after your current AMP coverage ends, you may pay a higher premium (a penalty) to join the Medicare drug plan later.

Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may always be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following Medicare annual enrollment period beginning in October to join.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current coverage under the AMP will be affected. Plan guidelines restrict you from enrolling in the AMP if you are enrolled in a Medicare drug plan. If your dependent is enrolled in a Medicare drug plan and you are not, you are able to enroll in the AMP, but your dependent would not be eligible for coverage.

If you decide to join a Medicare drug plan and drop your coverage under the AMP, be aware that you and your dependents will be able to reenroll, but only during Annual Enrollment or due to an election change event, provided you are not still enrolled in a Medicare drug plan.

If you enroll in a Medicare drug plan and decide within 60 days to switch back to a plan option under the AMP, you will need to call People Services at **800-421-1362** to reenroll. See the **Eligibility, enrollment, and effective dates** chapter for further details.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR PRESCRIPTION DRUG COVERAGE

Contact People Services at **800-421-1362** for further information. Note:

- You will get this notice each year before the next period during which you can join a Medicare drug plan.
- If we make a plan change that affects your creditable coverage under the AMP, you will receive another notice.
- If you need a copy of this notice, you can request one at any time from People Services at **800-421-1362**.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is available through the *Medicare & You* handbook from Medicare. You may also be contacted directly by Medicare drug plans. You will get a copy of the handbook in the mail every year from Medicare.

For more information about Medicare prescription drug coverage:

- Visit **medicare.gov**.
- Call your State Health Insurance Program for personalized help. (See your copy of the *Medicare & You* handbook for its telephone number.)
- Call **800-MEDICARE** (**800-633-4227**). TTY users should call **877-486-2048**.

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

REMEMBER

Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage, and therefore, whether or not you are required to pay a higher premium (a penalty).

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from Walmart Inc., your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed 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 dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial **877-KIDS NOW** or visit **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for the Plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Walmart Inc. Plan, the Plan must allow you and your dependents to enroll in the Plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **866-444-EBSA** (**3272**).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your state for more information on eligibility.

ALABAMA – Medicaid
Website: **http://myalhipp.com**
Phone: **855-692-5447**

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: **http://myakhipp.com**
Phone: **866-251-4861**
Email: **CustomerService@MyAKHIPP.com**
Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**

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

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program
https://www.dhcs.ca.gov/hipp
Phone: **916-445-8322**
Fax: **916-440-5676**
Email: **hipp@dhcs.ca.gov**

COLORADO – Health First Colorado (Medicaid) & Child Health Plan Plus (CHP+)
Health First Colorado website:
https://www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
800-221-3943 State Relay **711**
CHP+:
https://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
GA HIPP website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: **678-564-1162**, press **1**
GA-CHIPRA website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: **678-564-1162**, press **2**

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
HIPP phone: **888-346-9562**

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/masshealth/pa**
Phone: **800-862-4840**
TTY: **617-886-8102**

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**
Email: **HHSHIPPProgram@mt.gov**

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/programs-services/medicaid/health-insurance-premium-program**
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/Services/Assistance/Pages/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 and CHIP
Website: **https://dhhr.wv.gov/bms**
http://mywvhipp.com
Medicaid phone: **855-MyWVHIPP** (**855-699-8447**)
CHIP toll-free phone: **855-MyWVHIPP** (**855-699-8447**)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: **800-362-3002**

WYOMING – Medicaid
Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility**
Phone: **800-251-1269**

To see if any other states have added a premium assistance program since July 31, 2022, 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 Walmart 401(k) Plan

The legal name of the Plan is the Walmart 401(k) Plan. This document is being provided solely by your employer. No affiliate of Bank of America Corporation has reviewed or participated in the creation of the information contained herein.

The Walmart 401(k) Plan

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Enroll in or change your pretax contribution and/or 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**
• Enroll in or change your pretax, Roth, and/or your catch-up contributions • Set-up periodic automatic increases to your contribution rate • Request an In-Plan Roth Conversion • 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 to assist with birth or adoption expenses • Change your investment fund choices • Request a payout when you leave Walmart • Get information about your Plan investment options • Request a withdrawal of your rollover contributions • Request a loan from your Plan account	Go to **benefits.ml.com**	Call the Customer Service Center at **888-968-4015**
Designate a beneficiary	Go to **One.Walmart.com**	

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

- You are eligible to make your own contributions to the Plan as soon as administratively feasible after your hire date. You can contribute from 1% to 50% of your eligible pay each pay period.
- You can elect to make pretax salary deferral contributions and/or Roth salary deferral contributions. Pretax salary deferral contributions (and earnings thereon) are not subject to current federal income tax and, in most cases, state or local taxes, until distributed from the Plan. Roth salary deferral contributions are made on an after-tax basis, but the contributions and, in most cases, the earnings thereon are not subject to federal income tax when distributed to you (as long as the distribution meets certain requirements).
- You are also eligible to convert pretax contributions to after-tax Roth contributions by requesting an In-Plan Roth Conversion.
- If you are credited with at least 1,000 hours of service in your first year and contribute to your account, you begin receiving matching contributions on the first day of the calendar month following your first anniversary of employment.
- After you become eligible for matching contributions, Walmart matches each dollar you contribute, up to 6% of your eligible annual pay. (Contributions you make before you become eligible for matching contributions are not matched.)
- You are always 100% vested in the money you contribute and the money Walmart contributes to your Company Match Account.
- You choose how to invest all contributions to your Plan account.
- If you do not specify how your contributions will be invested, they are automatically invested in the Plan's default investment option, the myRetirement Funds.
- The Plan accepts rollover contributions from other eligible retirement plans. You can withdraw your rollover contributions at any time.
- You may request a loan from your Plan account, subject to Plan rules.
- You can now request a withdrawal of up to $5,000 in connection with the birth or adoption of your child.

This is a summary of benefits offered under the Plan as of October 1, 2022 (unless otherwise noted). Should any questions arise about the nature and extent of your benefits, the formal language of the Plan document, not the informal wording of this summary, will govern.

Walmart 401(k) Plan eligibility

ASSOCIATES WHO ARE ELIGIBLE TO PARTICIPATE IN THE PLAN

All associates of Walmart Inc. or a participating subsidiary are eligible to participate in the Plan, except:

- Leased employees; nonresident aliens with no income from U.S. sources; independent contractors or consultants
- Anyone not treated as an employee of Walmart or its participating subsidiaries
- Associates covered by a collective bargaining agreement, to the extent that the agreement does not provide for participation in this Plan, and
- Associates represented by a collective bargaining representative after Walmart has negotiated in good faith to impasse with the representative on the question of benefits.

For purposes of this Summary Plan Description, all participating subsidiaries are referred to as "Walmart."

WHEN PARTICIPATION BEGINS

For purposes of your contributions. If you are an eligible associate, you may begin contributing to the Plan as soon as administratively feasible after your date of hire is entered into the payroll system. See **Enrolling in the Plan** later in this summary for details about the enrollment process.

For purposes of matching contributions. If you are an eligible associate, you will begin receiving matching contributions on the first day of the calendar month following your first anniversary of employment with Walmart if you are credited with at least 1,000 hours of service during your first year and are contributing your own contributions (pretax contributions and/or Roth contributions) to the Plan. (If you are classified as a highly compensated employee, you must also have attained age 21.) (Matching contributions are not made with respect to contributions you make before you become eligible for matching contributions.) For example, if your date of hire was December 15, 2021 and you are credited with 1,095 hours by December 15, 2022 (your first anniversary), then you will begin receiving matching contributions on January 1, 2023, with respect to any contributions you make to the Plan on or after that date.

If you are not credited with 1,000 hours of service during your first year, your eligibility for the matching contributions will be determined on hours credited during the Plan year, which runs from February 1 to January 31. You will be eligible to receive matching contributions on any contributions you make to the Plan on or after the February 1 that follows the Plan year in which you are credited with at least 1,000 hours of service. For example, if your date of hire is December 15, 2021, and you are credited with only 895 hours by December 15, 2022 (your first anniversary), but you work 1,095 hours during the February 1, 2022–January 31, 2023 Plan year, you will begin receiving matching contributions on February 1, 2023 with respect to any contributions you make to the Plan on or after that date.

If you leave Walmart during your first year and you are credited with more than 500 hours of service, you will retain your hours and first anniversary date for purposes of determining eligibility for matching contributions. If you are later rehired, your eligibility for matching contributions will be determined on hours worked during the Plan year, which runs from February 1 to January 31, unless you are credited with 1,000 hours of service prior to your first anniversary date.

For example, if your date of hire is December 15, 2021, and you leave Walmart on February 25, 2022, with 600 hours of service, you will retain your hours of service and first anniversary date for matching eligibility purposes. If you return to Walmart on November 1, 2022 (prior to your first anniversary date) and are not credited with 1,000 hours of service by your first anniversary date of December 15, 2022, you will begin receiving matching contributions on any contributions you make to the Plan on or after the February 1 that follows the Plan year in which you are credited with at least 1,000 hours of service.

HOW HOURS OF SERVICE ARE CREDITED UNDER THE PLAN

If you are an hourly associate, the hours counted toward the 1,000-hour requirement are credited as follows:

- Hours, including overtime hours, you work for Walmart or any subsidiary are counted.
- Hours for which you receive paid leave or personal time off are also counted.
- When a payroll period overlaps two Plan years, hours are credited toward the Plan year in which they are actually worked.

If you are a salaried associate or truck driver, the hours counted toward the 1,000-hour requirement are credited as follows:

- You are credited with 190 hours per month for each month in which you work at least one hour for Walmart or a subsidiary.
- In general, you must work at least six months of the Plan year to have 1,000 hours credited for the year. (Vacation paid to you in cash after you leave Walmart does not give you additional service for this purpose.)

If you become an associate of Walmart or any subsidiary as the result of the acquisition of your prior employer, special service crediting rules may apply to you.

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), veterans who return to Walmart or a subsidiary after a qualifying deployment may be eligible to have their qualified military service considered toward their hours of service under the Plan. Call People Services at **800-421-1362** for more details.

Enrolling in the Plan

Shortly after you become eligible to contribute to the Plan, (i.e., shortly after your date of hire), you will receive an enrollment packet at your home address on file. This packet tells you how you can make contributions from your pay into your Pretax Account and/or Roth Account and explains how you can direct the investment of your Plan funds by choosing from among a menu of investment options with varying investment objectives and associated risks. Because the Plan is intended to be an important source for your financial security at retirement, you should read all information pertaining to the Plan carefully.

Once you satisfy the eligibility requirements for receiving matching contributions, Walmart will match all of your subsequent contributions dollar-for-dollar up to 6% of eligible annual pay, as explained in the **Walmart's contributions to your Company Match Account** section.

To begin contributing to the Plan, enroll online at **One.Walmart.com** or **benefits.ml.com**. You can also call the Customer Service Center at **888-968-4015**. Note, however, that if you wish to make Roth contributions to the Plan, you must enroll at **benefits.ml.com**. You can enroll at any time after you become eligible.

When you enroll, you can choose:

- The percentage of your pay that you want to contribute on a per-pay-period basis and whether your contributions will be pretax contributions or Roth contributions or a combination of both (see **Making contributions to your account** later in this summary), and
- How to invest your accounts among the Plan's investment options. The Plan's investment options and procedures are described in your enrollment packet.

After you enroll, a confirmation notice will be mailed to your home address, or, if you have chosen electronic delivery of Plan materials, you will receive an email notification when the confirmation is available. The confirmation will show the percentage of your pay that you have chosen to contribute from each check, whether you elected to make pretax contributions or Roth contributions, or both, and the investment options you have elected. Review the confirmation to make sure your enrollment information is correct.

Your contributions to the Plan will start as soon as administratively feasible, normally within two pay periods after you enroll. No contributions are taken from your pay before you become an eligible participant in the Plan. Only participants who contribute their own funds to the Plan will have those contributions matched by Walmart, subject to eligibility requirements outlined in the **Walmart's contributions to your Company Match Account** section.

It is your responsibility to review your paychecks to confirm that your election is implemented correctly. If you believe your election has not been implemented correctly, notify the Customer Service Center at **888-968-4015** in a timely manner so that corrective steps can be taken. Your notification will not be considered timely if it is made more than three months after the date you make your election.

Your Walmart 401(k) Plan accounts

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

- **Pretax Account:** This account holds your pretax contributions to the Plan (including your catch-up contributions, if any), as adjusted for earnings or losses on those contributions.
- **Roth Account:** This account holds your Roth contributions to the Plan (including your Roth catch-up contributions, if any), as adjusted for earnings or losses on those contributions. The Roth Account will also hold any amounts you elected to convert in an In-Plan Roth Conversion, to the extent those amounts were not otherwise distributable under the Plan at the time of conversion, as adjusted for earnings or losses.
- **Company Match Account:** This account holds Walmart's matching contributions, as adjusted for earnings or losses on those contributions.
- **Pretax Rollover Account:** This account holds any contributions that you rolled over to this Plan from another eligible retirement plan, as adjusted for earnings or losses on those contributions.
- **Roth Rollover Account:** This account holds any amounts you rolled over to this Plan from your designated Roth salary deferral account in another eligible retirement plan, as well as any amounts that you elected to convert in an In-Plan Roth Conversion, to the extent those amounts were otherwise distributable under the Plan at the time of conversion, as adjusted for earnings or losses.
- **Company Funded 401(k) Account:** This account holds the discretionary Walmart contributions to the Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.
- **Company Funded Profit Sharing Account:** This account holds the discretionary Walmart contributions to the Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.

Differences between these accounts are discussed in more detail throughout this summary.

Note that if you become an associate of Walmart or any subsidiary as the result of the acquisition of your prior employer, and you participated in your prior employer's 401(k) plan, you may have other accounts in this Plan that hold amounts you contributed to your prior employer's plan. If you think this applies to you, you can obtain more information on your other accounts by calling the Customer Service Center at **888-968-4015**.

Making a rollover from a previous employer's plan or IRA

When you come to work for Walmart, you may have funds owed to you from a previous employer's retirement plan (including a 401(k) plan, a profit-sharing plan, a 403(b) plan of a tax-exempt employer or a 457(b) plan of a governmental employer). If so, you may be able to roll over that money to this Plan. You may also roll over pretax funds you have in an individual retirement account (IRA). You may generally roll over only pretax funds, but you may directly roll into the Plan amounts from a designated Roth salary deferral account in another qualified retirement plan. If you roll over funds to this Plan, keep these points in mind:

- Once you roll funds into the Walmart 401(k) Plan, those funds are subject to the rules of this Plan, including payout rules, and not the rules of your former employer's plan or your IRA
- Your rollover contribution will be placed in your Rollover Account or your Roth Rollover Account, as applicable, and will be 100% vested, and
- You may withdraw all or any portion of your rollover contributions at any time.

