2025 Associate Benefits Book

Summary Plan Descriptions

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What's inside

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

Effective **January 1, 2025**
Walmart 401(k) Plan effective **February 1, 2025**
Associate Stock Purchase Plan effective **April 1, 2025**

Version 1.0 | Dec. 2024

Welcome to your 2025 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 2025 *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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The Associates' Health and Welfare Plan

Information obtained during communications with Walmart Inc. or any Plan service provider does not waive any provision or limitation of the Plan. Information given or statements made through any form of communication do not guarantee payment of benefits. In addition, benefits quotes that are given by phone are based wholly on the information supplied at the time. If additional relevant information is discovered, it may affect payment of your claim. All benefits are subject to eligibility, payment of premiums, limitations, and all exclusions outlined in the applicable Plan documents, including any insurance policies. You can request a copy of the documents governing these plans by writing to: Mail Stop 3610–Benefits Total Rewards Team, Custodian of Records, 508 SW 8th Street, Bentonville, Arkansas 72716-3610.

Atención Asociados Hispanos: Este folleto contiene un resumen en inglés de los derechos y beneficios para todos losasociados bajo el plan de beneficios de Walmart. Si Ud tienedificultades para entender cualquier parte de este folletopuede dirigirse a la siguiente dirección: Mail Stop 3610–Benefits Total Rewards Team, Custodian of Records, 508 SW 8th Street, Bentonville, Arkansas 72716-3610.

O puede llamar para cualquier pregunta al 800-421-1362. Tenemos asociados quienes hablan Español y pueden ayudarles a Ud comprender sus beneficios de Walmart. El Libro de beneficios para asociados esta disponible en Español. Si usted desea una copia en Español, favor de ver su Representante de Personal.

Eligibility, enrollment, and effective dates

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 308 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 cancellation of coverage retroactive to the last date for which premiums were paid. You may pay by credit or debit card with a Visa, MasterCard, American Express, or Discover card by going to **One.Walmart.com/Enroll** and choosing "make a payment" or by calling **800-421-1362** and saying "make a payment." You may also send a check or money order payable to the Associates' Health and Welfare Trust to: **Walmart People Services** **P.O. Box 1039** **Department 3001** **Lowell, Arkansas 72745** To ensure timely posting of your payment, be sure to include your WIN (Walmart ID) number and work location on the check. If you are unable to make your premium payments, the Plan will accept payments made by someone else on your behalf.

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

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

The Associates' Health and Welfare Plan

Walmart Inc. (Walmart) sponsors the Associates' Health and Welfare Plan (the Plan), which is a comprehensive employee benefit plan that offers medical, dental, vision, associate assistance resources, disability, life insurance, business travel accident insurance, accident insurance, accidental death and dismemberment insurance and critical illness insurance benefits to eligible associates and their eligible family members. Eligibility for these benefits is described in this chapter, and the terms and conditions of the specific benefits offered under the Plan are described in the applicable chapters of this 2025 *Associate Benefits Book*. You are enrolled automatically for certain benefits under the Plan on your date of hire or a later date. For other benefits, however, you must enroll to have coverage. Refer to the **Associate eligibility** section in this chapter for details about your eligibility, the **Dependent eligibility** section in this chapter for information about dependent eligibility, including which family members may be enrolled for coverage, and the **Enrollment and effective dates by job classification** section in this chapter for details about initial enrollment periods and when coverage is effective, for all benefits available under the Plan.

Eligibility for benefits and the terms and conditions of each benefit are described in the Plan document, insurance policies governing insured benefits, and this 2025 *Associate Benefits Book*. To the extent that any information provided to you through other sources, whether oral or written, including any AI-generated material or a third-party administrator's response to a request for information, conflicts with the Plan document, applicable insurance policies, or this 2025 *Associate Benefits Book*, the terms in the Plan document, applicable insurance policy, or 2025 *Associate Benefits Book* will control. In the event of any conflict between an insurance policy governing insured benefits and the Plan document or this 2025 *Associate Benefits Book*, terms of the insurance policy will control. In the event of any conflict between terms of the Plan document and this 2025 *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.

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

Chapter overview

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

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

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

1	**YOUR EMPLOYMENT CLASSIFICATION** Your employment classification in the Walmart's payroll system has an impact on your benefits. See page 7.
2	**BECOMING ELIGIBLE FOR BENEFITS** • Who can you cover? See page 19. • What benefits are you eligible for? See page 24. • 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 34. When do you have to make special arrangements to pay for your benefits? See page 36.
4	**EVENTS THAT CAN AFFECT YOUR COVERAGE** What might impact your benefits? • If you go on a leave of absence—see page 37. • A life event like a change in your family status—see page 40. • Special circumstances like a legal order or eligibility for a special enrollment period—see page 41.

Associate eligibility

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

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

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

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

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

EMPLOYMENT CLASSIFICATION FOR DETERMINING BENEFIT OPTIONS	THIS INCLUDES
Full-time hourly associate	• Full-time hourly associates, except full-time hourly Vision Center managers • Full-time hourly pharmacists, except California pharmacists • Full-time hourly field supply chain associates • Full-time hourly field supervisors in stores and clubs • Full-time hourly associates in Hawaii, except for medical and short-term disability benefits
Full-time hourly Vision Center manager	• Full-time hourly Vision Center managers
Part-time hourly or temporary associate	• Part-time hourly associates, except part-time truck drivers • Temporary associates
Part-time truck driver	• Part-time truck driver associates
Management or salaried associate	• Salaried associates • Management trainees • Full-time hourly California pharmacists • Full-time truck driver associates

FULL-TIME HOURLY ASSOCIATE ELIGIBILITY

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

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

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

FULL-TIME HOURLY VISION CENTER MANAGER ELIGIBILITY

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

PART-TIME HOURLY ASSOCIATE ELIGIBILITY

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

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

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

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

TEMPORARY ASSOCIATE ELIGIBILITY

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

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

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

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

PART-TIME TRUCK DRIVER ELIGIBILITY

To be eligible to enroll in benefits as a part-time truck driver, you must be classified in the Walmart'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 (INCLUDING FULL-TIME TRUCK DRIVERS)

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

INDIVIDUALS WHO ARE NOT ELIGIBLE

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

- A leased employee
- A nonresident alien (except that for purposes of optional associate life insurance, optional dependent life insurance, accidental death and 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 Walmart will be eligible for benefits described in those policies, subject to the terms of the policies)
- An independent contractor
- A consultant
- An associate residing outside the United States, except that associates covered under a specific insurance policy for expatriates will be eligible for the benefits described in those policies, subject to the terms of the policies.
- An individual who is not classified as an associate of Walmart or its participating affiliates
- An associate who is enrolled in a Medicare prescription drug plan (applicable only to eligibility for medical plan and pharmacy benefit options, including HMO 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 associate 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 Walmart 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 associates and temporary associates: eligibility checks for medical benefits

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

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

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

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

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

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

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

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

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

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

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

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

EXAMPLE: If your date of hire is April 16, 2025, your hours worked from that day through June 13, 2025 will be measured on your 60th day of employment, which is June 14, to determine whether you have worked the required number of hours during that 59-day measurement period. If you work the required number of hours during this first measurement period and you do not have a break in employment of more than 30 days during the measurement period, you will be eligible to enroll in benefits that are available to part-time hourly associates and temporary associates. If you are eligible, your benefits will be effective on the first day of the month in which your 89th day of employment occurs, assuming you enroll before the end of your initial enrollment period. Because your 89th day of employment would be July 13, your benefits will be effective on July 1, assuming you enroll before the end of your initial enrollment period. Your hours will not be measured again during your first 52 weeks of employment, even if you do not enroll during your initial enrollment period. The next time your eligibility for medical benefits will be checked is the annual eligibility check described in **Your annual eligibility check** in this section.

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

EXAMPLE: If your date of hire is April 16, 2025, your hours worked from that day through June 13, 2025, will be measured on your 60th day of employment, June 14. If you do not work the required number of hours over this 59-day measurement period, the next measurement period will be the 60-day period that runs from June 14 through August 12. The hours you work over this 60-day measurement period will be measured on August 13. If you work the required number of hours during this second measurement period and you do not have a break in employment of more than 30 days during the measurement period, you will be eligible to enroll in benefits that are available to part-time hourly associates and temporary associates, which would be effective on the first day of the month that contains the 89th day of employment,

counted from the first day of the second measurement period, assuming you enroll before the end of your initial enrollment period. Because the 89th day of employment, beginning with June 14, occurs on September 10, your benefits would be effective on September 1, assuming you enroll before the end of your initial enrollment period. Your hours will not be measured again during your first 52 weeks of employment, even if you do not enroll during your initial enrollment period. The next time your eligibility for medical benefits will be checked is the annual eligibility check described in **Your annual eligibility check** in this section.

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

If you become eligible for benefits during your first 52 weeks of employment as the result of working the required number of hours in a 60-day measurement period, your eligibility for medical benefits continues through the end of the second calendar year following the date you met your eligibility check requirements (your "medical coverage eligibility period"), assuming you remain a part-time hourly associate or temporary associate. In the examples above, the medical coverage eligibility period would continue through the end of the 2026 calendar year, which is the end of the second calendar year following the date you met your eligibility check requirements. Your eligibility for the other voluntary benefits described in the **Enrollment and effective dates by job classification** section will continue as long as you remain a part-time hourly associate or temporary associate, subject to applicable Plan terms. However, if you do not enroll in medical benefits when first eligible and prior to the end of the initial enrollment period, you will not be permitted to enroll in medical benefits during the remainder of your medical coverage eligibility period except during an Annual Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section later in this chapter. Likewise, if you do not enroll in most voluntary benefits (other than optional life insurance) during your initial enrollment period, you will also not be permitted to enroll except during an Annual Enrollment period, or if you have an election change event. Once eligible for voluntary benefits, you may enroll in optional life insurance at any time. The next time your eligibility for medical benefits will be checked is the annual eligibility check described in **Your annual eligibility check** in this section.

EXAMPLE: In the earlier examples, your medical benefits would continue through the end of 2027, unless you drop coverage during the 2025 Annual Enrollment period (for the 2026 calendar year), or the 2026 Annual Enrollment period (for the 2027 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 2027. However, you will not be permitted to change your election and enroll in medical coverage except during an Annual Enrollment period, or if you have an election change event. Your eligibility for the other voluntary benefits will continue as long as you remain a part-time hourly associate or temporary associate, subject to applicable Plan terms. However, if you do not enroll in most voluntary benefits during your initial enrollment period, you will also not be permitted to enroll except during an Annual Enrollment period, or if you have an election change event. Once eligible for voluntary benefits, you may enroll in optional life insurance at any time.

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

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

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

the required number of hours will be based on the number of days during the 60-day measurement period, less the number of days that you were on an approved leave of absence. For example, if you take an approved leave of absence during five days of the 60-day measurement period, your 60-day eligibility check will include 55 days rather than 60.

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

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

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

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

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

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

YOUR ONE-TIME ELIGIBILITY CHECK AT 52 WEEKS OF EMPLOYMENT

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

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

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

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

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

EXAMPLE: If your date of hire is April 16, 2024, your hours worked from that day through April 15, 2025 will be measured to determine whether you have worked the required number of hours during the initial measurement period. If you work the required number of hours during this initial measurement period and you do not have a break in employment of 13 weeks or more, you will be eligible to enroll in medical benefits. You will also be eligible to enroll in other voluntary benefits that are available to part-time hourly associates and temporary associates, subject to applicable Plan terms. In this example, all benefits you enroll in would be effective on June 1, 2025, which is the first day of the second calendar month following the day prior to your one-year anniversary date, April 15, 2025.

If you do not work the required number of hours during your initial measurement period to be eligible for medical benefits, your eligibility for medical benefits will be checked again at the annual eligibility check that follows your initial measurement period, as described in **Your annual eligibility check** in this section. If you had not worked the required number of hours at the one-time check at 52 weeks of employment in the example above, your first annual eligibility check for medical benefits would be in the fall of 2025 for 2026 medical coverage. You may still be eligible for other voluntary benefits that are available to part-time hourly associates and temporary associates, regardless of whether you work the required number of hours to be eligible for medical benefits, subject to applicable Plan terms. See the **Enrollment and effective dates by job classification** section in this chapter for other benefits you may be eligible for.

If you become eligible for benefits as a result of the one-time check at 52 weeks of employment, your eligibility for medical benefits continues through the end of the second calendar year following the date you met your eligibility check requirements, regardless of whether you actually enroll in medical coverage (your "medical coverage eligibility period"), subject to any applicable Plan terms and assuming you continue to be classified as a part-time hourly associate or temporary associate in Walmart's payroll system. For example, if you met the eligibility check requirements on April 15, 2025, the medical coverage eligibility period would continue through the end of the

2027 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 associate or temporary associate, subject to applicable Plan terms. However, if you do not enroll in medical benefits when first eligible and prior to the end of your initial enrollment period, you will not be permitted to enroll in medical benefits during the remainder of your medical coverage eligibility period except during Annual Enrollment, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section later in this chapter. Likewise, if you do not enroll in most voluntary benefits (other than optional life insurance) during your initial enrollment period, you will also not be permitted to enroll except during an Annual Enrollment period, or if you have an election change event. Once eligible for voluntary benefits, you may enroll in optional life insurance at any time. Your eligibility for medical benefits will not be checked again until the annual check that occurs in the final year of your medical coverage eligibility period, as described in **Your annual eligibility check** in this section.

If you take time off during the initial measurement period

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

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

If you leave Walmart and are rehired

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

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

IF YOU:	AND ARE REHIRED LESS THAN 13 WEEKS AFTER YOUR TERMINATION DATE:
Terminated during your initial measurement period	You will be treated as if you had not left, for the remainder of the initial measurement period. All hours worked during the initial measurement period will be used to determine your eligibility for medical benefits as a result of the one-time eligibility check. For example, if you have a four-week break in service during the 52-week initial measurement period, your average hours will be calculated using the 48 weeks during which you were employed, rather than 52 weeks. If you took any time off during the initial measurement period, see **If you take time off during the initial measurement period** in this section.
Terminated after your initial 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 AFTER YOUR TERMINATION DATE: (CONTINUED)
Terminated after your initial measurement period, *and* Were eligible for medical benefits when you terminated, *and* Rehired before the end of the medical coverage eligibility period	You will retain your previous eligibility status for medical benefits through the end of your medical coverage eligibility period. Your eligibility for the other voluntary benefits will continue as long as you remain a part-time hourly associate or temporary associate, subject to applicable Plan terms. Any coverage that was in effect (or the most similar coverage offered under the Plan) on your termination date will be reinstated, with a break in coverage during the period of your absence for which 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 period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section in this chapter. • Except as provided below, and subject to otherwise applicable Plan terms, if you were not enrolled in medical or other voluntary benefits on your termination date, you may not enroll in those benefits (other than optional life) when you return, until the next Annual Enrollment period, or if you have an election change event. • If you terminate in one calendar year after the Annual Enrollment period for the following calendar year has ended and you return before December 31 of the year in which you terminated, changes you made during Annual Enrollment (or coverage you defaulted to because you did not make any changes during Annual Enrollment) will be implemented. • If you terminate in one calendar year and return to work in the following calendar year and you fall into one of the following categories, you may call People Services at **800-421-1362** to enroll in medical or other voluntary benefits within 60 days of returning to work: – You were not eligible to enroll in benefits in the year you terminated but are eligible in the year you return to work – You were eligible to enroll in benefits in the year you terminated but were not enrolled – You were eligible and enrolled in benefits in the year you terminated and would like to add a dependent child (if applicable) in the year you return to work If you return after 30 days but less than 13 weeks after your termination date, you will have 60 days after returning to drop or otherwise change the reinstated coverage, subject to otherwise applicable Plan terms. After this 60-day period, and subject to otherwise applicable Plan terms, you will not be permitted to change your benefit elections (other than optional life), until the next Annual Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section in this chapter.
See the **If you leave Walmart and are rehired** section in **The medical plan** chapter for information on your deductible, out-of-pocket maximum, HRA, and maximum lifetime benefit applicable to fertility benefits under the Centers of Excellence family-building program if you terminate employment and then return to work. See the **If you leave Walmart and are rehired** section in **The dental plan** chapter for information on your required minimum enrollment period, deductible, and waiting period for orthodontia assistance if you terminate employment and then return to work.	