If you're interested in making a rollover contribution to the Plan, contact the Customer Service Center at **888-968-4015** or visit **benefits.ml.com** to obtain a rollover packet.

Repaying certain distributions to the Plan

If you previously received one of the following types of distributions from the Plan, you may repay all or any part of those distributions to the Plan and they will be considered part of your Rollover Account, subject to the rules above:

- If you were a "qualified individual" and received a CARES Act distribution from the Plan between April 20, 2020 and December 31, 2020 (or from another eligible retirement plan between January 1, 2020 and December 31, 2020), you may recontribute all or part of that distribution into this Plan as long as you are otherwise eligible to make a rollover to the Plan and you do so within three years of the date you received the distribution. You generally were a "qualified individual" if you or a family member were diagnosed with COVID-19 or experienced financial consequences as the result of COVID-19's impact on your work.
- If you receive a qualified birth or adoption distribution from this Plan after February 1, 2022 and you are otherwise eligible to make a rollover to the Plan, you can recontribute all or part of that distribution to the Plan at any time.

If you're interested in recontributing all or part of your prior distribution to the Plan, contact the Customer Service Center at **888-968-4015** or visit **benefits.ml.com**.

Making contributions to your account

After you become a participant in the Plan, you may generally choose to contribute from 1% up to 50% of each paycheck to your Pretax Account and/or your Roth Account. Your contributions (including both pretax contributions and Roth contributions) in any calendar year, however, may not exceed a limit set by the IRS. For 2023, the limit is $22,500. This amount will be increased from time to time by the IRS.

The IRS also limits the amount of compensation that can be taken into account under the Plan for any participant for a Plan year. For the Plan year ending January 31, 2023, this limit is $330,000.

In addition, you can choose whether your contributions will be "pretax contributions" and/or "Roth contributions." Together, these contributions are called your "401(k) contributions" in this summary.

- Pretax contributions are deducted from your pay before federal income taxes are withheld. This means that you don't pay federal income taxes on amounts you contribute to the Plan. Earnings on these contributions accumulate tax-free and are not taxed until your Pretax Account is actually distributed to you from the Plan (or until you elect an In-Plan Roth Conversion). You may also save on state and local taxes as well, depending on your location. Please note that your contributions are subject to Social Security taxes in the year the amount is deducted from your pay. Distributions from the Plan, however, are not subject to Social Security taxes.
- Roth contributions are deducted from your pay after federal income taxes are withheld. This means that you pay federal and state income taxes, and also Social Security taxes, on amounts you contribute to the Plan in the year the amount is deducted from your pay. Roth contributions, and earnings on those contributions, are normally not subject to federal and state income tax when your Roth Account is distributed to you from the Plan. In order for the earnings to be tax-free, the distribution must be a "qualified" distribution, as explained later. (Note that income limitations applicable to Roth IRAs are not applicable to Roth contributions to the Plan. You may choose to make Roth contributions regardless of your income.)

In addition, if you make contributions to the Plan, you may be eligible for a "Saver's Credit." If you are a married taxpayer who files a joint tax return and you have an adjusted gross income (AGI) of $73,000 or less (for 2023) or a single taxpayer with $36,500 or less (for 2023) in AGI on your tax return, you are eligible for this tax credit, which can reduce your taxes. For more details, your tax preparer may refer to IRS Announcement 2001-106.

HOW YOUR 401(K) CONTRIBUTION IS DETERMINED

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

- Regular salary or wages, including bonuses and any pretax dollars you use for your pretax contributions or to purchase benefits available under the Walmart Inc. Associates' Health and Welfare Plan
- Overtime, paid time off (used and paid out), bereavement, jury duty, and premium pay
- Most incentive plan payments
- Holiday bonuses
- Special recognition awards, such as the Outstanding Performance Award
- Differential wage payments you receive from Walmart while you are on a qualified military leave. This means that the contribution you have in effect when you go on the leave will continue to be applied to your differential wage payments while you are on the leave unless you change your election, and
- Transition pay designated as relating to a WARN Act event.

The percentage of pay you elect to contribute to the Plan will not be applied to the following types of pay:

- The 15% Walmart match on the Associate Stock Purchase Plan
- Reimbursement for expenses like relocation
- 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).

CHANGING YOUR 401(K) CONTRIBUTION AMOUNT

You can increase, decrease, stop, or begin your contributions at any time by logging on to **One.Walmart.com** or **benefits.ml.com**. You may also call the Customer Service Center at **888-968-4015**. Your change will be effective as soon as administratively feasible, normally within two pay periods. If you change your contribution amount, a confirmation notice will be sent to your home address or, if you have chosen electronic delivery of Plan documents, you will receive an email notification when the confirmation is available. It is your responsibility to review your paychecks to confirm that your election is implemented correctly. If you believe your election has not been implemented correctly, notify the Customer Service Center at **888-968-4015** in a timely manner, so that corrective steps can be taken. Your notification will not be considered timely if it is more than three months after the date you make your election. If you do not notify the Customer Service Center in a timely manner, the amount that is being withheld from your paycheck will be treated as your deferral election.

IF YOU ARE AGE 50 OR OLDER (CATCH-UP CONTRIBUTIONS)

If you are age 50 or older (or will be age 50 by the end of the applicable calendar year) and you are contributing up to the Plan or legal limits, you are allowed to make additional contributions. These are called "catch-up contributions" and are made by payroll deduction just like your other contributions. You can choose whether your catch-up contributions will be either pretax contributions or Roth contributions, or both. For 2023, your catch-up contributions may be any amount up to the lesser of $7,500 or 75% of your eligible annual pay. The dollar amount may be adjusted from time to time by the IRS. Your catch-up contributions will be credited to your Pretax Account or your Roth Account, depending on which type of contributions you elect to make. Remember, Roth contributions can be made only at **benefits.ml.com**.

For example, if you elect to contribute the maximum amount in the 2023 calendar year, which is the lesser of $22,500 or the maximum percentage of your eligible annual pay allowed under the Plan, you could elect to contribute up to an additional $7,500 during the 2023 calendar year. If you are interested in making catch-up contributions, you can enroll online at **One.Walmart.com** or **benefits.ml.com**, or by calling the Customer Service Center at **888-968-4015**.

CONTRIBUTING TO MORE THAN ONE PLAN DURING THE YEAR

The maximum total amount you can contribute (including pretax contributions and Roth contributions) to this Plan and to any other employer plan (including 403(b) annuity plans, simplified employee pensions or other 401(k) plans) is $22,500 for the 2023 calendar year, or $30,000 if you are eligible for catch-up contributions. This amount may be increased from time to time by the IRS. If you contribute to more than one plan during the year, it is your responsibility to determine if you have exceeded the legal limit.

If your total contributions go over the legal limit for a calendar year, you should request that the excess amount be refunded to you. The excess amount (except as noted below with respect to Roth contributions) must be included in your income for the year deferred and will be taxed. Earnings on the excess amount are taxable in the year refunded to you. In addition, if the excess amount is not refunded to you by April 15 following the year the amount was deferred, you will be taxed a second time when the excess amount is distributed to you. To request that excess contributions be returned to you from this Plan, contact the Customer Service Center at **888-968-4015** no later than April 1 following the calendar

year in which the excess contributions were made. The Administrator will establish procedures for determining whether your pretax contributions or Roth contributions will be returned to you, if you contributed both types of contributions during the calendar year. To the extent excess amounts are distributed from your Roth contributions, the Roth contributions will not be taxable to you, but related earnings that are distributed will be taxable to you. Any matching contributions related to refunded contributions will be forfeited.

IF YOU HAVE QUALIFIED MILITARY SERVICE

If you miss work because of qualified military service, you may be entitled under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) to make up contributions you miss during your military service (that is, to make contributions equal to the amount you would have been eligible to make if you were working for Walmart). For more information, contact the Customer Service Center at **888-968-4015**.

Making an In-Plan Roth Conversion

You can choose to convert all or any part of the vested contributions in your account (other than Roth contributions and related earnings, and funds that are part of an outstanding loan balance) to Roth contributions through an "In-Plan Roth Conversion." The contributions you choose to convert, along with any earnings on those contributions through the date of the conversion, will be subject to applicable federal, state, and local taxes in the year of conversion. No taxes will be withheld at the time of conversion, however, so it will be up to you to ensure that you can pay the related taxes when due. Accordingly you may want to increase your payroll withholdings or make estimated tax payments. The amount converted is not subject to a 10% penalty. Once converted, the funds may not be converted back to pretax funds.

The rules applicable to your funds after conversion differ depending on whether the funds were eligible for distribution from the Plan at the time of the conversion.

- If the funds you convert were otherwise eligible for distribution (for instance, you are age 59½) and eligible for rollover, then the funds will be treated as though they were distributed from the Plan and then rolled back into the Plan. This means they will be credited to your Roth Rollover Account and may be withdrawn at any time.
- If the funds you convert were not eligible for distribution, they will be credited to your Roth Account and will remain subject to the same distribution rules after the conversion as they were before the conversion. For instance, if you elect to convert your pretax salary deferral contributions, those funds generally will not be eligible for distribution until you reach age 59½, incur a financial hardship, or terminate employment.

Walmart's contributions to your Company Match Account

Once you are eligible to receive matching contributions, Walmart will make matching contributions to your Company Match Account equal to 100% of your subsequent contributions (including pretax, Roth, and catch-up contributions) for the Plan year, up to 6% of your eligible annual pay for the Plan year. Matching contributions are not made with respect to contributions you make before you become eligible for matching contributions. After you become eligible for matching contributions, the company matching contribution will be made to your Company Match Account each pay period until you reach the full amount of the company matching contribution for which you are eligible for that Plan year. Your eligible annual pay for this purpose is the same as outlined above for determining your 401(k) contributions to the Plan, but does not include amounts paid to you before you become eligible to receive matching contributions.

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 ($22,500 for 2023) 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 $22,500 in 401(k) contributions in January of 2023, 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, 2023.

As previously noted, if you miss work because of qualified military service, you may be entitled under USERRA to make up 401(k) contributions that you missed during your military service. If you do make up any 401(k) contributions, Walmart is required to make up matching contributions you would have received with respect to those contributions. If you think this rule applies to you, contact People Services at **800-421-1362**.

VESTING IN YOUR COMPANY MATCH ACCOUNT

You are always 100% vested in Walmart's matching contributions to your Company Match Account.

VESTING IN YOUR COMPANY FUNDED PROFIT SHARING ACCOUNT

If you have a Company Funded Profit Sharing Account (see **Your Walmart 401(k) Plan accounts** earlier in this summary), the vested percentage of your Company Funded Profit Sharing Account is the portion that you are entitled to receive if you leave Walmart. Your account statements show your vested percentage.

You become vested in your Company Funded Profit Sharing Account (other than rollovers in that account, which are always 100% vested) depending on your years of service with Walmart as follows:

PROFIT SHARING VESTING SCHEDULE*	
Years of service	**Vested percentage**
Less than 2	0%
2	20%
3	40%
4	60%
5	80%
6 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 for that year. (Note that years of service for this purpose are not determined by your anniversary date.)

If you leave Walmart because of retirement (at age 65 or older) or death, your Company Funded Profit Sharing Account will be 100% vested, regardless of your years of service. Your Company Funded Profit Sharing Account will also be 100% vested if the Plan is ever terminated.

VESTING IN YOUR COMPANY FUNDED 401(K) ACCOUNT

You are always 100% vested in Walmart's contributions to your Company Funded 401(k) Account.

Investing your account

YOUR INVESTMENT OPTIONS

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

- **The myRetirement Funds.** The myRetirement Funds are a series of customized investment options created solely for Plan participants by the Benefits Investment Committee, and are commonly known as "target retirement date" funds. The myRetirement Funds are diversified investment options that automatically change their asset allocation over time to become more conservative as you get closer to retirement. This is done by shifting the amount of money invested in more aggressive investments, such as stocks, and allocating those amounts to more conservative investments, such as bonds, as you near retirement.
- **From among a menu of investment options made available under the Plan.** Note that Walmart stock is an investment option only for your Company Funded Profit Sharing Account. Walmart stock is not available for investment through any of your other Plan accounts (although to the extent these other accounts hold Walmart stock, you may always sell such shares, but no future purchases of Walmart stock are allowed).

You may choose one of the investment options or you may spread your money among the various investment options. The investment gains or losses on your accounts depend on the performance of the investments you choose.

If you do not make an investment choice for current contributions to your account, they will be invested in one of the myRetirement Funds based on your age. For more information, refer to the Qualified Default Investment Alternative (QDIA) notice and the Investment Guide. These documents can be obtained by going to **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

Because the Company Funded Profit Sharing Account is an Employee Stock Ownership Plan, all or a significant portion of Walmart's profit-sharing contribution was invested in Walmart stock for Plan years ending prior to January 31, 2006. If you were a participant in the Plan prior to that date, you may have Walmart stock in your Company Funded Profit Sharing Account. For Plan years ending January 31, 2007 or later, Walmart's profit-sharing contribution was not invested in Walmart stock.

A description of all investment options, including the myRetirement Funds, is included in the enrollment packet you receive when you are eligible to enroll. You also may obtain additional information for each investment option by reviewing the Annual Participant Fee Disclosure Notice and Investment Guide. You may obtain these documents free of charge by accessing your account online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

Please note that this Plan is intended to be an "ERISA Section 404(c) plan." This means that you assume all investment risks connected with the investment options you choose in the Plan, or in which your funds are invested if you fail to make investment selections, including the increase or decrease in market value. Walmart Inc., the Benefits Investment Committee, and the trustee are not responsible for losses to your accounts which are the direct and necessary result of investment decisions you make or, if you fail to make an affirmative investment decision, as a result of your accounts being invested in a default fund.

If you have a Company Funded Profit Sharing Account (see **Your Walmart 401(k) Plan accounts** earlier in this summary) and you choose to invest some or all of your Company Funded Profit Sharing Account in Walmart stock or retain Walmart stock in your other accounts, be aware that since this option is a single stock investment, it generally carries more risk than the options offered through the Plan.

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 type "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 your Plan materials. It is your responsibility to make sure your change is made. If you do not receive a confirmation notice or you do not see that your change has been applied, contact the Customer Service Center at **888-968-4015**.

If you call the Customer Service Center prior to 3:00 p.m. Eastern time, your investment change generally will be processed on the day you call. Depending on the investment change, there may be up to a three-day settlement period before your funds are invested in your new election.

DIVERSIFICATION

To help you diversify your retirement savings, the Plan offers a variety of investment options with different levels of risk and potential for increase in value. To "diversify" means that you spread your assets among different types of investments. To help achieve long-term retirement security, you should give careful consideration to the benefits of a well-balanced and diversified investment portfolio. This strategy can help reduce risk and may provide consistent returns because a decline in the value of one investment may potentially be offset by an increase in the value of another. If you invest more than 20% of your retirement savings in any one stock, such as Walmart stock, or any one industry, your savings may not be properly diversified. Although diversification cannot ensure a profit or protect against loss, it can be an effective strategy to help you manage investment risk.