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

YOUR ANNUAL ELIGIBILITY CHECK

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

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

If you were a full-time hourly associate or management associate who transferred to a part-time hourly associate or temporary associate job classification, your first annual eligibility check will be first one that occurs after you transfer.

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

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

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

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

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

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

If you take time off during the annual measurement period

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

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

If you leave Walmart and are rehired

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

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

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

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

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

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

Dependent eligibility

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

EMPLOYMENT CLASSIFICATION	ELIGIBLE DEPENDENTS (AS DEFINED BELOW)
• Management (including full-time hourly truck drivers) • Full-time hourly (including full-time hourly Vision Center managers)	**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 associates, temporary associates, and part-time truck drivers may not cover a spouse/partner	• Your spouse, as long as you are not legally separated • Your domestic partner (or "partner"), as long as you and your domestic partner: – Are in an exclusive and committed relationship similar to marriage and have been for at least 12 months – Are not married to each other or anyone else – Meet the age for marriage in the state where you live and are mentally competent to consent to contract – Are not related in a manner that would bar a legal marriage in the state in which you live, and – Are not in the relationship solely for the purpose of obtaining benefits coverage. • Any other person to whom you are joined in a legal relationship recognized as creating some or all of the rights of marriage in the state or country in which the relationship was created (also referred to as "partner")
DEPENDENT CHILD(REN)	• Except as provided below, your dependent children through the end of the month in which the child reaches age 26. 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 AMP option's service area, you may still enroll your eligible dependents, but they will not have access to network providers in the geographic area in which they live and may have access only to emergency coverage. If you are unsure whether your eligible dependent lives outside your AMP option's service area, call your health care advisor at the number on your plan ID card.

IF YOUR CHILD IS OVER AGE 26 AND INCAPABLE OF SELF-SUPPORT

If your child is age 26 or older and incapable of self-support, you may enroll them in coverage beyond the end of the month in which your child reaches age 26 if:

- The child is physically or mentally incapable of self-support and primarily dependent on you for financial support, and
- The child's doctor provides written medical evidence of the child's incapacity.

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

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

Legal documentation for dependent coverage

The Plan reserves the right to conduct a verification audit of dependent eligibility. You may be required to provide legal documentation to prove the eligibility of your dependent. It is your responsibility to provide the written documentation if requested to do so by the Plan. If you do not provide necessary documentation in a timely manner, the Plan has the right to cancel your dependent's coverage. It is your responsibility to notify the Plan, in a timely manner, of any changes in your dependent's eligibility.

Examples of valid documentation are as follows:

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

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

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

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

Children: Copy of the following documents, as applicable:

- **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 partner:** State or county-issued birth certificate and proof of established partnership.
- **Foster child:** Signed letter from social service agent confirming the child has been placed under your care.
- **Child you have legal guardianship of:** Signed court order.
- **Child you are ordered by a court or agency to cover:** Signed qualified medical child support order. See **Medical child support orders** later in this chapter.
- **Child over the age of 26 who is incapable of self-support:** Medical evidence of ongoing incapacity.

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

Dependents who are not eligible

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

- Residing outside the U.S. (not applicable to optional dependent life insurance, AD&D, critical illness, and accident insurance, and not applicable if your dependent is attending college full-time outside the U.S.)
- Covered under an expatriate plan
- Not an eligible dependent as defined under **Dependent eligibility** earlier in this chapter
- 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 a Medicare prescription drug plan (applicable only to eligibility for AMP options and the pharmacy benefit, 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 classification that you transfer from. For more information, see **Enrollment and effective dates by job classification** later in this chapter and refer to the chart that applies to your job classification. 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 period, unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter:

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

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

Proof of Good Health. If you enroll in optional associate life or optional dependent life insurance for your spouse/partner 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. Proof of Good Health is not required for dependent child optional life insurance regardless of when you enroll.

Late enrollees. If you do not enroll in the 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 spouse/partner 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. Proof of Good Health is not required for dependent child optional life insurance regardless of when you enroll. 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.

CONFIRMING YOUR ENROLLMENT

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

NOTE: It is a good idea to keep a copy of your confirmation statement in your important papers for future reference.

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

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

If the Plan Administrator determines that an error did not occur or you ask for correction of an error outside the time frames described above, you may appeal that determination by following the process described in the **Appealing an enrollment or eligibility status decision** section of the **Claims and appeals** chapter of this 2025 *Associate Benefit Book*.

Refer to the **How your premiums are paid** section later in this chapter for details regarding how errors in premium deductions are handled.

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.

"ACTIVE WORK" OR "ACTIVELY AT WORK"

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

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

AUTOMATIC REENROLLMENT

If you are currently enrolled in benefits and are eligible for those same benefits during the following calendar year, but do not make an affirmative election related to those benefits during the Annual Enrollment period, you and any dependents you cover will be automatically reenrolled in the coverage options closest to what you have currently. For more information, refer to the Annual Enrollment materials provided to you and posted online at **One.Walmart.com**. Call People Services at **800-421-1362** for information.

If you do not make an affirmative election during Annual Enrollment and are enrolled automatically in coverage as described above, you 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 Walmart and are rehired

NOTE: If you terminated employment when you were in one job classification and are rehired less than 13 weeks after your date of termination in a different job classification, for purposes of determining eligibility and effective dates you will be treated as if you had never terminated, and instead, had transferred from one job classification to another. You

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

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

MANAGEMENT, FULL-TIME HOURLY, AND FULL-TIME AND PART-TIME TRUCK DRIVER ASSOCIATES

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

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

PART-TIME HOURLY ASSOCIATES AND TEMPORARY ASSOCIATES

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

Effective dates for benefits under the Plan

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

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

Enrollment and effective dates by job classification

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

NOTE: *The initial enrollment period should not be mistaken for the coverage effective date. You must enroll in coverage* ***prior*** *to the coverage effective date for most benefits.*

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

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

NOTE: *The initial enrollment period should not be mistaken for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.*

Plan	Enrollment periods and coverage effective dates
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** Your initial enrollment period starts on your first payday and ends the day *prior* to the first day of the calendar month during which your 89th day of continuous full-time employment falls. You can also enroll in, increase, or drop coverage at any time after your initial enrollment period ends **When coverage is effective:**** **If you enroll during your initial enrollment period:** • If you enroll for the guaranteed amount, coverage is effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous full-time employment falls. • If you enroll for more than the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. If approved, 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 any coverage above the guaranteed amount is not approved, and you (or your spouse/partner) are not already enrolled in coverage for the guaranteed amount, you (or your spouse/partner) will be enrolled in coverage for the guaranteed amount and coverage will be effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous full-time employment falls. **If you enroll in or increase coverage after your initial enrollment period:** • Coverage for you and/or your spouse/partner (including an increase to previously elected coverage) is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. If approved, your coverage is effective on the date Prudential approves your coverage. • You are not required to provide Proof of Good Health for children you enroll in optional dependent coverage. 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.

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

NOTE: *The initial enrollment period should not be mistaken for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.*

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

*If you are classified as a "full-time hourly California pharmacist" in Walmart's 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: *The initial enrollment period should not be mistaken for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.*

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

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FULL-TIME HOURLY VISION CENTER MANAGERS (CONTINUED)
NOTE: *The initial enrollment period should not be mistaken for the coverage effective date. You must enroll in coverage* ***prior*** *to the coverage effective date for most benefits.*

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

*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 ASSOCIATES AND TEMPORARY ASSOCIATES
Excludes part-time truck drivers

NOTE: *The initial enrollment period should not be mistaken for the coverage effective date. You must enroll in coverage* ***prior*** *to the coverage effective date for most benefits.*

Plan	Enrollment periods and coverage effective dates
• Medical* • HMO plans • Dental – Enrollment is for two consecutive calendar years • Vision • Critical illness insurance • Accident insurance • AD&D	**Initial enrollment period:** **If you are eligible for medical and other benefits during the first 52 weeks of employment as a result of working the required number of hours in a 60-day measurement cycle:** You must enroll in coverage between the date you are first notified that you have met the eligibility requirements and the day *prior* to the 60th day following notification. See the section titled **Part-time hourly associates and temporary associates: eligibility checks for medical benefits**.* **If you are eligible for medical benefits as a result of the annual eligibility check that occurs at 52 weeks of employment:** You must enroll in coverage between the date following your 52-week anniversary and the day *prior* to the 60th day following the date of your 52-week anniversary.* **Regardless of whether you are eligible for medical benefits as a result of the eligibility checks described above:** You are still eligible to enroll in all other benefits available to part-time hourly associates and temporary associates after 52 weeks of employment. You must enroll between the date following your 52-week anniversary and the day *prior* to the 60th day following the date of your 52-week anniversary.* **When coverage is effective:** **If you are eligible during the first 52 weeks of employment as a result of working the required number of hours in a 60-day measurement cycle:** Your coverage is effective on the first day of the month in which your 89th day of employment occurs, counting from the date on which the successful 60-day measurement cycle began. See the section titled **Part-time hourly associates and temporary associates: eligibility checks for medical benefits**. **If you are eligible as a result of the 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 the day *prior* to your 52-week anniversary date. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter. *To be eligible for medical coverage, part-time hourly associates and temporary associates must work the required number of hours and pass one of the eligibility checks described under **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** earlier in this chapter. Part-time hourly pharmacists hired before February 1, 2012, are exempt from this requirement.
• Associate assistance resources • Business travel accident insurance	You are enrolled automatically on your date of hire, and your coverage is effective on that date.

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PART-TIME HOURLY ASSOCIATES AND TEMPORARY ASSOCIATES (CONTINUED)
Excludes part-time truck drivers

NOTE: *The initial enrollment period should not be mistaken for the coverage effective date. You must enroll in coverage* ***prior*** *to the coverage effective date for most benefits.*

Plan	Enrollment periods and coverage effective dates
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** **If you are eligible during the first 52 weeks of employment as a result of working the required number of hours in a 60-day measurement cycle:** Your initial enrollment period starts the date you are first notified that you have met the eligibility requirements and ends the day *prior* to the 60th day following notification. **If you are eligible on your 52-week anniversary:** Your initial enrollment period starts the date following your 52-week anniversary and ends the day *prior* to the 60th day following the date of your 52-week anniversary. You can also enroll in, increase, or drop coverage at any time after your initial enrollment period ends. **When coverage is effective:**** For purposes of determining the effective date of your optional life insurance, you will need to refer to the discussion of eligibility for medical coverage. If you become eligible for medical coverage before your first 52-week anniversary because you worked the required number of hours in a 60-day measurement period, the effective date of your medical coverage is the "applicable date" for determining the effective date for optional life insurance. If you did not become eligible for medical coverage before your 52-week anniversary and instead become eligible on your 52-week anniversary, the "applicable date" for determining the effective date for optional life insurance is the first day of the second calendar month following the day prior to your 52-week anniversary. **If you enroll during your initial enrollment period:** • If you enroll for the guaranteed amount, coverage is effective on the later of 1) the date you enroll, or 2) the "applicable date." • If you enroll for more than the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and your spouse/partner and may be required to undergo a medical exam. If approved, your coverage is effective on the later of 1) the date Prudential approves your coverage, or 2) the "applicable date." If any coverage above the guaranteed amount is not approved, and you are not already enrolled in coverage for the guaranteed amount, you will be enrolled in coverage for the guaranteed amount and coverage will be effective on the later of 1) the date you enroll, or 2) the "applicable date." **If you enroll in or increase coverage after your initial enrollment period:** • Coverage for you and/or your spouse/partner (including an increase to previously elected coverage) is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. If approved, your coverage is effective on the date Prudential approves your coverage. • You are not required to provide Proof of Good Health for children you enroll in optional dependent life coverage. 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 associates 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 associates and temporary associates.

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

PART-TIME TRUCK DRIVERS
NOTE: *The initial enrollment period should not be mistaken for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.*

<table>
<tr><th>Plan</th><th colspan="2">Enrollment periods and coverage effective dates</th></tr>
<tr><td>• Medical
• HMO plans
• Dental
– Enrollment is for two consecutive calendar years
• Vision
• Critical illness insurance
• Accident insurance
• AD&D</td><td>Initial enrollment period:
You must enroll in coverage between your first payday and your 60th day of employment, measured from your date of hire.

When coverage is effective:
Your coverage is effective the first day of the calendar month during which your 89th day of continuous employment falls.</td><td>If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the Permitted election changes outside Annual Enrollment section of this chapter.</td></tr>
<tr><td>• Associate assistance resources
• Business travel accident insurance</td><td colspan="2">You are enrolled automatically on your date of hire and your coverage is effective on that date.</td></tr>
<tr><td>• Optional associate life insurance
• Optional dependent life insurance</td><td colspan="2">Initial enrollment period:
Your initial enrollment period begins on your first payday and ends the day prior to the first day of the calendar month during which your 89th day of continuous employment falls.

You can also enroll in, increase, or drop coverage at any time after your initial enrollment period ends.

When coverage is effective:*
If you enroll during your initial enrollment period:
• If you enroll for the guaranteed amount, coverage is effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous employment falls.
• If you enroll for more than the guaranteed amount, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, your coverage is effective on the later of 1) the date Prudential approves your coverage, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. If any coverage above the guaranteed amount is not approved, you will be enrolled in coverage for the guaranteed amount and coverage will be effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous employment falls.
If you enroll in or increase coverage after your initial enrollment period:
• Coverage (including an increase in previously elected coverage) is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, your coverage is effective on the date Prudential approves your coverage.
• You are not required to provide Proof of Good Health for dependent children you enroll in optional dependent life coverage.
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>

*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, full-time hourly California pharmacists,* and full-time truck drivers

NOTE: *The initial enrollment period should not be mistaken for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.*

<table>
<tr><th>Plan</th><th colspan="2">Enrollment periods and coverage effective dates</th></tr>
<tr><td>• Medical
• HMO plans
• Dental
– Enrollment is for two consecutive calendar years
• Vision
• Critical illness insurance
• Accident insurance
• AD&D</td><td>Initial enrollment period:
You must enroll in coverage between your first payday and your 60th day of employment, measured from your date of hire.

When coverage is effective:
Your coverage is effective on your date of hire.</td><td>If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the Permitted election changes outside Annual Enrollment section of this chapter.</td></tr>
<tr><td>• Associate assistance resources
• Company-paid life insurance
• Business travel accident insurance
• Short-term disability 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:
Your initial enrollment period starts on your first payday and ends on your 60th day of employment, measured from your date of hire.