When deciding how to invest your retirement savings, you should take into account all of your assets, including any retirement savings outside of the Plan. For example, you may own Walmart stock through other means. No single approach is right for everyone because, among other factors, individuals have different financial goals, different time horizons for meeting their goals, and different tolerances for risk. Keep in mind your rights to diversify your Plan account and carefully consider how you choose to invest your Plan account. For information about your right to diversify your account and all of the investment options available under the Plan, access your account online at **benefits.ml.com** or call the Customer Service Center at **888-968-4015**. It is also important to periodically review your investment portfolio, your investment objectives, and the investment options under the Plan to help ensure that your investments remain appropriate for your retirement goals and your tolerance for investment risk. For more sources on individual investing and diversification, visit the website of the Department of Labor's Employee Benefits Security Administration at **www.dol.gov/agencies/ebsa** and type "investing and diversification" in the search field.

More about owning Walmart stock

VOTING

If any of your account is invested in Walmart stock through the Plan, each year you will receive 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 are mailed to your home address or sent electronically, based on your online elections.

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 on how you would like your shares voted, the Benefits Investment Committee will vote those shares at its discretion. If neither you nor the Benefits Investment Committee exercise voting rights, the trustee or an independent fiduciary appointed by the trustee may vote the unvoted shares.

CONFIDENTIALITY

Procedures have been designed to protect the confidentiality of your rights with respect to shares of Walmart stock held under the Plan, including the right to purchase, sell, hold, or vote on proxy matters. For example, procedures with the Company's transfer agent for Walmart stock have been implemented that prevent Walmart Inc. and the Benefits Investment Committee from finding out how any individual participant or beneficiary voted (except as necessary to comply with securities laws) and from having access to your individual proxy cards or proxy card shareholder comments.

In addition, access to information about your decisions to buy, sell, or hold Walmart stock generally is limited to those assisting in the administration of the Plan. The Benefits Investment Committee is responsible for ensuring that these procedures are sufficient to protect the confidentiality of this information and that the procedures are being followed. If the Benefits Investment Committee determines that a situation has potential for undue influence by the Walmart with respect to your rights as shareholder (through your Plan Account), the Benefits Investment Committee will appoint an independent party to perform activities that are necessary to prevent undue influence.

DIVIDENDS ON YOUR WALMART STOCK

If you have Walmart stock in your accounts, your accounts will be credited with any dividends paid by Walmart Inc. with respect to its stock. Dividends allocated to your Pretax Account, your Company Funded 401(k) Account or your 401(k) Rollover Account will be automatically reinvested in Walmart stock. Dividends allocated to your Company Funded Profit Sharing Account (and Profit Sharing Rollover Account) will also be reinvested in Walmart stock, except as noted below.

If you are an active participant (excludes beneficiaries and alternate payees, as defined in the **If you get divorced** section) with six or more years of service, you have an option to take a cash payout of any dividends paid on Walmart stock held in your Company Funded Profit Sharing Account or Profit Sharing Rollover Account (even if those amounts have been converted to a Roth Account or a Roth Rollover Account). Also, if you are a terminated participant who had more than six years of service when you terminated and you continue to maintain your accounts in the Plan after you leave, you will have the option to elect a cash payout of dividends paid on Walmart stock held in your Company Funded Profit Sharing Account or Profit Sharing Rollover Account (even if those amounts have been converted to a Roth Account or a Roth Rollover Account). If you do not opt for the cash payout, your dividends will be reinvested in Walmart stock.

You may make an election any time by calling the Customer Service Center at **888-968-4015**. Your most recently filed election will apply to all subsequent dividends until you change your election. (You may change your election only once each business day.) Keep in mind that your election must be made no later than the close of business on the day prior to the record date for the dividend in order to be effective for that dividend. You will not be able to make any elections or election changes during the period from the record date of the dividend through the dividend pay date (which is usually three to four weeks after the record date).

Each year, Walmart Inc. releases the quarterly record dates for dividend payouts. You can find this information on **walmart.com**. You may also contact the Customer Service Center at **888-968-4015** if you need information about upcoming record dates for dividends. Keep in mind that a dividend payout is taxable to you.

Note that if you request a hardship payout within five business days of the record date for a dividend and you have the right to elect a cash distribution of the dividend, tax laws require that the dividend be automatically paid to you in cash.

Account balances and statements

At least once a year, you'll receive a statement on your accounts showing contributions made by you and by Walmart, if any, the performance of your investment options, the values of your accounts, and fees assessed to your account. You can easily get information about your accounts, including a quarterly statement, at any time online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**. You can also request a paper copy of any quarterly statement at any time free of charge by calling the Customer Service Center.

FEES CHARGED TO YOUR ACCOUNT

Administrative and investment fees may be assessed to your accounts. Information on fees can be found in the Annual Participant Fee Disclosure Notice and online at **benefits.ml.com**.

Receiving a payout while working for Walmart

Generally, you are not entitled to a payout from the Walmart 401(k) Plan until you stop working for Walmart. However, in the following limited situations you may be entitled to receive a payout or loan of some or all of your vested accounts while you're still working:

- In the case of a financial hardship.
- After you reach age 59½.
- In connection with the birth or adoption of your child.
- Rollovers can be withdrawn at any time.
- You may request a loan from your Plan account.

It's important to understand how any type of payout or loan from the Walmart 401(k) Plan affects your tax situation. For more information, see **The income tax consequences of a payout** later in this summary.

Note that if you become an associate of Walmart or any subsidiary as the result of the acquisition of your prior employer, and you participated in your prior employer's 401(k) plan and that plan was merged into this Plan, you may have other withdrawal options with respect to amounts from your prior employer's plan. For more information regarding withdrawal options available for your other accounts, call the Customer Service Center at **888-968-4015**.

FINANCIAL HARDSHIP WITHDRAWALS

You may withdraw some or all of your vested Account as necessary to meet a "financial hardship." You will be required to certify that you have insufficient cash or other liquid assets to satisfy the need.

Under IRS guidelines, a financial hardship may exist if the request is for:

- Payment of medical care expenses not covered by insurance for you, your spouse, your dependents, or your affirmatively designated primary beneficiary
- Costs directly related to the purchase of your primary residence
- Payment of tuition, fees, and room and board expenses for up to the next 12 months of post-high school education for you, your spouse, your dependents, or your affirmatively designated primary beneficiary
- Payments necessary to prevent eviction from, or foreclosure on, your primary residence
- Payment for burial or funeral expenses for your deceased parent, spouse, children, dependent, or your affirmatively designated primary beneficiary, or
- Expenses for the repair of damage to your principal residence that would qualify for a casualty deduction under federal income tax rules (determined without regard to whether the casualty was a federally declared disaster and whether the loss exceeds 10% of your adjusted gross income).
- Expenses and losses (including loss of income) incurred by you on account of a disaster declared by the Federal Emergency Management Act (FEMA) under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, provided your principal residence or principal place of employment at the time of the disaster was in an area designated for individual assistance with respect to disaster.

Federal tax law requires that you must have already obtained all in-service payouts available (including in-service withdrawals of rollover contributions and withdrawals after age 59½) before you can request a financial hardship payout. Also, please note that if you request a financial hardship payout within five business days of the record date of a dividend and you are entitled to elect a cash payout of that dividend, the dividend will automatically be distributed to you in cash.

A financial hardship payout is immediately taxable to you (other than Roth contributions and, if the payout is a qualified distribution, earnings on your Roth contributions), including a 10% penalty tax if you are under age 59½ or if the payout is not for certain medical purposes. 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. 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 RELATED TO THE BIRTH OR ADOPTION OF YOUR CHILD

You may request a withdrawal of up to $5,000 from the vested portion of your Plan account within one year of the birth or adoption of your child. In the case of adoption, the adoptee must be under the age of 18 or physically or mentally incapable of self-support, and must not be the child of your spouse. You are required to make a representation to the Plan that the withdrawal is related to the birth or adoption of your child.

NOTE: Your distribution will not be considered a qualified birth or adoption distribution unless you include the name, age, and taxpayer identification number of the child or adoptee on your federal income tax return for the year in which the distribution is made.

WITHDRAWALS OF ROLLOVER CONTRIBUTIONS

You may withdraw all or any portion of your Pretax Rollover Account, Roth Rollover Account, and your Profit Sharing Rollover Account at any time even if you are still working for Walmart or its subsidiaries. (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. The Administrator has established a written loan program explaining the Plan's loan requirements in detail. You can request a copy of the loan program or make a request for a loan online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

Generally, the rules for loans include the following:

- The maximum loan amount is limited by IRS rules, which generally limit your total loan balances to the lesser of (1) 50% of the total of your vested Plan account, or (2) $50,000 (reduced by the excess, if any, of your highest outstanding loan balance during the one-year period prior to the date of the loan over your current outstanding balance of loans). The minimum loan amount is $1,000.
- All loans must be secured by a pledge of up to one-half of your vested Plan account.
- A fee will be charged to process your loan application. Additional fees may be 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 (other than Roth contributions) is taxable to you as ordinary income and could be subject to excise taxes. A Form 1099-R will be issued to you and the total amount of the distribution will be reported to the IRS.

When you are on an authorized unpaid leave of absence, you may be excused from making scheduled loan repayments for a period of up to one year. If you have an outstanding loan when you are called to qualified military service, special rules under USERRA may apply. Call the Customer Service Center at **888-968-4015** for more details.

If you die: your designated beneficiary

In the event of your death, your entire Plan balance will be paid out to your beneficiary. It is very important for you to keep your beneficiary information up to date to ensure that your beneficiary under the Plan reflects your current intent. Active associates may make beneficiary choices at **One.Walmart.com**. (Note that your spouse's consent must still be completed on Form B, as explained below.) If you are no longer employed by Walmart, you may obtain a paper beneficiary designation form by contacting People Services.

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. (Note that spousal consents or waivers in any other documents between you and your spouse are not recognized by the Plan for this purpose.) The Spousal Consent form must be notarized and must accompany the Form B in order to be valid. Form B and the Spousal Consent form may be obtained by calling People Services. Any beneficiary designation you make will be effective for all of your Plan accounts.

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 beneficiary designation will not be effective after the divorce unless you complete a new beneficiary 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.

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.

NOTE: Effective June 26, 2013, your same-sex spouse is treated in the same manner as an opposite-sex spouse for Plan purposes. Keep in mind that if you had a same-sex spouse on that date, any beneficiary designation you had in effect which designated someone other than your spouse as your beneficiary became invalid on that date. Your spouse will automatically be your beneficiary unless you make a new beneficiary designation with your spouse's consent.

Effective January 1, 2014, 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 Pretax Account, your Roth Account, your Company Funded 401(k) Account, your Company Match Account, and your Rollover Accounts. Similarly, if you made a beneficiary designation under the Profit Sharing Plan on or before October 31, 2003, that designation will continue to apply to your Company Funded Profit Sharing Account and Profit Sharing Rollover Account. If you change your beneficiary designation after October 31, 2003, it will apply to all Plan accounts and any prior designations will be ineffective.

Note that changes in your relationship status may affect your beneficiary designation, as explained above.

Again, it is very important for you to keep your beneficiary information up to date. Beneficiary designations should be made at **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 account or as directed in the Order.

If you leave Walmart

When you stop working for Walmart, you are entitled to receive a payout of your vested accounts in the Plan.

It is important to understand how any type of payout from the Walmart 401(k) Plan affects your tax situation. For more information, see **The income tax consequences of a payout** later in this summary.

You may elect to receive your payout 30 calendar days after your termination is entered into the payroll system. For example, if your termination is entered into and processed by the payroll system on July 19, 2022, you may elect your payout on or after August 18, 2022.

A notice informing you that you are entitled to payment will normally be mailed to your home address or sent electronically, based on your delivery elections, after you leave Walmart and its subsidiaries. Please make sure that your address is correct on your payroll check when you leave Walmart and its subsidiaries or that you give a forwarding address during your exit interview. If you have not received any information regarding your payout within 60 days of your termination date, contact the Customer Service Center at **888-968-4015**. To request your payout, you will need to access your account on **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

Your consent to the payout is not required and payout of your entire vested account will automatically be made to you:

- **If your total vested Plan balance is $1,000 or less at any time.** This automatic payout will be made as soon as possible after the last business day of the third calendar month following the calendar month in which your termination date is entered into the payroll system, unless you consent to an earlier payout, as described above. In the example above, if your account is eligible for automatic payout and you do not consent to payout on or after August 19, 2022, your payout will automatically be made to you as soon as possible after October 31, 2022, or
- **If you are over age 71½, 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 71½, unless you consent to an earlier

payout as described above. For instance, if you turn age 71½ in July 2022 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, 2022, according to Plan provisions.

If your total vested Plan balance is more than $1,000 and you are under age 71½, you must consent to payout of all or any portion of your account. Payout will be made as soon as possible after the Customer Service Center receives your consent, but no earlier than 30 calendar days after your termination is entered into the payroll system.

If your total vested Plan balance is more than $1,000, you can choose to delay some or all of your payout until any date up to age 71½, but your Plan balance will be subject to an annual maintenance fee and possibly other expenses. For information regarding these charges, refer to the Annual Participant Fee Disclosure Notice. If you choose to delay your payout, you will be able to continue to make changes in your investment choices just as you did while you were an active participant in the Plan.

If you return to work with Walmart before your payout is completed, the payout will be canceled and no payout will be made from your account.

THE AMOUNT OF YOUR PAYOUT

The entire value of your Pretax Account, your Roth Account, your Company Funded 401(k) Account, your Rollover Accounts, and the Company Match Account will be available to be paid out to you. In addition, if you have a Company Funded Profit Sharing Account (see **Your Walmart 401(k) Plan accounts** earlier in this summary), the vested portion of your Company Funded Profit Sharing Account will also be available for payout to you. You will forfeit (give up) the nonvested portion of your Company Funded Profit Sharing Account, as explained in the **Vesting in your company funded profit sharing account** section earlier in this summary.

The amount you will receive will be based on the value of your accounts as of the date the payout is processed. If a cash payout is made directly to you rather than rolled over to an IRA or other employer plan, applicable taxes will be withheld from your check.

A check processing fee will be applied to your Plan balance when it is paid out to you.

HOW YOU RECEIVE YOUR PAYOUT

You have several options for receiving your payout.