You can also enroll in, increase, or drop coverage at any time after your initial enrollment period ends.

When coverage is effective:***
If you enroll during your initial enrollment period:
• If you enroll for the guaranteed amount, coverage is effective on the date you enroll.
• If you enroll for more than the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. If approved, your coverage is effective on the date Prudential approves your coverage. If any coverage above the guaranteed amount is not approved, you (or your spouse/partner) will be enrolled in coverage for the guaranteed amount and coverage will be effective on your date of hire.
If you enroll in or increase coverage after your initial enrollment period:
• Coverage for you and/or your spouse/partner (including an increase to previously elected coverage) is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. If approved, your coverage is effective on the date Prudential approves your coverage.
• You are not required to provide Proof of Good Health for dependent children you enroll in dependent life insurance coverage.
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, full-time hourly California pharmacists,* and full-time truck drivers

NOTE: *The initial enrollment period should not be mistaken for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.*

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

*Pharmacists who work in California and have the designation of "full-time hourly 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. If your coverage changes during the year, your premiums will be adjusted accordingly. You are not required to pay premiums for any benefit that you are automatically enrolled in (i.e., associate assistance resources, basic short-term disability for hourly associates, short-term disability for salaried associates, short-term disability for truck drivers, company-paid life insurance coverage, and business travel accident insurance).

For benefits that have a corresponding 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 that impact the premium amounts for that benefit, including whether you are eligible for tobacco-free rates. However, your eligibility for tobacco-free rates will depend on questions you answer during the enrollment process.

TOBACCO RATES

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

- You and/or your covered spouse/partner do not use tobacco products, or
- You and/or your covered spouse/partner use tobacco and you and/or your covered spouse/partner agree to enroll and participate in a quit-tobacco program of your/their choice by the end of the Plan year for which you are enrolling. Alternatively, if you/they call Walmart's Quit Tobacco program at **855-955-1905**, the program will work with you/them (and, if you wish, your/their doctor) to find a program that is right for you/them.

Not using tobacco products means that you and/or your covered spouse/partner have not used any type of tobacco product in the last 30 days, and you and/or your covered spouse/partner agree not to use any tobacco products in 2025. "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, the tobacco use of your covered spouse/partner, and whether you and/or your covered spouse/partner agree to enroll and participate in a quit-tobacco program to determine your eligibility for tobacco-free rates. You will be asked to make this attestation at your initial enrollment for the remainder of the calendar year and each year during Annual Enrollment for the next calendar year. Please note that your eligibility for tobacco-free rates can be established only at your initial enrollment and during Annual Enrollment. If you and/or your covered spouse/partner do not attest during initial enrollment or Annual Enrollment that you agree to enroll and participate in a quit-tobacco program, but you nonetheless become tobacco-free during the plan year, you will not become eligible for tobacco-free rates until the following calendar year.

The statement below is shown on the screen when you enroll for benefits and answer the questions regarding tobacco use:

"Our expectation is that you will apply for or enroll in benefits using correct and accurate information. If not, you may be subject to the loss of benefits and/or loss of employment."

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

For information, see **Quit Tobacco program** in **The medical plan** chapter.

HOW YOUR PREMIUMS ARE PAID

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

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

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

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

Your pay for the first pay period after your coverage effective date will generally reflect deductions for each day you had coverage during that pay period. If a pay period spans two calendar years, your deductions will reflect the

amount for the prior year through December 31 and the new amount for the new year, prorated for the number of days covered from January 1 until the end of the pay period.

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

If you believe the coverage or deductions are not correct on your paystub, call People Services immediately at **800-421-1362**. Requests for a review of 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. Refer to the **Confirming your enrollment** section earlier in this chapter for details on how to request correction of an enrollment error, including the time limits for doing so.

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

If you are enrolled in the Saver 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:

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

There are some instances where 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 or you are a newly hired associate with benefits effective as of your date of hire). See the **Permitted election changes outside Annual Enrollment** section of this chapter.
- Deductions for premiums that are past due.

TAX CONSEQUENCES OF PARTNER BENEFITS

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

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

How your imputed income is determined

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

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

How imputed income appears on your paystub

If you enrolled your partner and/or your partner's children in medical coverage and have imputed income, your paystub will reflect the imputed income as a line item,

with a dollar amount, in both the earnings column of your paystub and the deductions column. Imputed income may increase your taxable income and affect the amount of taxes withheld from your paycheck, but does not increase your take-home pay.

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

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

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

Keeping your premiums current

If you receive pay from Walmart (i.e., any pay processed through Walmart's payroll system), any premiums you currently owe (including past-due premiums) will be deducted from that pay, to the extent permitted by law. There may be times when your 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 pay processed through Walmart's payroll system (regardless of whether it is for wages, incentive payments, paid time off, paid leave, etc.), any past-due 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 for any benefit remain past due for more than 30 days, all of the coverage you elected will be canceled effective back to the date for which premiums are current. This means the cancellation of your coverage will be effective retroactively. If your coverage is canceled due to nonpayment of premiums you will be unenrolled as if you had voluntarily dropped coverage, and:

- If you are an active associate, you will not be able to enroll again until the next Annual Enrollment period unless you experience 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 that was in effect immediately prior to your leave of absence (or the most similar coverage offered under the Plan), unless you have otherwise elected other coverage as permitted by the Plan. Your coverage will be effective the first day of the pay period in which you return to active work.
- If you are on a leave of absence and return to active work after more than one year after the first day of the leave, you will be considered a new associate and will be required to meet any applicable eligibility requirements before you may enroll in coverage.

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

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

Payments made through the payment portal or by calling People Services can be made with a VISA, MasterCard, American Express, or Discover credit or debit card. Payments of premiums may also be made by check or money order and should be made payable to Associates' Health and Welfare Trust and mailed to:

Walmart People Services
P.O. Box 1039
Department 3001
Lowell, Arkansas 72745

To ensure proper credit when you send payment, include your name and WIN number on your payment. Please allow 10–14 days for processing.

If you are unable to make your premium payments, the Plan will accept payments made by someone else on your behalf.

Premiums will be deducted from your final pay since those deductions pay for coverage during that pay period.

WHEN YOU ARE ON A LEAVE

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

Coverages you can retain include medical, dental, vision, critical illness insurance, accident insurance, optional associate life, optional dependent life, and AD&D. You will also retain associate assistance resources, but no 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, Walmart's leave administrator, for additional information about FMLA, personal, or military leave, or refer to Walmart's Leave of Absence Policy on **One.Walmart.com** for specific information. You may also contact your personnel representative if you have questions about the FMLA, personal, or military leave policy. Decisions about leaves of absence are made by Walmart, not the Plan.

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

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

PAYING 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 for any benefit remain past due for more than 30 days, all coverage you elected will be canceled effective back to the date for which 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, 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 pay from Walmart (i.e., any pay processed through Walmart's payroll system), any premiums you currently owe (including past-due premiums) will be deducted from that pay to the extent permitted by law. This includes pay for wages, short-term disability benefits, and other paid leave processed through Walmart's payroll system, incentive payments, paid time off, etc. You must make arrangements to pay any premiums still due after payroll deductions, or risk cancellation of coverage.

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

DISABILITY PREMIUMS WHEN ON PAID LEAVE

If you have enrolled in any disability coverage, coverage may continue for a limited period of time if you are on a leave of absence or temporary layoff. To the extent you are required to pay 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 are 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 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 Walmart's 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 Walmart's payroll system depends on the type of pay it is. Not every type of pay you receive will be eligible pay for purposes of calculating disability benefits, so not every type of pay you receive will have a corresponding deduction for disability premiums. For example, in some cases, if you are disabled and receiving short-term disability benefits processed through Walmart's payroll system because you have been determined to be disabled under a short-term disability plan, no 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 non-disability 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 are disabled and receiving disability benefits processed through Walmart's 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 otherwise due with respect to those current disability benefits, other than health and welfare management associates during the first 90 days of disability.