Your accounts will normally be paid to you in cash. However, you may elect to have your Company Funded Profit Sharing Account and Profit Sharing Rollover Account (even if those amounts have been converted to your Roth Account or Roth Rollover Account) distributed to you in the form of Walmart stock (even if it is not invested in Walmart stock at the time your payout is processed) or partly in cash and partly in Walmart stock. (Only whole shares of Walmart stock will be distributed; partial shares will be distributed in cash.) You may also elect to have your Pretax Account, your Company Funded 401(k) Account, and your Rollover Accounts (even if those amounts have been converted to your Roth Account or Roth Rollover Account) paid to you in Walmart stock to the extent those accounts are invested in Walmart stock at the time your payout is processed. Any part of those accounts not invested in Walmart stock at the time of your payout will be distributed in cash.

If the total of your vested accounts is $1,000 or less, or if you are over age 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 an IRA or other employer plan, you must contact the Customer Service Center at **888-968-4015** with your payout instructions within the time period shown in your payout notice. If you fail to contact the Customer Service Center in a timely manner, your payout will be made in a single cash payment to you.

If the total of your vested accounts in the Plan is more than $1,000, your payout will not be made until you make an election regarding the form of payout and consent to the distribution, or until you reach age 71½. You can choose to take all or any portion of your vested account. (Note, however, that if you take a partial payout of your account and the amount remaining in your account drops to $1,000 or less, it will be cashed-out as explained above.) To obtain your payout, contact the Customer Service Center at **888-968-4015**.

Your accounts normally will be distributed directly to you, unless you elect to roll them over to an IRA or to another employer's retirement plan.

NOTE: If your vested account cannot be paid to you because you cannot be found, the Administrator will make a diligent attempt to locate you. If you still cannot be found, your vested account will be forfeited. If you are later found, your account will be reinstated but you will not receive any earnings for the period after forfeiture. (This also applies if you die and your beneficiary cannot be located.) Thus, it is important that you make sure you update your contact information if there is a change.

If you leave and are rehired by Walmart

If you leave Walmart and its subsidiaries and are later rehired as an eligible associate, you will be immediately eligible to make your own contributions to the Plan on your date of rehire.

If you leave Walmart and its subsidiaries after you became eligible to receive matching contributions and are later rehired by Walmart, you will automatically be eligible to receive matching contributions on your rehire date. Similarly, if you leave Walmart and its subsidiaries after you have met the 1,000-hour requirement for matching contribution eligibility but before your actual participation date, you will be eligible to receive matching contributions beginning on the later of the date you would have initially become a participant or your rehire date (with respect to contributions you make after that date). If you were not a participant when you left, or had not satisfied the 1,000-hour requirement, you will be required to complete the eligibility requirements (see **When participation begins** earlier in this summary) in order to be eligible to receive matching contributions under 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 of service or less. If you are absent from work due to an FMLA leave and have worked 500 hours or less in the Plan year, you will be credited with enough hours to bring you up to 500.01 hours so that you will not incur a break in service.

The nonvested portion of your Company Funded Profit Sharing Account that was forfeited will be reinstated (at its former value) if you are rehired by Walmart or subsidiary before you have five consecutive breaks in service and you pay back to the Plan the total amount of your payout within five years after you are rehired. If you return to work with Walmart or a subsidiary after five or more consecutive breaks in service, or if you chose not to repay your payout as discussed above, the nonvested portion of your Company Funded Profit Sharing Account that was forfeited will not be reinstated.

If you were zero percent vested in your Company Funded Profit Sharing Account when you terminated employment, your nonvested Company Funded Profit Sharing Account will automatically be reinstated if you are rehired prior to five consecutive breaks in service.

Forfeitures of nonvested Company Funded Profit Sharing Accounts of terminated participants generally are used to pay Plan expenses and for certain other purposes, such as to restore account balances as discussed above.

When you are rehired, your years of service with Walmart before you left will be counted for purposes of determining your vesting in your Company Funded Profit Sharing Account.

The income tax consequences of a payout

The tax consequences of your participation in the Plan are your responsibility. This explanation is only a brief description of the U.S. federal tax consequences related to your participation in the Plan. This description is based on current law and current interpretations of the law by the Internal Revenue Service. Because the law is subject to change and because the application of the law may vary depending on your particular circumstances, this description is general in nature and you should not rely on it in determining your tax consequences. You are strongly urged to consult a tax advisor.

Walmart is entitled to a deduction on the amount of its contributions, as well as your contributions, to the Plan. Your pretax contributions and Walmart's contributions to the Plan, as well as earnings on those contributions, generally are not subject to federal income taxes until they are paid to you (or you elect to make an In-Plan Roth Conversion of such amounts). You are taxed on your Roth contributions when you contribute them to the Plan. Earnings on Roth contributions are not taxed unless you take a distribution that is not a qualified distribution. (See **Taxation of payouts of Roth contributions** below.)

POSTPONE PAYING TAXES ON PAYOUTS THROUGH A ROLLOVER (OTHER THAN A ROTH IRA ROLLOVER)

Although payouts from the Plan (other than from your Roth and Roth Rollover Accounts) are subject to federal income taxes, the Internal Revenue Code provides favorable tax treatment to payouts in certain circumstances. For example, you can postpone paying taxes on your payout if you direct the Plan to issue your payout directly to an IRA or to another employer's qualified retirement plan, a 403(b) plan, or a governmental 457 plan. This is called a direct rollover. (The check will be made payable to the IRA or other plan trustee and will be delivered to you or your IRA or rollover institution. If the check is mailed to you, you will be responsible for delivering it to the IRA or other plan trustee within 60 days.)

If you elect this method for your payout, no taxes will be withheld from the amount you are rolling over. It will not be taxed until you later receive a payout from the IRA or other plan.

If you do not elect to have your payout directly rolled over, federal law requires that Walmart withhold 20% of the payout for federal taxes, in addition to any required state withholding. In some cases, 20% withholding may not be enough, which could mean that you will owe additional taxes when you file your income tax return.

If you do not elect a direct rollover (and instead receive an actual payout from the Plan), you may still roll over those funds to an IRA or an employer's qualified retirement plan, 403(b) plan, or governmental 457 plan, as long as you do so within 60 calendar days after you received the distribution. The amount rolled over will not be subject to federal income tax until you take it out of the IRA or other plan. If you want to roll over 100% of your payout to an IRA or other plan, however, you will have to use other money to replace the 20% that was withheld from your payout. If you roll over only the 80% that you received, you will be taxed on the 20% that was withheld.

NOTE: You may roll over all or any portion of your account that is eligible for rollover to a Roth IRA. Any amount rolled over that would have been taxable if not rolled over will be taxable at the time of the rollover to the Roth IRA. (Note that you may voluntarily choose to have taxes withheld from amounts at the time you roll over to a Roth IRA.)

For more information regarding these rollover rules, review the **Special tax notice addendum** that follows. Retain this addendum for review when you are eligible to take a distribution.

TAXATION OF PAYOUTS OF ROTH CONTRIBUTIONS

Your Roth contributions and earnings on those contributions are not taxed when distributed from the Plan as long as the distribution is a "qualified" distribution. A "qualified" distribution is a distribution that is made: (1) on account of your death, disability, or after you attain age 59½, and (2) after you have completed a five-year participation period. The five-year participation period is the five-year period beginning with the first calendar year in which in which you first make a Roth contribution to the Plan (or to another 401(k) plan or 403(b) plan, if such amount was rolled over to this Plan) and ending on the last day of the fourth calendar year thereafter. For instance, if you make your first Roth contribution in July 2020, your five-year participation period will end on December 31, 2024. It is not necessary that you make a Roth contribution in each of the five years.

If you receive a distribution from your Roth contributions and earnings on those contributions that is not a "qualified" distribution, the earnings on your Roth contributions will be taxable to you at the time of distribution (unless you roll over the distribution to a Roth IRA or a designated Roth account in another employer plan). If you do roll over your Roth contributions and earnings, you will not have to pay taxes currently on the earnings and you will not have to pay taxes later on payouts that are qualified distributions.

Your Roth contributions may be rolled over only to a Roth IRA or a designated Roth account in another employer plan. If the rollover is to a designated Roth account in another employer plan, the rollover generally must be a direct rollover (unless the amount being rolled over includes only amounts that would have been taxable if distributed to you).

NOTE: if you elect an In-Plan Roth Conversion, the amount converted is treated as a Roth contribution made at the time of the conversion. When those amounts are later distributed, the rules described above generally apply. For this purpose, an In-Plan Roth Contribution will be considered a contribution for purposes of starting the five-year participation period described above.

For more information regarding these rollover rules, review the **Special tax notice addendum: Roth contributions** that follows. Retain this addendum for review when you are eligible to take a distribution.

EARLY WITHDRAWAL PENALTY

If you take a payout prior to age 59½ rather than rolling it over, in most cases you will be subject to a 10% early withdrawal penalty by the IRS on the taxable portion of your payout. Thus, Roth contributions and, if they are distributed in a "qualified" distribution, earnings on those contributions, are not subject to the 10% early withdrawal penalty. There are some other exceptions to the penalty, such as death, disability, retirement after age 55, payouts for certain medical expenses, and payouts related to the birth or adoption of your child. Special rules also apply to distributions made to reservists who are called to active military duty.

TAXATION OF PAYOUTS OF WALMART STOCK

There are also special rules for distributions of Walmart common stock. If you receive cash (in excess of $200) in addition to Walmart stock and the cash is not directly rolled over, some withholding may apply, but the withheld amount will not be greater than the amount of cash you receive.

Generally, if you receive Walmart common stock as part of your payout that is not rolled over, you are taxed only on the value of the stock at the time it was purchased by the Plan.

Keep in mind that if you elect cash payouts of dividends paid on Walmart stock held in your Company Funded Profit Sharing Account, the dividend is taxable to you and is not eligible for rollover. The dividend is also taxable if you request a financial hardship payout from your account within five business days of the record date for a dividend and the dividend is automatically paid out to you in cash. The dividend payout is not subject to the 10% early withdrawal penalty discussed above. In some cases, Walmart Inc. will be entitled to deduct dividends paid on shares subject to this election.

TAXATION OF PAYOUTS TO BENEFICIARIES AND ALTERNATE PAYEES

The tax treatment discussed above applies only to payouts to participants. Different rules may apply to payouts to beneficiaries of deceased participants. In general, if your spouse is your beneficiary, he or she will have the same federal income tax treatment and rollover options that you would have had. Other beneficiaries, including partners, will only be entitled to a direct rollover to an inherited IRA or Roth IRA. The 10% early withdrawal penalty does not apply to payouts to your beneficiary.

The spouse or former spouse of a participant who receives a payout from the Plan under a qualified domestic relations order (QDRO) generally has the same federal income tax treatment and options as the participant would have had. In some cases, however, a payout on behalf of a non-spouse dependent, including a partner, pursuant to a QDRO (e.g., state-ordered child support) may result in federal income taxation to the participant even though the payout is made to or on behalf of the dependent alternate payee.

TAXATION OF LOANS

Under current tax law, loans made from the Plan, regardless of their purpose, are not considered taxable income to the participant unless a default occurs. If you default on a loan from the Plan (as discussed above), your tax statement will show the amount of income to report for the year of the default. You may also be subject to 10% early withdrawal penalty.

TAXATION OF QUALIFIED BIRTH OR ADOPTION DISTRIBUTIONS

If you receive a distribution related to the birth or adoption of your child, the distribution is taxable to you for federal income tax purposes, but is not subject to the 10% early withdrawal penalty. You may not roll over the distribution and Walmart is not required to withhold 20%, but you may voluntarily elect withholding.

Filing a Walmart 401(k) Plan claim

If you think you are entitled to a benefit beyond that processed by the Plan's recordkeeper (Bank of America), you may file a claim with the Administrator or its delegate at:

Walmart Inc.
Attn: 401(k) Plan Administrator
508 SW 8th Street
Bentonville, Arkansas 72716-0295

For questions about filing a claim, contact People Services at **800-421-1362**.

If your claim is partially or fully denied, you will receive written notice of the decision within a reasonable time, but no later than 90 days after the Administrator receives your claim. The Administrator or its delegate can extend this period for up to an additional 90 days if it determines that special circumstances require an extension. You will receive notice of any extension before the expiration of the original 90-day period. The written notice you receive will state the specific reasons for the denial of your claim, a specific reference to the provisions of the Plan upon which the denial is based, and a description of the review procedures and the time limits applicable to such procedures, including your right to bring a court action following a denial on appeal.

If you do not agree with the decision of the Administrator or its delegate, you can request a review of the decision by the Administrator. The Administrator has discretionary authority to resolve all questions concerning administration, interpretation or application of the Plan. Your request must be made in writing and sent to the Administrator at:

Walmart Inc.
Attn: Benefits Compliance
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.

NOTE: Due to COVID, your 60-day time period for requesting a review of your claim has been extended. The period from the date your claim is denied (but not earlier than March 1, 2020) through the earlier of one year from that date or the date that is 60 days after the announced end of the National Emergency related to the COVID-19 outbreak is disregarded.

The Administrator will promptly conduct the review. Written notice of the Administrator's decision on review will be provided to you within 60 calendar days after the receipt of your request, unless special circumstances require an

extension of up to 60 additional days. In those circumstances where the review is delayed to allow you to provide additional information necessary for a proper review, the length of the delay will not be included in the calculation of the 60-day deadline and extension periods set forth above. The written notice of the Administrator's decision will include specific reasons for the decision and will refer to the specific provisions of the Plan on which the decision is based.

You must exhaust these procedures before you can file a lawsuit with respect to your Plan benefits. If you file a lawsuit, it must be filed within one year from the date of your payout or, if no payout is made, the date your request for benefits is denied, in whole or in part, by the Administrator on appeal (or, if earlier, the date the Administrator fails to respond to your claim or appeal within the time periods provided above).

Administrative information

PLAN NAME

The legal name of the Plan is the Walmart 401(k) Plan.

PLAN SPONSOR AND ERISA PLAN ADMINISTRATOR

Walmart Inc. is the Plan Sponsor. Its contact information for matters pertaining to the Plan is:

Walmart Inc.
Attn: 401(k) Plan Administrator
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 Internal Revenue Code and ERISA, except for those obligations delegated to the Administrator, the Benefits Investment Committee or the trustee of the Trust. ERISA is the federal law that imposes certain responsibilities on Walmart Inc., the Administrator, the Benefits Investment Committee and the trustee with respect to your retirement benefits.

Subsidiaries of Walmart Inc. are permitted to participate in the Plan. You may obtain a list of subsidiaries currently participating in the Plan by contacting People Services.

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER

71-0415188

NAMED ADMINISTRATIVE FIDUCIARY

The individual from time to time holding the position of Senior Vice President, Global 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
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. 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

Northern Trust Company
50 S. LaSalle Street
Chicago, Illinois 60603

One or more trusts hold all Plan assets, such as contributions by participants and Walmart's contributions. As trustee of the Trust, Northern Trust Company receives and holds contributions made to the Plan in trust and invests those contributions according to the policies established under the Plan.