PAYING PREMIUMS WHEN RECEIVING DISABILITY BENEFITS

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

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

TO MAINTAIN COVERAGE UNDER THESE BENEFITS	
• Medical • Dental • Vision • Critical illness insurance • Accident insurance	• Optional associate life • Optional dependent life • AD&D • Short-term disability • Long-term disability
WHILE YOU ARE RECEIVING…	
Short-term disability benefits under the full-time hourly short-term disability plan (except for associates who work in CA, HI, NJ, NY, and RI)	Short-term disability benefits are processed through Walmart's payroll system. You may also receive pay for paid time off, incentives, etc., which is also processed through Walmart's payroll system. • Any past-due premiums (including past-due premiums for disability coverage) will be deducted from short-term disability payments and other pay you receive. This means that if you owe any past-due premiums for disability coverage, those past-due premiums will be deducted from short-term disability benefits. No current disability premiums will be deducted from short-term disability benefits. • Any other benefit premiums (non-disability) due for the current pay period will be deducted from short-term disability payments and other pay you receive through Walmart's payroll system (from paid time off, incentives, etc.). • You must make arrangements to pay any premiums still due after payroll deductions or risk cancellation of your coverage.
Short-term disability benefits under the full-time hourly short-term disability plan (associates who work in CA, HI, NJ, NY, or RI)	Short-term disability benefits are not processed through Walmart's payroll system.* However, you may receive pay for paid time off, incentives, etc., which is processed through Walmart's payroll system. • No current short-term or long-term disability premiums will be deducted from short-term disability benefits. Any past-due premiums (including past-due premiums for short-term or long-term disability coverage) will be deducted from short-term disability payments and other pay you receive through Walmart's payroll system. • Any other benefit (non-disability) premiums due for the current pay period will be deducted from other pay you receive through Walmart's payroll system (from paid time off, incentives, etc.). • You must make arrangements to pay any premiums still due after payroll deductions or risk cancellation of your coverage.
	*In some states, your maternity benefit may be supplemented by payments processed through Walmart's payroll system. In that case, any past-due premiums and current (non-disability) premiums would be deducted from those payments.

(Continued on the next page)

WHILE YOU ARE RECEIVING... (CONTINUED)	
Long-term disability benefits under the: • Full-time hourly and salaried long-term disability plan • Truck driver long-term disability plan	Long-term disability benefits are not processed through Walmart's payroll system. However, you may receive pay for paid time off, incentives, etc., which is processed through Walmart's payroll system. • No current short-term or long-term disability premiums will be deducted from long-term disability benefits. Any past-due premiums (including past-due premiums for short-term or long-term disability coverage) will be deducted from other pay you receive through Walmart's payroll system. • Any other benefit (non-disability) premiums due for the current pay period will be deducted from other pay you receive through Walmart's payroll system (from paid time off, incentives, etc.). • You must make arrangements to pay any premiums still due after payroll deductions 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 Walmart's payroll system. You may also receive pay for paid time off, incentives, etc., which is also processed through Walmart's payroll system. You do not pay premiums for short-term disability coverage under these plans. • If you are classified as a health and wellness management associate, no current long-term disability premiums will be deducted from short-term disability benefits. Any past-due premiums (including past-due premiums for long-term disability coverage) will be deducted from short-term disability payments and other pay you receive through Walmart's payroll system. • If you are a full-time truck driver or a management associate other than a health and wellness associate, long-term disability premiums will be deducted from short-term disability benefits for the first 90 days of disability. Following 90 days, no current long-term disability premiums will be deducted from short-term disability benefits. Any past-due premiums (including past-due premiums for long-term disability coverage) will be deducted from all short-term disability payments and other pay you receive through Walmart's payroll system. • Any other benefit (non-disability) premiums due for the current pay period will be deducted from short-term disability payments and other pay you receive through Walmart's payroll system (from paid time off, incentives, etc.). • You must make arrangements to pay any premiums still due after payroll deductions or risk cancellation of your coverage.
Paid leave (non-disability) under a company paid leave program	Paid leave is processed through Walmart's payroll system. You may also receive pay (e.g., incentives), etc., which is also processed through Walmart's payroll system. • Any past-due benefit premiums will be deducted from any payments you receive. • Any benefit premiums due for the current pay period will be deducted from any payments you receive. • You must make arrangements to pay any premiums still due after payroll deductions or risk cancellation of your coverage.

Permitted election changes outside Annual Enrollment

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

- The medical plan options (including 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 to both your pretax and after-tax benefit choices if you experience an election change event. An election change event, for purposes of this *Associate Benefits Book*, is a life event or other event listed in federal regulations that allows you to make changes to your coverage outside of annual or initial enrollment. Any change you make in response to a life event must be directly related to the impact of the event on your benefits and affect your eligibility. In other words, there must be a logical relationship between the life event and the change you request, and the life event that occurs must also make an individual eligible or ineligible for coverage. This is referred to in federal regulations as "the consistency rule." For example, if you (the associate) and your spouse divorce, your spouse loses eligibility for benefits under the Plan on the date of the divorce 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
  - Gain or loss of coverage due to a change in employment impacting your eligibility
  - A change in work location that affects your medical coverage. If the change affects your medical 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. The Plan determines what, if any, election changes you may make in response to the addition or improvement of a benefit option. You will be informed if an election change opportunity is available.
- Eligibility under Medicare, Medicaid, TRICARE, or a state children's health insurance plan. (If you or your eligible dependents gain coverage under any other governmental plan, you cannot drop medical coverage (including an HMO 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. You will be informed if an election change opportunity is available.
- If you or your eligible dependents lose coverage under a governmental plan, including Medicaid or a state children's health insurance plan, an educational institution's plan, or a tribal government plan, you can add medical coverage (including an HMO 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 significantly, you may be able to change your election accordingly. The Plan determines when a significant change in cost has occurred and what election changes you may make in response. You will be informed if an election change opportunity is available.

LEGAL ORDER

If an order resulting from a divorce, legal separation, annulment, or change in legal custody (including a medical child support order—see **Medical child support orders** later in this chapter) requires you to provide medical, dental, and/or vision coverage for your eligible dependent child, you may add coverage for your eligible dependent child

(and yourself, if you are not already covered). If the order requires your spouse, former spouse, or other person to provide medical, dental, and/or vision coverage for your dependent child, and that other coverage is in fact provided, you may drop coverage for the dependent child.

MEDICARE OR MEDICAID ENTITLEMENT

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

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

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

If your work location changes

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

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

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

INTERSTATE TRANSFERS

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

If you transfer from a work location in a state without mandated short-term disability benefits to a state or locality with mandated short-term disability benefits, you will not be eligible for the Walmart short-term disability basic or enhanced plans because you may be eligible for disability benefits through the state.

For more information about legally mandated benefits, refer to the **Legally mandated benefits** chart in the **Full-time hourly short-term disability** chapter.

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

If your job classification changes

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

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

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

NOTE: If your job classification changes to part-time hourly associate or temporary associate, see **Your annual eligibility check**, which can be found earlier in this chapter in the section titled **Part-time hourly associates and temporary associates: eligibility checks for medical benefits**.

Transferring from one job classification to another

PART-TIME HOURLY ASSOCIATE OR TEMPORARY ASSOCIATE TRANSFERRING TO PART-TIME TRUCK DRIVER

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Part-time truck drivers*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a part-time hourly associate or temporary associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your part-time hourly associate or temporary associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance

As a part-time truck driver, you are eligible for medical, dental, vision, AD&D, critical illness and accident insurance coverage and may cover your eligible dependent children. You are not eligible for spouse/partner coverage.