AGENT FOR SERVICE OF LEGAL PROCESS

Corporation Trust Company
1209 Orange Street
Corporation Trust Center
Wilmington, Delaware 19801

Service of legal process may also be made on the ERISA Plan Administrator or the trustee.

PLAN NUMBER

003

PLAN YEAR

February 1 through January 31

TYPE OF PLAN

The Walmart 401(k) Plan is a defined contribution plan (401(k), profit sharing, and employee stock ownership plan).

ASSIGNMENT

Because this is a retirement plan governed by ERISA and other federal laws, your accounts cannot be assigned or used as collateral for a loan, nor can your accounts be garnished or be subject to bankruptcy proceedings. They can, however, be part of a divorce settlement, as explained in the **If you get divorced** section earlier in this summary. Additionally, in some cases, the IRS may enforce a federal tax levy against your accounts to repay federal taxes you owe.

NO PBGC COVERAGE

ERISA created a governmental agency called the Pension Benefit Guaranty Corporation (PBGC). One of the purposes of the PBGC is to insure the benefits payable under defined benefit plans. The PBGC does not, however, provide coverage for defined contribution plans. Because the Plan is a defined contribution plan, it is not eligible for coverage by the PBGC.

PLAN AMENDMENT OR TERMINATION

Walmart reserves the right to amend or terminate the Plan at any time. Amendments are made by Walmart's Board of Directors or by its Executive Vice President, 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 or a participating subsidiary, by the Administrator, by any member of the Benefits Investment Committee or by Merrill Lynch.

You may obtain a copy of the formal Plan document by writing to:

Walmart Inc.
Attn: Benefits Compliance
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 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 NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Special tax notice addendum

YOUR ROLLOVER OPTIONS

The law requires that participants receive this notice before receiving a distribution from the Plan that is eligible to be rolled over to an IRA or an employer plan. You may or may not currently be eligible to receive a distribution from the Plan. If you are eligible for a distribution, however, you should review this notice carefully before you elect a distribution from the Plan. This notice is intended to help you decide whether to elect a rollover. If you are not currently eligible for a distribution, you should retain this notice and review it when you are eligible for a distribution.

Rules that apply to most payments from the Plan are described in the **General information about rollovers** section. Special rules that only apply in certain circumstances are described in the **Special rules and options** section.

This notice describes the rollover rules that apply to payouts from the Plan, other than those from a designated Roth account. If you also receive a payment from your Roth or Roth Rollover Account in the Plan, see the **Special tax notice addendum: Roth contributions** addendum that follows this notice.

GENERAL INFORMATION ABOUT ROLLOVERS

How can a rollover affect my taxes? You will be taxed on a payment from the Plan if you do not roll it over. If you are under age 59½ and do not do a rollover, you will also have to pay a 10% additional income tax on early distributions (generally, distributions made before age 59½), unless an exception applies. However, if you do a rollover, you will not have to pay tax until you receive payments later and the 10% additional income tax will not apply if those payments are made after you are age 59½ (or if an exception to the 10% additional income tax applies).

What types of retirement accounts and plans may accept my rollover? You may roll over the payment to either an IRA (an individual retirement account or individual retirement annuity) or an employer plan (a tax-qualified plan, section 403(b) plan, or governmental section 457(b) plan) that will accept the rollover. The rules of the IRA or employer plan that holds the rollover will determine your investment options, fees, and rights to payment from the IRA or employer plan (for example, IRAs are not subject to spousal consent rules, and IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the IRA or employer plan.

Where may I roll over the payment? You may roll over the payment to either an IRA (an individual retirement account or individual retirement annuity, including a Roth IRA) or an employer plan (a tax-qualified plan, section 403(b) plan or governmental section 457(b) plan) that will accept the rollover. The rules of the IRA or employer plan that holds the rollover will determine your investment options, fees and rights to payment from the IRA or employer plan (for example, no spousal consent rules apply to IRAs and IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the IRA or employer plan.

How do I do a rollover? There are two ways to do a rollover. You can do either a "direct rollover" or a "60-day rollover."

If you do a "direct rollover," the Plan will make the payment directly to your IRA or an employer plan. You should contact the IRA sponsor or the administrator of the employer plan for information on how to do a direct rollover.

If you do not do a direct rollover, you may still do a rollover by making a deposit into an IRA or eligible employer plan that will accept it. You will have 60 days after you receive the payment to make the deposit. If you do not do a direct rollover, the Plan is required to withhold 20% of the payment for federal income taxes (up to the amount of cash and property received, other than employer stock). This means that, in order to roll over the entire payment in a 60-day rollover, you must use other funds to make up for the 20% withheld. If you do not roll over the entire amount of the payment, the portion not rolled over will be taxed and will be subject to the 10% additional income tax on early distributions if you are under age 59½ (unless an exception applies).

How much may I roll over? If you wish to do a rollover, you may roll over all or part of the amount eligible for rollover. Any payment from the Plan is eligible for rollover, except:

- Required minimum distributions after age 70½ (if you were born before July 1, 1949), after age 72 (if you were born after June 30, 1949), or after death
- Hardship distributions
- Payments of employee stock ownership plan (ESOP) dividends
- Corrective distributions of contributions that exceed tax law limitations, and
- Loans treated as deemed distributions (for example, loans in default due to missed payments before your employment ends).

The Plan Administrator or the payor can tell you what portion of a payment is eligible for rollover.

If I don't do a rollover, will I have to pay the 10% additional income tax on early distributions? If you are under age 59½, you will have to pay the 10% additional income tax on early distributions for any payment from the Plan (including amounts withheld for income tax) that you do not roll over, unless one of the exceptions listed below applies. This tax applies to the part of the distribution that you must include in income and is in addition to the regular income tax on the payment not rolled over.

The 10% additional income tax does not apply to the following payments from the Plan:

- Payments made after you separate from service if you will be at least age 55 in the year of the separation
- Payments made due to disability
- Payments after your death
- Payments of ESOP dividends
- Corrective distributions of contributions that exceed tax law limitations
- Payments made directly to the government to satisfy a federal tax levy
- Payments made under a qualified domestic relations order (QDRO)
- Payments of up to $5,000 made to you from a defined contribution plan if the payment is a qualified birth or adoption distribution
- Payments up to the amount of your deductible medical expenses (without regard to whether you itemize deductions for the taxable year)
- Certain payments made while you are on active duty if you were a member of a reserve component called to duty after September 11, 2001 for more than 179 days, and
- Payments excepted from the additional income tax by federal legislation relating to certain emergencies and disasters.

If I do a rollover to an IRA, will the 10% additional income tax apply to early distributions from the IRA? If you receive a payment from an IRA when you are under age 59½, you will have to pay the 10% additional income tax on early distributions on the part of the distribution that you must include in income, unless an exception applies. In general, the exceptions to the 10% additional income tax for early distributions from an IRA are the same as the exceptions listed above for early distributions from a plan. However, there are a few differences for payments from an IRA, including:

- The exception for payments made after you separate from service if you will be at least age 55 in the year of the separation does not apply.
- The exception for qualified domestic relations orders (QDROs) does not apply (although a special rule applies under which, as part of a divorce or separation agreement, a tax-free transfer may be made directly to an IRA of a spouse or former spouse).
- The exception for payments made at least annually in equal or close to equal amounts over a specified period applies (without regard to whether you have had a separation from service).
- Additional exceptions apply for payments from an IRA, including: (1) payments for qualified higher education expenses, (2) payments up to $10,000 used in a qualified first-time home purchase, and (3) payments for health insurance after you have received unemployment compensation for 12 consecutive weeks (or would have been eligible to receive unemployment compensation but for self-employed status).

Will I owe state income taxes? This notice does not address any state or local income tax rules (including withholding rules).

SPECIAL RULES AND OPTIONS

If your payment includes after-tax contributions: If you have after-tax contributions that were merged into the Walmart 401(k) Plan, those contributions are subject to special tax rules when they are distributed from the Walmart 401(k) Plan. (See the following Addendum if you have made Roth contributions to the Plan.)

After-tax contributions included in a payment are not taxed. If you receive a partial payment of your total benefit, an allocable portion of your after-tax contributions is included in the payment, so you cannot take a payment of only after-tax contributions. However, if you have pre-1987 after-tax contributions maintained in a separate account, a special rule may apply to determine whether the after-tax contributions are included in the payment. In addition, special rules apply when you do a rollover, as described below.

You may roll over to an IRA a payment that includes after-tax contributions through either a direct rollover or a 60-day rollover. You must keep track of the aggregate amount of the after-tax contributions in all of your IRAs (in order to determine your taxable income for later payments from the IRAs). If you do a direct rollover of only a portion of the amount paid from the Plan and at the same time the rest is paid to you, the portion rolled over consists first of the amount that would be taxable if not rolled over. For example, assume you are receiving a distribution of $12,000, of which $2,000 is after-tax contributions. In this case, if you directly roll over $10,000 to an IRA that is not a Roth IRA, no amount is taxable because the $2,000 amount not rolled over is treated as being after-tax contributions. If you do a direct rollover of the entire amount paid from the Plan to two or more destinations at the same time, you can choose which destination receives the after-tax contributions.

Similarly, if you do a 60-day rollover to an IRA of only a portion of a payment made to you, the portion rolled over consists first of the amount that would be taxable if not rolled over. For example, assume you are receiving a distribution of $12,000, of which $2,000 is after-tax contributions, and no part of the distribution is directly rolled over. In this case, if you roll over $10,000 to an IRA that is not a Roth IRA in a 60-day rollover, no amount is taxable because the $2,000 amount not rolled over is treated as being after-tax contributions.

You may roll over to an employer plan all of a payment that includes after-tax contributions, but only through a direct rollover (and only if the receiving plan separately accounts for after-tax contributions and is not a governmental section 457(b) plan). You can do a 60-day rollover to an employer plan of part of a payment that includes after-tax contributions, but only up to the amount of the payment that would be taxable if not rolled over.

If you miss the 60-day rollover deadline: Generally, the 60-day rollover deadline cannot be extended. However, the IRS has the limited authority to waive the deadline under certain extraordinary circumstances, such as when external events prevented you from completing the rollover by the 60-day rollover deadline. To apply for a waiver, you must file a private letter ruling request with the IRS. Private letter ruling requests require the payment of a nonrefundable user fee. For more information, see IRS Publication 590, *Individual Retirement Arrangements (IRAs).*

If your payment includes employer stock that you do not roll over: If you do not do a rollover, you can apply a special rule to payments of employer stock that are either attributable to after-tax contributions or paid in a lump sum after separation from service (or after age 59½, disability, or the participant's death). Under the special rule, the net unrealized appreciation on the stock will not be taxed when distributed from the Plan and will be taxed at capital gain rates when you sell the stock. Net unrealized appreciation is generally the increase in the value of employer stock after it was acquired by the Plan. If you do a rollover for a payment that includes employer stock (for example, by selling the stock and rolling over the proceeds within 60 days of the payment), the special rule relating to the distributed employer stock will not apply to any subsequent payments from the IRA or generally, the Plan. The Plan Administrator can tell you the amount of any net unrealized appreciation.

If you have an outstanding loan that is being offset: If you have an outstanding loan from the Plan, your Plan benefit may be offset by the outstanding amount of the loan, typically when your employment ends. The loan offset amount is treated as a distribution to you at the time of the offset. Generally, you may roll over all or any portion of the offset amount. Any offset amount that is not rolled over will be taxed (including the 10% additional income tax on early distributions, unless an exception applies). You may roll over offset amounts to an IRA or an employer plan (if the terms of the employer plan permit the plan to receive plan loan offset rollovers).

How long you have to complete the rollover depends on what kind of plan loan offset you have. If you have a qualified plan loan offset, you will have until your tax return due date (including extensions) for the tax year during which the offset occurs to complete your rollover. A qualified plan loan offset occurs when a plan loan in good standing is offset because your employer plan terminates, or because you sever from employment. If your plan loan offset occurs for any reason (such as a failure to make level loan repayments that results in a deemed distribution), then you have 60 days from the date the offset occurs to complete your rollover.

If you were born on or before January 1, 1936: If you were born on or before January 1, 1936 and receive a lump sum distribution that you do not roll over, special rules for calculating the amount of the tax on the payment might apply to you. For more information, see IRS Publication 575, *Pension and Annuity Income*.

If you roll over your payment to a Roth IRA: If you roll over a payment from the Plan to a Roth IRA, a special rule applies under which the amount of the payment rolled over (reduced by any after-tax amounts) will be taxed. In general, the 10% additional income tax on early distributions will not apply. However, if you take the amount rolled over out of the Roth IRA within the five-year period that begins on January 1 of the year of the rollover, the 10% additional income tax will apply (unless an exception applies). If you roll over the payment to a Roth IRA, later payments from the Roth IRA that are qualified distributions will not be taxed (including earnings after the rollover). A qualified distribution from a Roth IRA is a payment made after you are age 59½ (or after your death or disability, or as a qualified first-time homebuyer distribution of up to $10,000) and after you have had a Roth IRA for at least five years. In applying this five-year rule, you count from January 1 of the year for which your first contribution was made to a Roth IRA. Payments from the Roth IRA that are not qualified distributions will be taxed to the extent of earnings after the rollover, including the 10% additional income tax on early distributions (unless an exception applies). You do not have to take required minimum distributions from a Roth IRA during your lifetime. For more information, see IRS Publication 590, *Individual Retirement Arrangements (IRAs).*

If you do a rollover to a designated Roth account in the Plan: You cannot roll over a distribution to a designated Roth account in another employer's plan. However, you can roll the distribution over into a designated Roth account in the distributing Plan. If you roll over a payment from the Plan to a designated Roth account in the Plan, the amount of the payment rolled over (reduced by any after-tax amounts directly rolled over) will be taxed. In general, the 10% additional income tax on early distributions will not apply. However, if you take the amount rolled over out of the Roth IRA within the five-year period that begins on January 1 of the year of the rollover, the 10% additional income tax will apply (unless an exception applies). If you roll over the payment to a designated Roth account in the Plan, later payments from the designated Roth account that are qualified distributions will not be taxed (including earnings after the rollover). A qualified distribution from a designated Roth account is a payment made both after you are age 59½ (or after your death or disability) and after you have had a designated Roth account in the Plan for at least five years. In applying this five-year rule, you count from January 1 of the year your first contribution was made to the designated Roth account. However, if you made a direct rollover to a designated Roth account in the Plan from a designated Roth account in a plan of another employer, the five-year period begins on January 1 of the year you made the first contribution to the designated Roth account in the Plan or, if earlier, to the designated Roth account in the plan of the other employer. Payments from the designated Roth account that are not qualified distributions will be taxed to the extent of earnings after the rollover, including the 10% additional income tax on early distributions (unless an exception applies).

If you are not a Plan participant

Payments after death of the participant. If you receive a distribution after the participant's death that you do not roll over, the distribution generally will be taxed in the same manner described elsewhere in this notice. However, the 10% additional income tax on early distributions does not apply, and the special rule described under the section **If you were born on or before January 1, 1936** applies only if the deceased participant was born on or before January 1, 1936.

If you are a surviving spouse: If you receive a payment from the Plan as the surviving spouse of a deceased participant, you have the same rollover options that the participant would have had, as described elsewhere in this notice. In addition, if you choose to do a rollover to an IRA, you may treat the IRA as your own or as an inherited IRA.

An IRA you treat as your own is treated like any other IRA of yours, so that payments made to you before you are age 59½ will be subject to the 10% additional income tax on early distributions (unless an exception applies) and required minimum distributions from your IRA do not have to start until after you are age 70½ (if you were born before July 1, 1949) or age 72 (if you were born after June 30, 1949).

If you treat the IRA as an inherited IRA, payments from the IRA will not be subject to the 10% additional income tax on early distributions. However, if the participant had started taking required minimum distributions, you will have to receive required minimum distributions from the inherited IRA. If the participant had not started taking required minimum distributions from the Plan, you will not have to start receiving required minimum distributions from the inherited IRA until the year the participant would have been age 70½ (if the participant was born before July 1, 1949) or age 72 (if the participant was born after June 30, 1949).

If you are a surviving beneficiary other than a spouse: If you receive a payment from the Plan because of the participant's death and you are a designated beneficiary other than a surviving spouse, the only rollover option you have is to do a direct rollover to an inherited IRA or Roth IRA. Payments from the inherited IRA or Roth IRA will not be subject to the 10% additional income tax on early distributions. You will have to receive required minimum distributions from the inherited IRA or Roth IRA.

Payments under a QDRO: If you are the spouse or former spouse of the participant who receives a payment from the Plan under a QDRO, you generally have the same options and the same tax treatment that the participant would have (for example, you may roll over the payment to your own IRA or an eligible employer plan that will accept it). However, payments under the QDRO will not be subject to the 10% additional income tax on early distributions.

If you are a nonresident alien: If you are a nonresident alien and you do not do a direct rollover to a U.S. IRA or U.S. employer plan, instead of withholding 20%, the Plan is generally required to withhold 30% of the payment for federal income taxes. If the amount withheld exceeds the amount of tax you owe (as may happen if you do a 60-day rollover), you may request an income tax refund by filing Form 1040NR and attaching your Form 1042-S. See Form W-8BEN for claiming that you are entitled to a reduced rate of withholding under an income tax treaty. For more information, see also IRS Publication 519, *U.S. Tax Guide for Aliens*, and IRS Publication 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*.

OTHER SPECIAL RULES

If your payments for the year are less than $200 (not including payments from a designated Roth account in the Plan), the Plan is not required to allow you to do a direct rollover and is not required to withhold for federal income taxes. However, you may do a 60-day rollover.

You may have special rollover rights if you recently served in the U.S. Armed Forces. For more information on special rollover rights related to the U.S. Armed Forces, see IRS Publication 3, *Armed Forces' Tax Guide*. You also may have special rollover rights if you were affected by a federally declared disaster (or similar event), or if you received a distribution on account of a disaster. For more information on special rollover rights related to disaster relief, see the IRS website at **www.irs.gov**.

FOR MORE INFORMATION

You may wish to consult with the Plan Administrator or payor, or a professional tax advisor, before taking a payment from the Plan. Also, you can find more detailed information on the federal tax treatment of payments from employer plans in IRS Publication 575, *Pension and Annuity Income*; IRS Publication 590, *Individual Retirement Arrangements (IRAs)*; and IRS Publication 571, *Tax-Sheltered Annuity Plans (403(b) Plans)*. These publications are available from a local IRS office, on the web at **www.irs.gov**, or by calling **800-TAX-FORM**.

Special tax notice addendum: Roth contributions

YOUR ROLLOVER OPTIONS

The law requires that participants receive this notice before receiving a distribution from the Plan from your Roth Account (or any Roth amounts that were merged into the Plan from your prior employer's plan). You may or may not currently be eligible to receive a distribution from the Plan. If you are eligible for a distribution, however, you should review this notice carefully before you elect a distribution from the Plan. This notice is intended to help you decide whether to elect a rollover. If you are not currently eligible for a distribution, you should retain this notice and review it when you are eligible for a distribution.

Rules that apply to most payments from your Roth or Roth Rollover Account (referred to collectively in this addendum as your "Roth Account") are described in the **General information about rollovers** section. Special rules that only apply in certain circumstances are described in the **Special rules and options** section.

Rules that apply to payments from the Plan other than from your Roth Account are described in the separate **Special tax notice addendum** above.

GENERAL INFORMATION ABOUT ROLLOVERS

How can a rollover affect my taxes? After-tax contributions included in a payment from your Roth Account are not taxed, but earnings might be taxed. The tax treatment of earnings included in the payment depends on whether the payment is a qualified distribution. If a payment is only part of your Roth Account, the payment will include an allocable portion of the earnings in your Roth Account.

If the payment from the Plan is not a qualified distribution and you do not do a rollover to a Roth IRA or a designated Roth account in an employer plan, you will be taxed on the portion of the payment that is earnings. If you are under age 59½, a 10% additional income tax on early distributions (generally, distributions made before age 59½) will also apply to the earnings (unless an exception applies). However, if you do a rollover, you will not have to pay taxes currently on the earnings and you will not have to pay taxes later on payments that are qualified distributions.

If the payment from the Plan is a qualified distribution, you will not be taxed on any part of the payment even if you do not do a rollover. If you do a rollover, you will not be taxed on the amount you roll over and any earnings on the amount you roll over will not be taxed if paid later in a qualified distribution.

A qualified distribution from your Roth Account in the Plan is a payment made after you are age 59½ (or after your death or disability) and after you have had a Roth Account in the Plan for at least five years. In applying the five-year rule, you count from January 1 of the year your first contribution was made to the Roth Account. However, if you did a direct rollover to a Roth Account in the Plan from a designated Roth account in another employer plan, your participation will count from January 1 of the year your first contribution was made to the Roth Account in the Plan or, if earlier, to the designated Roth account in the other employer plan.

What types of retirement accounts and plans may accept my rollover? You may roll over the payment to either a Roth IRA (a Roth individual retirement account or Roth individual retirement annuity) or a designated Roth account in an employer plan (a tax-qualified plan, section 403(b) plan, or governmental section 457 plan) that will accept the rollover. The rules of the Roth IRA or employer plan that holds the rollover will determine your investment options, fees, and rights to payment from the Roth IRA or employer plan (for example, Roth IRAs are not subject to spousal consent rules, and Roth IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the Roth IRA or the designated Roth account in the employer plan. In general, these tax rules are similar to those described elsewhere in this notice, but differences include:

- If you do a rollover to a Roth IRA, all of your Roth IRAs will be considered for purposes of determining whether you have satisfied the five-year rule (counting from January 1 of the year for which your first contribution was made to any of your Roth IRAs).
- If you do a rollover to a Roth IRA, you will not be required to take a distribution from the Roth IRA during your lifetime and you must keep track of the aggregate amount of the after-tax contributions in all of your Roth IRAs (in order to determine your taxable income for later Roth IRA payments that are not qualified distributions).
- Eligible rollover distributions from a Roth IRA can only be rolled over to another Roth IRA.

How do I do a rollover? There are two ways to do a rollover. You can either do a direct rollover or a 60-day rollover.

If you do a direct rollover, the Plan will make the payment directly to your Roth IRA or designated Roth account in an employer plan. You should contact the Roth IRA sponsor or the administrator of the employer plan for information on how to do a direct rollover.

If you do not do a direct rollover, you may still do a rollover by making a deposit (generally within 60 days) into a Roth IRA, whether the payment is a qualified or nonqualified distribution. In addition, you can do a rollover by making a deposit within 60 days into a designated Roth account in an employer plan if the payment is a nonqualified distribution and the rollover does not exceed the amount of the earnings in the payment. You cannot do a 60-day rollover to an employer plan of any part of a qualified distribution. If you receive a distribution that is a nonqualified distribution and you do not roll over an amount at least equal to the earnings allocable to the distribution, you will be taxed on the amount of those earnings not rolled over, including the 10% additional income tax on early distributions if you are under age 59½ (unless an exception applies).

If you do a direct rollover of only a portion of the amount paid from the Plan and a portion is paid to you at the same time, the portion directly rolled over consists first of earnings. If you do not do a direct rollover and the payment is not a qualified distribution, the Plan is required to withhold 20% of the earnings for federal income taxes (up to the amount of cash and property received other than employer stock). This means that, in order to roll over the entire payment in a 60-day rollover to a Roth IRA, you must use other funds to make up for the 20% withheld.

How much may I roll over? If you wish to do a rollover, you may roll over all or part of the amount eligible for rollover. Any payment from the Plan is eligible for rollover, except:

- Required minimum distributions after age 70½ (if you were born before July 1, 1949), after age 72 (if you were born after June 30, 1949), or after death
- Hardship distributions
- Payments of employee stock ownership plan (ESOP) dividends
- Corrective distributions of contributions that exceed tax law limitations, and
- Loans treated as deemed distributions (for example, loans in default due to missed payments before your employment ends).

The Administrator or the payor can tell you what portion of a payment is eligible for rollover.

If I don't do a rollover, will I have to pay the 10% additional income tax on early distributions? If a payment is not a qualified distribution and you are under age 59½, you will have to pay the 10% additional income tax on early distributions with respect to the earnings allocated to the payment that you do not roll over (including amounts withheld for income tax), unless one of the exceptions listed below applies. This tax is in addition to the regular income tax on the earnings not rolled over.

The 10% additional income tax does not apply to the following payments from the Plan:

- Payments made after you separate from service if you will be at least age 55 in the year of the separation
- Payments made due to disability
- Payments after your death
- Payments of ESOP dividends
- Corrective distributions of contributions that exceed tax law limitations
- Payments made directly to the government to satisfy a federal tax levy
- Payments made under a qualified domestic relations order (QDRO)
- Payments of up to $5,000 made to you from a defined contribution plan if the payment is a qualified birth or adoption distribution
- Payments up to the amount of your deductible medical expenses (without regard to whether you itemize deductions for the taxable year)
- Certain payments made while you are on active duty if you were a member of a reserve component called to duty after September 11, 2001 for more than 179 days, and
- Payments for certain distributions relating to certain federally declared disasters.

If I do a rollover to a Roth IRA, will the 10% additional income tax apply to early distributions from the IRA? If you receive a payment from a Roth IRA when you are under age 59½, you will have to pay the 10% additional income tax on early distributions on the earnings paid from the Roth IRA, unless an exception applies or the payment is a qualified distribution. In general, the exceptions to the 10% additional income tax for early distributions from a Roth IRA listed above are the same as the exceptions for early distributions from a plan. However, there are a few differences for payments from a Roth IRA, including:

- The exception for payments made after you separate from service if you will be at least age 55 in the year of the separation does not apply.
- The exception for qualified domestic relations orders (QDROs) does not apply (although a special rule applies under which, as part of a divorce or separation agreement, a tax-free transfer may be made directly to a Roth IRA of a spouse or former spouse).
- An exception for payments made at least annually in equal or close to equal amounts over a specified period applies without regard to whether you have had a separation from service.
- There are additional exceptions for (1) payments for qualified higher education expenses, (2) payments up to $10,000 used in a qualified first-time home purchase, and (3) payments for health insurance premiums after you have received unemployment compensation for 12 consecutive weeks (or would have been eligible to receive unemployment compensation but for self-employed status).

Will I owe state income taxes? This notice does not describe any state or local income tax rules (including withholding rules).

SPECIAL RULES AND OPTIONS

If you miss the 60-day rollover deadline: Generally, the 60-day rollover deadline cannot be extended. However, the IRS has the limited authority to waive the deadline under certain extraordinary circumstances, such as when external events prevented you from completing the rollover by the 60-day rollover deadline. Under certain circumstances, you may claim eligibility for a waiver of the 60-day rollover deadline by making a written self-certification. Otherwise, to apply for a waiver from the IRS, you must file a private letter ruling request with the IRS. Private letter ruling requests require the payment of a nonrefundable user fee. For more information, see IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs).*

If your payment includes employer stock that you do not roll over: If you receive a payment that is not a qualified distribution and you do not roll it over, you can apply a special rule to payments of employer stock (or other employer securities) that are paid in a lump sum after separation from service (or after age 59½, disability, or the participant's death). Under the special rule, the net unrealized appreciation on the stock included in the earnings in the payment will not be taxed when distributed to you from the Plan and will be taxed at capital gain rates when you sell the stock. If you do a rollover to a Roth IRA for a nonqualified distribution that includes employer stock (for example, by selling the stock and rolling over the proceeds within 60 days of the distribution), you will not have any taxable income and the special rule relating to the distributed employer stock will not apply to any subsequent payments from the Roth IRA or, generally, the Plan. Net unrealized appreciation is generally the increase in the value of the employer stock after it was acquired by the Plan. The Plan administrator can tell you the amount of any net unrealized appreciation.

If you receive a payment that is a qualified distribution that includes employer stock and you do not roll it over, your basis in the stock (used to determine gain or loss when you later sell the stock) will equal the fair market value of the stock at the time of the payment from the Plan.

If you have an outstanding loan that is being offset: If you have an outstanding loan from the Plan, your Plan benefit may be offset by the outstanding amount of the loan, typically when your employment ends. The offset amount is treated as a distribution to you at the time of the offset. Generally, you may roll over all or any portion of the offset amount. If the distribution attributable to the offset is not a qualified

distribution and you do not roll over the offset amount, you will be taxed on any earnings included in the distribution (including the 10% additional income tax on early distributions, unless an exception applies). You may roll over the earnings included in the loan offset to a Roth IRA or designated Roth account in an employer plan (if the terms of the employer plan permit the plan to receive plan loan offset rollovers). You may also roll over the full amount of the offset to a Roth IRA.

How long you have to complete the rollover depends on what kind of plan loan offset you have. If you have a qualified plan loan offset, you will have until your tax return due date (including extensions) for the tax year during which the offset occurs to complete your rollover. A qualified plan loan offset occurs when a plan loan in good standing is offset because your employer plan terminates, or because you sever from employment. If your plan loan offset occurs for any other reason, then you have 60 days from the date the offset occurs to complete your rollover.

If you receive a nonqualified distribution and you were born on or before January 1, 1936: If you were born on or before January 1, 1936, and receive a lump sum distribution that is not a qualified distribution and that you do not roll over, special rules for calculating the amount of the tax on the earnings in the payment might apply to you. For more information, see IRS Publication 575, *Pension and Annuity Income*.