If you were eligible for coverage on the date of your transfer, you may not make changes as a result of your transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a part-time hourly associate or temporary associate.

If you were not eligible for coverage on the date of your transfer, you may enroll in associate-only or associate + child(ren) coverage.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll online, coverage is effective the later of 1) the date you enroll or 2) the first day of the month in which your 89th day of continuous employment falls.
- If you enroll by calling People Services, coverage is effective the later of:
  - the first day of the month in which your 89th day of continuous employment falls, or
  - your choice of either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive premiums back to that effective date will be deducted from your pay on an after-tax basis.

Optional associate life insurance, optional dependent (child) life insurance

As a part-time truck driver, you are eligible for optional associate life insurance coverage and optional dependent life insurance coverage for your eligible dependent children. Proof of Good Health requirements may apply to you, but they do not apply to your children. You are not eligible for optional dependent life insurance coverage for your spouse/partner.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:
If you were eligible for coverage on the date of your transfer, you may elect or change optional associate and dependent life insurance coverage at any time. But see the **Part-time truck drivers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply if you change coverage for yourself or your child after your initial enrollment period.

If you were not eligible for coverage on the date of your transfer:

- If you enroll for the guaranteed amount for yourself, or any amount for your child, coverage is effective the later of 1) the date you enroll, or 2) the first day of the month in which your 89th day of continuous employment falls.
- If enroll for more than the guaranteed amount for yourself, coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the later of 1) the date Prudential approves your coverage, or 2) the first day of the month in which your 89th day of continuous employment falls.

  If any coverage above the guaranteed amount is not approved, you will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled for only the guaranteed amount when you were first eligible.

PART-TIME HOURLY ASSOCIATE OR TEMPORARY ASSOCIATE TRANSFERRING TO FULL-TIME HOURLY ASSOCIATE

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Full-time hourly associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a part-time hourly associate or temporary associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your part-time hourly associate or temporary associate classification through the end of your initial enrollment period. The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance

As a full-time hourly associate, you are eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children and spouse/partner.

If you were eligible for coverage on the date of your transfer, you may not enroll in associate-only or associate + children coverage as a result of your transfer because you already had the opportunity to enroll yourself and your children in coverage as a part-time hourly associate or temporary associate. However, you may enroll in associate + spouse/partner or associate + family coverage to add your spouse/partner.

If you were not eligible for coverage on the date of your transfer, you may enroll in any coverage level.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:
If you were eligible for coverage on the date of your transfer:

- If you enroll online, coverage is effective the date you enroll.
- If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive premiums back to that effective date will be deducted from your pay on an after-tax basis.

If you were not eligible for coverage on the date of your transfer:

- If you enroll online, coverage is effective the later of 1) the date you enroll, or 2) the first day of the month in which your 89th day of continuous employment falls.
- If you enroll by calling People Services, coverage is effective the later of:
  - the first day of the month in which your 89th day of continuous employment falls, or
  - your choice of either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive premiums back to that effective date will be deducted from your pay on an after-tax basis.

Company-paid life insurance

As a full-time hourly associate, you are automatically enrolled in company-paid life insurance coverage, effective the later of 1) the first day of the pay period in which your transfer occurs, or 2) the first day of the month in which your 89th day of continuous employment falls.

Optional associate life insurance, optional dependent life insurance

As a full-time hourly associate, you are eligible for optional associate life insurance coverage. You may also cover your eligible dependent children and spouse/partner under optional dependent life insurance coverage. Proof of Good Health requirements may apply to you and your spouse/partner, but they do not apply to your children.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:
If you were eligible for coverage on the date of your transfer, you can elect or change optional associate and dependent life insurance coverage at any time. But see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply if you change coverage for yourself or your child after your initial enrollment period.

If you were not eligible for coverage on the date of your transfer, you may enroll in optional associate life insurance coverage for yourself and optional dependent life insurance coverage for your child and spouse/partner. You and your spouse/partner may be subject to Proof of Good Health requirements.

- If you enroll for the guaranteed amount for yourself or your spouse/partner, or any amount for your child, coverage is effective the later of 1) the date you enroll or 2) the first day of the month in which your 89th day of continuous employment falls.
- If you enroll for more than the guaranteed amount for yourself or your spouse/partner, coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the later of 1) the date Prudential approves your or your spouse/partner coverage, or 2) the first day of the calendar month during which your 89th day of continuous employment falls.

  If any coverage above the guaranteed amount is not approved, you or your spouse/partner will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled yourself or your spouse/partner for only the guaranteed amount when you were first eligible.

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PART-TIME HOURLY ASSOCIATE OR TEMPORARY ASSOCIATE TRANSFERRING TO FULL-TIME HOURLY ASSOCIATE (CONTINUED)

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Full-time hourly associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a part-time hourly associate or temporary associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your part-time hourly associate or temporary associate classification through the end of your initial enrollment period. The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Short-term disability
As a full-time hourly associate, you are eligible for short-term disability coverage.

You are automatically enrolled for the basic and maternity coverage under the **full-time hourly short-term disability basic plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York will be enrolled in the **New York short-term disability basic plan**. Coverage is effective the later of: 1) the first day of the pay period in which your transfer occurs, or 2) the 12-month anniversary of your date of hire.

You may enroll in the **full-time hourly short-term disability enhanced plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York may enroll in the **New York short-term disability enhanced plan**.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:
- If you enroll online, coverage is effective the later of 1) the date you enroll, or 2) the 12-month anniversary of your date of hire.
- If you enroll by calling People Services, coverage is effective the later of:
  - the 12-month anniversary of your date of hire, or
  - your choice of either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs.

Long-term disability
As a full-time hourly associate, you are eligible for long-term disability coverage under the **full-time hourly and salaried long-term disability plan**.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:
- If you enroll online, coverage is effective the later of 1) the first day of the pay period in which your transfer occurs or 2) the 12-month anniversary of your date of hire.
- If you enroll by calling People Services, coverage is effective the later of
  - the 12-month anniversary of your date of hire or
  - your choice of either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs.

PART-TIME HOURLY ASSOCIATE OR TEMPORARY ASSOCIATE TRANSFERRING TO FULL-TIME HOURLY VISION CENTER MANAGER

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Full-time hourly Vision Center managers*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a part-time hourly associate or temporary associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your part-time hourly associate or temporary associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance

As a full-time hourly Vision Center manager, you are eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children and spouse/partner.

If you were eligible for coverage on the date of your transfer, you may not enroll in associate-only or associate + children coverage as a result of your transfer because you already had the opportunity to enroll yourself and your children in coverage as a part-time hourly associate or temporary associate. However, you may enroll in associate + spouse/partner or associate + family coverage to add your spouse/partner to coverage.

If you were not eligible for coverage on the date of your transfer, you may enroll in any coverage level.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll online, coverage is effective the date you enroll.
- If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive premiums back to that effective date will be deducted from your pay on an after-tax basis.

Company-paid life insurance

As a full-time hourly Vision Center manager, you are automatically enrolled in company-paid life insurance coverage, effective the first day of the pay period in which your transfer occurs.

Optional associate life insurance, optional dependent life insurance

As a full-time hourly Vision Center manager, you are eligible for optional associate life insurance coverage. You may also cover your eligible dependent children and spouse/partner under optional dependent life insurance coverage. Proof of Good Health requirements may apply to you and your spouse/partner, but they do not apply to your children.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:
If you were eligible for coverage on the date of your transfer, you may enroll or make changes at any time. But see the **Full-time hourly Vision Center managers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply if you change coverage for yourself or your child after your initial enrollment period.