If you are not a Plan participant

Payments after death of the 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. However, whether the payment is a qualified distribution generally depends on when the participant first made a contribution to the designated Roth account in the Plan. Also, the 10% additional income tax on early distributions and the special rules for public safety officers do not apply, and the special rule described under the section "If you receive a nonqualified distribution and you were born on or before January 1, 1936" applies only if the participant was born on or before January 1, 1936.

If you are a surviving spouse: If you receive a payment from the Plan as the surviving spouse of a deceased participant, you have the same rollover options that the participant would have had, as described elsewhere in this notice. In addition, if you choose to do a rollover to a Roth IRA, you may treat the Roth IRA as your own or as an inherited Roth IRA.

A Roth IRA you treat as your own is treated like any other Roth IRA of yours, so that you will not have to receive any required minimum distributions during your lifetime and earnings paid to you in a nonqualified distribution before you are age 59½ will be subject to the 10% additional income tax on early distributions (unless an exception applies).

If you treat the Roth IRA as an inherited Roth IRA, payments from the Roth IRA will not be subject to the 10% additional income tax on early distributions. An inherited Roth IRA is subject to required minimum distributions. If the participant had started taking required minimum distributions from the Plan, you will have to receive required minimum distributions from the inherited Roth IRA. If the participant had not started taking required minimum distributions, you will not have to start receiving required minimum distributions from the inherited Roth IRA until the year the participant would have been age 70½ (if the participant was born before July 1, 1949) or age 72 (if the participant was born after June 30, 1949).

If you are a surviving beneficiary other than a spouse: If you receive a payment from the Plan because of the participant's death and you are a designated beneficiary other than a surviving spouse, the only rollover option you have is to do a direct rollover to an inherited Roth IRA. Payments from the inherited Roth IRA, even if made in a nonqualified distribution, will not be subject to the 10% additional income tax on early distributions. You will have to receive required minimum distributions from the inherited Roth IRA.

Payments under a QDRO: If you are the spouse or a former spouse of the participant who receives a payment from the Plan under a QDRO, you generally have the same options and the same tax treatment that the participant would have (for example, you may roll over the payment to your own Roth IRA or to a designated Roth account in an eligible employer plan that will accept it).

If you are a nonresident alien: If you are a nonresident alien and you do not do a direct rollover to a U.S. IRA or U.S. employer plan, and the payment is not a qualified distribution, the Plan is generally required to withhold 30% (instead of withholding 20%) of the earnings for federal income taxes. If the amount withheld exceeds the amount of tax you owe (as may happen if you do a 60-day rollover), you may request an income tax refund by filing Form 1040NR and attaching your Form 1042-S. See Form W-8BEN for claiming that you are entitled to a reduced rate of withholding under an income tax treaty. For more information, see also IRS Publication 519, *U.S. Tax Guide for Aliens*, and IRS Publication 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*.

OTHER SPECIAL RULES

If your payments for the year (only including payments from the designated Roth account in the Plan) are less than $200, the Plan is not required to allow you to do a direct rollover and is not required to withhold federal income taxes. However, you can do a 60-day rollover.

You may have special rollover rights if you recently served in the U.S. Armed Forces. For more information on special

rollover rights related to the U.S. Armed Forces, see IRS Publication 3, *Armed Forces' Tax Guide*. You also may have special rollover rights if you were affected by a federally declared disaster (or similar event), or if you received a distribution on account of a disaster. For more information on special rollover rights related to disaster relief, see the IRS website at **www.irs.gov**.

FOR MORE INFORMATION

You may wish to consult with the Plan Administrator or payor, or a professional tax advisor, before taking a payment from the Plan. Also, you can find more detailed information on the federal tax treatment of payments from employer plans in IRS Publication 575, *Pension and Annuity Income*; IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*; IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*; and IRS Publication 571, *Tax-Sheltered Annuity Plans (403(b) Plans)*. These publications are available from a local IRS office, on the web at **www.irs.gov**, or by calling **800-TAX-FORM**.

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 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 a benefits online enrollment session on **One.Walmart.com/ASPP**	Call Computershare at **800-438-6278** (hearing impaired: **800-952-9245**)
• 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	Get the Associate Stock app by downloading at **wmt.link/stock-app** or scanning the QR code below (available for Apple or Android devices)
Send money directly to Computershare		Send check to: **Computershare** **Attn: Walmart ASPP** **P.O. Box 43080** **Providence, Rhode Island 02940-3080** (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 age of majority in your payroll state to participate (19 is the age of majority in Alabama and Nebraska). If you live in Puerto Rico, you must be 21 years of age to participate. If you have questions about the age requirement, review your respective state laws on the age of majority.

Enrolling in the Associate Stock Purchase Plan

You can enroll in the Plan by completing a benefits online enrollment session 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 Plan allows all eligible associates to buy Walmart stock conveniently through payroll deductions. Any whole dollar amount from $2 to $1,000 can be withheld from your paycheck to buy stock.

Walmart contributes to your stock purchase account by matching $0.15 for every $1 you contribute to the Plan through payroll deductions, up to your first $1,800 you contribute each Plan year. The Plan year runs from April through March. The company match is reflected as income on your check stub and on your Form W-2.

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 43080
Providence, Rhode Island 02940-3080

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 guarantee that your stock will have the same value in the future that it had when purchased or that the value of the stock will increase.

When deciding about purchasing Walmart stock, consider all your investments, including other Walmart stock you may own. For investment questions, consult a financial advisor. Investment in the stock is subject to certain risks as described in the Plan Prospectus and Walmart's most recent Annual Report on Form 10-K, which is incorporated by reference in the Plan Prospectus.

Selling stock through the Plan

No fees are charged to you for buying stock; 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.

WALMART'S CONTRIBUTION TO YOUR COMPANY STOCK OWNERSHIP

If you contribute	Your Plan year payroll deduction contribution is	Walmart's annual 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.

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 be reasonably 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 sale you execute.

You can sell stock from **computershare.com/walmart**, from the Associate Stock app, **wmt.link/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. Please note it will vary depending upon your bank when the funds will be reflected in your checking or savings account. If you select to receive your sale proceeds via check, you should receive your check within seven to 10 business days after you place an order to sell stock in your Plan account.

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

It's important to understand the tax consequences of a stock sale. If you have tax-related questions, please consult a financial advisor or tax consultant.

Keeping track of your Computershare account

You will receive a statement from Computershare at least annually (first quarter) that shows the activity in your account. If you opted to receive your statements electronically, you will receive an email informing you that your statement is ready and can be found on **computershare.com/walmart** or on the Associate Stock app which can be downloaded at **wmt.link/stock-app**.

The annual statement will contain important tax information. Maintain your statement so that you know the difference between your purchase price and sale price of any shares of stock you sell. You will need this information for your income taxes.

You can access your account information online at **computershare.com/walmart**, by the Associate Stock app, **wmt.link/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. 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 a benefits online 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 and confirm the latest share purchase has been posted to your account before closing your account. You also have the option to stop payroll deductions and to hold your Plan shares at 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 without 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 request to move shares to the Walmart Direct Stock Purchase Plan.
- You can close your account and transfer your shares to another broker.
- You can close your account and sell some or all shares in your account.

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

Please 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.

46,247,166 Shares

WALMART INC.

Common Stock
($.10 par value per share)

WALMART INC.
2016 Associate Stock Purchase Plan
(formerly, the Wal-Mart Stores, Inc. 2016 Associate Stock Purchase Plan,
the Wal-Mart Stores, Inc. 2004 Associate Stock Purchase Plan,
and the Walmart Stores, Inc. Associate Stock Purchase Plan of 1996)

This prospectus relates to the purchase of the number of shares of the common stock, $0.10 par value per share, of Walmart Inc. ("Walmart," the "Company" or "we") shown above under the Walmart Inc. 2016 Associate Stock Purchase Plan (the "Plan") by eligible Walmart associates who elect to participate in the Plan.

These securities have not been approved or disapproved by the Securities and Exchange Commission ("SEC") or any state securities commission nor has the Securities and Exchange Commission or any state securities commission passed upon the accuracy or adequacy of this prospectus. Any representation to the contrary is a criminal offense.

No one is authorized to give any information or to make any representations other than those contained in this Prospectus and, if given or made, you should not rely on them. This Prospectus is not an offer to sell or a solicitation of an offer to buy any of the securities referred to in this Prospectus in any state or other jurisdiction where such an offer or solicitation would be unlawful. Neither the delivery of this Prospectus nor acquisition of securities described in this Prospectus implies that no change in the affairs of the company has occurred since the date of this Prospectus.

Investment in shares of the Common Stock offered hereby involves certain risks. See "Part I, Item 1A. **Risk Factors**" in Walmart's Annual Report on Form 10-K most recently filed with the SEC for a discussion of certain risks that may affect our business, operations, financial condition, results of operations and cash flows. See "**Stock ownership, fees, and risks**" below.

The date of this Prospectus is August 31, 2022

Introduction and overview

The Plan is an amendment and restatement of the Wal-Mart Stores, Inc. 2004 Associate Stock Purchase Plan which had previously amended and restated the Wal-Mart Stores, Inc. Associate Stock Purchase Plan of 1996. The Plan was most recently approved by the shareholders of Walmart at our Annual Shareholders' Meeting held on June 1, 2022. As of August 31, 2022, up to 46,247,166 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 SEC 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 ("NYSE"). 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 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 of absence must be approved by the Committee.

Plan contributions—Associate Stock Purchase Program

To make payroll deduction contributions, you need to complete a benefits online enrollment session at **One.Walmart.com/ASPP**. Once you have properly enrolled in the Plan, your payroll deduction contributions will continue in accordance with your most recent payroll deduction authorization (subject to any restrictions imposed by the Plan) as long as you are employed by the company or a Participating Employer, unless you change or terminate your payroll deduction authorization or the Plan itself is terminated.

Please note that no deduction will be drawn from any paycheck in which your payroll deduction contribution exceeds your net pay after taxes are withheld. You can change or terminate your payroll deduction authorization by completing a benefits online enrollment session at **One.Walmart.com/ASPP**. 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. The amount of any biweekly deduction in excess of the minimum must be in $1 increments. The Company or your Participating Employer will make a matching cash contribution on your behalf to your Plan account when you make contributions to the Plan by payroll deduction. The matching contribution is currently fifteen percent (15%) of the first $1,800 you contribute to the Plan by payroll deduction, or up to $270 per Plan year. The company's matching contribution will be used to buy Stock for your Plan account.

If you 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 outstanding performance in your job over the period of a month, a quarter or a year. The Committee approves all Outstanding Performance Awards and sets maximum dollar limitations on these awards periodically.

Your Stock under the Outstanding Performance Award component will be delivered through an account maintained on your behalf by Computershare.

STOCK PURCHASES

Your employer will send all 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 (5) 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 (5) 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. 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 NYSE—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 the Stock is purchased from the company. While the Plan permits the Committee to designate another methodology for valuing Stock purchased from the company, as of the date of this Prospectus no other methodology has been designated.

The number of shares allocated to your Plan account in connection with any purchase of Stock will equal the total amount of the contributions and dividends available for your Plan account, divided by the purchase price for each share of Stock attributable to those purchases as discussed above.

Non-U.S. Participants Please Note: All amounts contributed to the Plan by payroll deduction, 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; however, 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 do one of three things: 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, similar to any other shareholders of the company. You may not transfer or assign your Plan account to another person who is not an eligible participant in the Plan. The company does not maintain an automatic lien or security interest on the shares of Stock held in your Plan account, and the terms of the Plan do not provide for anyone to have or to have the ability to create a lien on any funds or shares of Stock credited to your Plan account; however, you may pledge, hypothecate or deal with the shares of Stock credited to your Plan accounts in the same manner as you may with other shares of Stock you may own, subject to compliance with our Insider Trading Policy.

DIVIDENDS AND VOTING

Dividends on shares in your account will be automatically reinvested in additional shares of Stock. You will be able to direct the vote on each full share of Stock held in your Plan account, but not fractional shares. You will receive at no cost and as promptly as practicable (by mail or otherwise) all notices of meetings, proxy statements, notices of internet availability of proxy materials and other materials distributed by the company to its shareholders. To vote the shares of Stock held in your Plan account, you must deliver in a timely manner signed voting instructions, also known as proxy instructions, described in the company's proxy materials. If you do not provide properly completed and

executed voting instructions as described in the company's proxy materials, your shares will not be voted with respect to any election of directors, any advisory vote on executive compensation, or many other matters that may be subject to a shareholder vote. In those circumstances, your shares of Stock may be voted in the manner recommended by the company in its proxy statement or as directed by the Committee on matters defined by the NYSE as "routine," such as the ratification of the appointment of the company's independent auditors, provided that doing so would comply with applicable law and any applicable listing standard of a national stock exchange.

FEES AND ACCOUNT STATEMENTS

The company pays all fees associated with the purchase of Stock. Generally, no maintenance fees or other charges will be assessed to your Plan account as long as you are employed by the company or one of its affiliates (even if that affiliate is not a Participating Employer). You must pay any commissions or charges resulting from other Computershare services you request, for example, brokerage commissions and other fees applicable to the sale of Stock. Computershare can advise if a particular request will incur a charge. The fees charged by Computershare described in this Prospectus are subject to change periodically.

At least annually, you will receive a statement of your account under the Plan, reflecting all activity with respect to your Plan account for the time specified in the statement. You may elect to receive your statements online. If you do so, you will receive an email informing you that your statement is ready and can be found on **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 preparation of your income tax return.

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. 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 shareholder of the company, in that you assume the risk that the value of the Stock may increase or decrease. There are no guarantees as to the value of a share of Stock. This means that you assume the risk of fluctuations in the value or market price of the Stock. Our latest Annual Report on Form 10-K filed with the SEC and as noted below, incorporated by reference in this Prospectus, discusses, and other of our reports filed with the SEC may discuss, certain risks relating to the company, its operations and financial performance that can affect the value, market price and liquidity of the Stock. The company urges you to review those discussions in connection with any determination to participate in the Plan, to change the terms of your participation in the Plan, to terminate your participation in the Plan, or to make any voluntary contributions under the Plan.

If you are a non-U.S. participant, you also assume the risk of fluctuation in currency exchange rates. Also, your payroll deductions (as well as the corresponding matching contributions) are applied by 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 maintain and the dividends related to those shares will not be reinvested under the Plan.

You may also have Computershare transfer any or all the shares of Stock credited to your Plan account into your name in the Direct Registration System. Such a transfer means that you would hold your shares as "book-entry" securities and your ownership would be shown on our stock transfer records and represented by a statement which shows your holdings of shares of Stock.

You may at any time request that Computershare sell all or a portion of the shares of Stock (including any fractional interests) credited to your Plan account, whether or not you want to close your Plan account.

You will be charged a brokerage commission, as well as any other applicable fees, if for any reason you have 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. Please note the price at which your order will be executed is not guaranteed, and the last-traded price for the Stock prior to the execution of your order to sell your shares of Stock is not necessarily the price at which your order will be executed. From time to time, we repurchase shares of Stock in the open market under a stock repurchase program adopted by our Board of Directors. As a result, if Computershare sells shares credited to your Plan account in the open market, we could be the purchaser of such shares. We will typically not know if any of the shares of Stock we purchase in the open market are purchased from you. Your shares of Stock will be sold as soon as your request can reasonably be processed. Generally, market orders are executed immediately after they are placed. We expect that any sales of your shares of Stock will be executed over the 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 shareholder approval of an amendment is required under law or the applicable rules of a national stock exchange, the amendment will be subject to that approval. No amendment or termination of the Plan will cause you to forfeit: (1) any funds you have contributed to the Plan or matching funds the company has contributed that have not yet been used to purchase shares of Stock; (2) any shares (or fractional shares) of the Stock credited to your Plan account; or (3) any dividends or distributions declared with respect to the Stock after you have made a contribution to the Plan but before the effective date of the amendment or termination.

Tax information

The following summary of the U. S. income tax consequences of the Plan is based on the Internal Revenue Code and any regulations thereunder as in effect as of the date of this Prospectus. The summary does not cover any state or local income taxes or taxes in jurisdictions other than the United States. You should consult your tax advisor regarding individual tax consequences before purchasing Stock under the Plan.

STOCK PURCHASES UNDER THE STOCK PURCHASE PLAN

You have no federal income tax consequences when you enroll in the Plan or when shares of Stock are purchased for you under the Stock Purchase Plan either by payroll deduction or voluntary contribution. The amount of your payroll deductions and any voluntary contributions under the Plan are not deductible for purposes of determining your federal taxable income. The amount of your wages that you have deducted under the Plan and the full value of company matching contributions are ordinary income to you in the calendar year of deduction or the contribution and will be reported on your pay stub and your W-2. The company deducts all applicable wage withholding and other required taxes from your other compensation (by increasing your payroll withholding and other tax deductions for such purposes) with respect to the amount of your wages deducted under the Plan and the matching contributions to your Plan account, if any. The company is entitled to a tax deduction equivalent to the amount of the matching contribution in the same year as you realize the income.

OUTSTANDING PERFORMANCE AWARDS UNDER THE OUTSTANDING PERFORMANCE AWARD PROGRAM

Stock grants under the Outstanding Performance Award Program are taxable as ordinary income in the calendar year of the award, regardless of whether the Stock certificates are given directly to you or the Stock is awarded to your Plan account. Your ordinary income will be the market value of a share of Stock on the date the award is granted, times the number of shares of Stock granted. The market value of any Stock awarded will be reported on your W-2. The company will deduct applicable wage withholding and other required taxes from your other compensation (by increasing your payroll deduction for such purposes). The company is entitled to a tax deduction in equal amount and in the same year as you realize the ordinary income.

STOCK SALES OR CERTIFICATE DISTRIBUTIONS

You will not recognize any taxable income when you request to have certificates delivered to you for some or all the shares of Stock held in your Plan account. When you sell or otherwise dispose of your shares of Stock—whether through 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: **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 43080
Providence, Rhode Island 02940-3080

Electronic delivery of prospectuses and other documents

To help reduce costs of operating the Plan and to help with our sustainability efforts, we ask you to allow us to deliver prospectuses and other documents related to the Plan electronically and that you access the prospectuses and documents we provide to participants in the Plan via **One.Walmart.com**. Your enrollment in the Plan will constitute your consent to receive or access communications from us about the Plan and prospectuses relating to the purchase of shares of Stock under the Plan electronically through access on **One.Walmart.com**, unless you affirmatively elect to receive paper copies of such communications. At any time after enrollment you may revoke that consent by sending a written revocation of the consent to receive Plan documents electronically to the Benefits Department at the address appearing below. In addition, you may request a paper copy of the then current prospectus relating to purchases of shares of Stock under the Plan and of our most recent Annual Report on Form 10-K by writing the Benefits Department and those documents will be provided to you free of charge.

Documents incorporated by reference

The following documents filed by the company with the Securities and Exchange Commission (the "Commission") (File No. 1-6991) are hereby incorporated by reference in and made a part of this Prospectus:

- The company's Annual Report on Form 10-K for the fiscal year ended January 31, 2022;
- The company's Quarterly Reports on Form 10-Q for the fiscal quarters ended April 30, 2022 and July 31, 2022;
- The company's Current Reports on Form 8-K filed with the Commission on June 3, 2022;
- The company's definitive Proxy Statement for the 2022 Annual Shareholders' Meeting, filed with the Commission on April 21, 2022; and
- Exhibit 99.1 to the Company's Registration Statement on Form S-8 (File No. 333-214060)

All documents filed by the company pursuant to Sections 13(a), 13(c), 14 and 15(d) of the Securities Exchange Act of 1934 (the "Exchange Act") on or after the date of this Prospectus shall be deemed to be incorporated by reference in this Prospectus and to be a part hereof from the date of filing of such documents, except for information furnished to the Commission that is not deemed to be "filed" for purposes of the Exchange Act (such documents, and the documents listed above, being hereinafter referred to as "Incorporated Documents"). Any statement contained in an Incorporated Document shall be deemed to be modified or superseded for purposes of this Prospectus to the extent that a statement contained herein or in any other subsequently filed Incorporated Document modifies or supersedes such statement. Any such statement so modified or superseded shall not be deemed, except as so modified or superseded, to constitute a part of the Section 10(a) prospectus of the company relating to purchases under the Plan of the shares of Stock described on the cover page of this Prospectus. This document and the documents incorporated by reference herein constitute such Section 10(a) prospectus.

These documents and the company's latest Annual Report to Shareholders and any other documents required to be delivered to you under Rule 428(b) under the Securities Act of 1933, as amended, are available to you without charge upon written or oral request. Please direct your requests for documents to:

Walmart Inc.
Benefits Department
508 SW 8th Street
Bentonville, Arkansas 72716-0295

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

For more information

IF YOU HAVE QUESTIONS ABOUT…	WEBSITE	PHONE
When you're eligible for benefits or how to enroll	**One.Walmart.com/Benefits**	People Services: **800-421-1362**
Medical benefits, claims, or care management	See **Find a doctor and get medical plan help** on the next page	
Naming your beneficiaries	**One.Walmart.com/Beneficiary**	People Services: **800-421-1362**
Pharmacy benefits	**One.Walmart.com/Prescriptions**	OptumRx: **844-705-7493**
Health savings account (HSA) for associates enrolled in the Saver Plan	**One.Walmart.com/Saver** **Learn.HealthEquity.com/Walmart/HSA**	HealthEquity: **866-296-2860**
Centers of Excellence	**One.Walmart.com/COE**	BlueAdvantage: **866-823-3790** Aetna, Chicago metro, south FL: **800-525-6257** Aetna, GA, OH: **800-626-9170** Aetna, AK, AL, AR, AZ, CO, IA, IL, IN, KY, LA, MN, MO, MS, NC, SC, TN, VA, WI, WV: **833-554-1544** Aetna, other states: **855-548-2387** UMR: **855-870-9177** HealthSCOPE: **800-804-1272** *(Or see back of plan ID card)*
Digestive health program: AK, AL, AR, AZ, CO, GA, IA, IL, IN, KY, LA, MN, MO, MS, NC, OH, SC, TN, VA, WI, WV	**One.Walmart.com/GIThrive**	GIThrive: **833-336-9488** *(Or see back of plan ID card)*
Digital physical therapy program: AK, AL, AR, AZ, CO, GA, IA, IL, IN, KY, LA, MN, MO, MS, NC, OH, SC, TN, VA, WI, WV	**One.Walmart.com/OmadaHealth**	*(See back of plan ID card)*
Vision plan	**One.Walmart.com/Vision**	VSP: **866-240-8390**
Dental plan	**One.Walmart.com/Dental**	Delta Dental: **800-462-5410**
Short-term disability insurance	**One.Walmart.com/ShortTermDisability** (CA, CT, DC, HI, MA, NJ, NY, RI, WA; refer to state guide)	Sedgwick/Lincoln: **800-492-5678**
Long-term disability insurance	**One.Walmart.com/LongTermDisability**	Lincoln: **877-353-6404**
Accident and critical illness insurance	**One.Walmart.com/Accident** **One.Walmart.com/Critical**	Allstate Benefits: **800-514-9525**
Life, accidental death and dismemberment (AD&D), and business travel accident insurance	**One.Walmart.com/Life** **One.Walmart.com/ADD**	Prudential: **877-740-2116**
Resources for Living	**One.Walmart.com/RFL**	**800-825-3555**, available 24/7
Quit Tobacco	**One.Walmart.com/QuitTobacco**	Kick Buts: **855-955-1905**
Walmart 401(k) Plan	**One.Walmart.com/401k** **Benefits.ML.com**	Merrill: **888-968-4015**
Associate Stock Purchase Plan	**One.Walmart.com/ASPP** **ComputerShare.com/Walmart**	ComputerShare: **800-438-6278**

Find a doctor and get medical plan help

Your contact information for medical plan help depends on two things:

- Where you work, or in some cases which plan you're enrolled in.
- Which of our four plan administrators serves your area. You'll find yours on the back of your plan ID card.

LOCATION OR PLAN	PLAN ADMINISTRATOR	FIND A DOCTOR	CLAIMS, CUSTOMER SERVICE, CARE MANAGEMENT
Most areas	BlueAdvantage Aetna HealthSCOPE	**IncludedHealth.com/Walmart** IncludedHealth: **800-941-1384** Virtual doctor visit: **One.Walmart.com/DOD**	BlueAdvantage: **866-823-3790** Aetna: **855-548-2387** HealthSCOPE: **800-804-1272**
Most areas	UMR	**IncludedHealth.com/Walmart** UMR: **855-870-9177** Virtual doctor visit: **One.Walmart.com/DOD**	UMR: **855-870-9177**
IL, IN, MO, NC, SC, VA	BlueAdvantage Aetna	**IncludedHealth.com/Walmart** Personal Healthcare Assistant: **855-377-2200** Virtual primary care doctor: **One.Walmart.com/VirtualPrimaryCare**	Included Health: **855-377-2200**
AL, CO, IA, IL, MN, MO, MS, NC, SC, WI	UMR	**IncludedHealth.com/Walmart** UMR: **855-870-9177** Virtual primary care doctor: **One.Walmart.com/VirtualPrimaryCare**	UMR: **855-870-9177**
AK, AL, AR, AZ, CO, GA, IA, KY, LA, MN, MS, OH, TN, WI, WV	BlueAdvantage Aetna	**IncludedHealth.com/Walmart** Included Health: **800-941-1384** Virtual primary care doctor: **One.Walmart.com/VirtualPrimaryCare**	Included Health: **800-941-1384** (care management) Aetna, GA and OH: **800-626-9170** Aetna, other states: **833-554-1544** BlueAdvantage: **866-823-3790**
TX: Austin, Dallas, Houston, San Antonio AR: Northwest Arkansas OK: Tulsa, Oklahoma City FL: Tampa, Orlando, Jacksonville, Gainesville, West Palm Beach, Port St. Lucie	BlueAdvantage	**IncludedHealth.com/Walmart** BlueAdvantage: **866-823-3790** Virtual primary care doctor, AR only: **One.Walmart.com/VirtualPrimaryCare** Virtual doctor visit, all other areas: **One.Walmart.com/DOD**	BlueAdvantage: **866-823-3790**
FL: Port Charlotte, Cape Coral/Ft. Myers, Naples, Miami/ Ft. Lauderdale	Aetna	**IncludedHealth.com/Walmart** Aetna: **800-525-6257** Virtual doctor visit: **One.Walmart.com/DOD**	Aetna: **800-525-6257**
IL, IN: Chicago metro	Aetna BlueAdvantage	**IncludedHealth.com/Walmart** Aetna: **800-525-6257** BlueAdvantage: **866-823-3790** Virtual primary care doctor: **One.Walmart.com/VirtualPrimaryCare**	Aetna: **855-548-2387** BlueAdvantage: **866-823-3790**

(Continued on the next page)

Find a doctor and get medical plan help (continued)

LOCATION OR PLAN	PLAN ADMINISTRATOR	FIND A DOCTOR	CLAIMS, CUSTOMER SERVICE, CARE MANAGEMENT
Mercy Arkansas Local Plan	HealthSCOPE	**IncludedHealth.com/Walmart** Included Health: **800-941-1384** Virtual primary care doctor: **One.Walmart.com/VirtualPrimaryCare**	HealthSCOPE Benefits: **800-804-1272**
Banner Local Plan	Aetna	**IncludedHealth.com/Walmart** Aetna: **855-548-2387** Virtual primary care doctor: **One.Walmart.com/VirtualPrimaryCare**	Aetna: **855-548-2387**
Hawaii	HMSA Kaiser	**HMSA.com**: **808-948-6111** **KP.org**: **800-966-5955**	**HMSA.com**: **808-948-6111** **KP.org**: **800-966-5955**
PPO Plan	Aetna	**IncludedHealth.com/Walmart** Included Health: **800-941-1384** Virtual doctor visit: **Teladoc.com/Aetna**	Aetna: **855-548-2387** Teladoc: **800-835-2362**

Associates enrolled in HMO plans: Find a doctor and get medical plan help

If you have questions about finding a doctor, benefits, medical claims, or care management for an HMO plan:

HMO PLAN	WEBSITE	PHONE
Geisinger Health Plan Geisinger Extra Health Pan Geisinger Health Plan—Eastern Geisinger Extra Health Plan—Eastern	**GeisingerHealthPlan.com**	Geisinger: **844-863-6850**
Health Net Low Option ExcelCare Health Net High Option ExcelCare Health Net Salud y Mas HMO	**HealthNet.com**	Health Net: **800-722-5342**
HMSA Hawaii	**HMSA.com**	HMSA: **808-948-6111**
Kaiser of California	**kp.org**	**800-464-4000** (English) **800-788-0616** (Spanish)
Kaiser of Colorado	**kp.org**	Denver metro: **303-338-3800** Other areas: **800-632-9700**
Kaiser of Georgia	**kp.org**	Atlanta metro: **404-261-2590** Other areas: **888-865-5813**
Kaiser of Hawaii	**kp.org**	Kaiser: **800-966-5955**
Kaiser of the Mid-Atlantic Low-MD Kaiser of the Mid-Atlantic Low-VA	**kp.org**	Kaiser: **855-249-5018**
Kaiser of Oregon	**kp.org**	Portland area: **503-813-2000** Other areas: **800-813-2000**
Kaiser Foundation Health Plan of WA	**kp.org**	Kaiser: **888-901-4636**

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