If you were not eligible for coverage on the date of your transfer, you may enroll in optional associate life insurance coverage for yourself and optional dependent life insurance coverage for your child and spouse/partner. You and your spouse/partner may be subject to Proof of Good Health requirements.

- If you enroll for the guaranteed amount for yourself or your spouse/partner, or any amount for your child, coverage is effective the date you enroll.
- If you enroll for more than the guaranteed amount for yourself or your spouse/partner, coverage is subject to Prudential's approval. You or your spouse/partner will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the date Prudential approves your or your spouse/partner coverage. If any coverage above the guaranteed amount is not approved, you or your spouse/partner will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled yourself or your spouse/partner for only the guaranteed amount when you were first eligible.

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PART-TIME HOURLY ASSOCIATE OR TEMPORARY ASSOCIATE TRANSFERRING TO FULL-TIME HOURLY VISION CENTER MANAGER (CONTINUED)

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Full-time hourly Vision Center managers*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a part-time hourly associate or temporary associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your part-time hourly associate or temporary associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Short-term disability

As a full-time hourly Vision Center manager, you are eligible for short-term disability coverage.

You are automatically enrolled for the basic and maternity coverage under the **full-time hourly short-term disability basic plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York will be enrolled in the **New York short-term disability basic plan**. Coverage is effective the first day of the pay period in which your transfer occurs.

You may enroll in the **full-time hourly short-term disability enhanced plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York may enroll in the **New York short-term disability enhanced plan**.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs.
- If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs.

Long-term disability

As a full-time hourly Vision Center manager, you are eligible for long-term disability coverage under the **full-time hourly and salaried long-term disability plan**.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs.
- If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.

PART-TIME HOURLY ASSOCIATE OR TEMPORARY ASSOCIATE TRANSFERRING TO MANAGEMENT ASSOCIATE (INCLUDING FULL-TIME TRUCK DRIVER)

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Management associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a part-time hourly associate or temporary associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your part-time hourly associate or temporary associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance

As a management associate, you are eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children and spouse/partner. Additionally, the maximum coverage amount for AD&D insurance coverage increases to $1,000,000.

If you were eligible for coverage on the date of your transfer, you may not enroll in associate-only or associate + children coverage as a result of your transfer because you already had the opportunity to enroll yourself and your children in coverage as a part-time hourly associate or temporary associate. However, you may enroll in associate + spouse/partner or associate + family coverage to add your spouse.

If you were not eligible for coverage on the date of your transfer, you may enroll in any coverage level.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll online, coverage is effective the date you enroll.
- If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive premiums back to that effective date will be deducted from your pay on an after-tax basis.

Company-paid life insurance

As a management associate, you are automatically enrolled in company-paid life insurance coverage, effective the first day of the pay period in which your transfer occurs.

Optional associate life insurance, optional dependent life insurance

As a management associate, you remain eligible for optional associate life insurance coverage but the maximum coverage amount increases to $1,000,000. Proof of Good Health requirements apply if you increase your coverage.

As a management associate, you may cover your eligible dependent children and spouse/partner under optional dependent life insurance coverage. Proof of Good Health requirements may apply to your spouse/partner, but they do not apply to your children.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

If you were eligible for coverage on the date of your transfer, you can elect or change optional associate and dependent life insurance coverage at any time. But see the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply if you change coverage for yourself (including increasing the coverage amount) or your child after your initial enrollment period.

If you were not eligible for coverage on the date of your transfer, you may enroll in optional associate life insurance coverage for yourself and optional dependent life insurance coverage for your eligible dependent children and spouse/partner. You and your spouse/partner may be subject to Proof of Good Health requirements.

- If you enroll for the guaranteed amount for yourself or your spouse/partner, or any amount for your child, coverage is effective the date you enroll.
- If you enroll for more than the guaranteed amount for yourself or your spouse/partner, coverage is subject to Prudential's approval. You or your spouse/partner will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the date Prudential approves your or your spouse/partner coverage.

  If any coverage above the guaranteed amount is not approved, you or your spouse/partner will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled yourself or your spouse/partner for only the guaranteed amount when you were first eligible.

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PART-TIME HOURLY ASSOCIATE OR TEMPORARY ASSOCIATE TRANSFERRING TO MANAGEMENT ASSOCIATE (INCLUDING FULL-TIME TRUCK DRIVER) (CONTINUED)

*You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a part-time hourly associate or temporary associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your part-time hourly associate or temporary associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Short-term disability

Management associate (non–truck driver): You are automatically enrolled for the basic and maternity coverage under the **salaried short-term disability plan**. Coverage is effective on the first day of the pay period in which your transfer occurs.

Management associate (full-time truck driver): You are automatically enrolled for the basic and maternity coverage under the **truck driver short-term disability plan**. Coverage is effective on the first day of the pay period in which your transfer occurs.

Long-term disability

Management associate (non–truck driver): You are eligible for long-term disability coverage under the **full-time hourly and salaried long-term disability plan**.

Management Associate (full-time truck driver): You are eligible for long-term disability coverage under the **truck driver long-term disability plan**.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follow:

- If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs.
- If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.

PART-TIME TRUCK DRIVER TRANSFERRING TO PART-TIME HOURLY ASSOCIATE OR TEMPORARY ASSOCIATE

*You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the **Part-time hourly associates and temporary associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a part-time truck driver, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your part-time truck driver classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance

As a part-time hourly associate or temporary associate transferring from a part-time truck driver classification, you will be eligible for medical, dental, vision, AD&D, critical illness and accident coverage and may cover your eligible dependent children. However, see the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in this chapter for important information about the period of time that you will remain eligible for medical benefits and future eligibility checks for medical benefits.

You may not make changes to your coverage as a result of your transfer because you already had the opportunity to enroll as a part-time truck driver.

Optional associate life insurance, optional dependent (child) life insurance

As a part-time hourly associate or temporary associate, you remain eligible for optional associate life insurance and optional dependent life insurance coverage for your eligible dependent children.

PART-TIME TRUCK DRIVER TRANSFERRING TO FULL-TIME HOURLY ASSOCIATE

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Full-time hourly associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a part-time truck driver, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your part-time truck driver classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance

As a full-time hourly associate, you are eligible for medical, dental, vision, AD&D, critical illness and accident insurance coverage and may cover your eligible dependent children and spouse/partner. You may not enroll in associate-only or associate + children coverage as a result of the transfer because you already had the opportunity to enroll yourself and your children. However, you may enroll in associate + spouse/partner or associate + family coverage to add your spouse/partner as a result of your transfer.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll online, coverage is effective the later of 1) the date you enroll, or 2) the first day of the month in which your 89th day of continuous employment falls.
- If you enroll by calling People Services, coverage is effective the later of:
  - the first day of the month in which your 89th day of continuous employment falls, or
  - your choice of either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive premiums back to that effective date will be deducted from your pay on an after-tax basis.

Company-paid life insurance

As a full-time hourly associate, you are automatically enrolled in company-paid life insurance coverage, effective the later of 1) the first day of the pay period in which your transfer occurs, or 2) the first day of the month in which your 89th day of continuous employment falls.

Optional associate life insurance, optional dependent life insurance

As a full-time hourly associate, you remain eligible for optional associate life insurance and optional dependent life insurance coverage for your eligible children. You may also cover your spouse/partner under dependent life insurance coverage. Proof of Good Health requirements may apply.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll in dependent life insurance coverage for your spouse/partner, they may be subject to Proof of Good Health requirements:
  - If you enroll for the guaranteed amount for your spouse/partner, coverage is effective the later of 1) the date you enroll or 2) the first day of the month in which your 89th day of continuous employment falls.
  - If you enroll for more than the guaranteed amount for your spouse/partner, coverage is subject to Prudential's approval. Your spouse/partner will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the later of 1) date Prudential approves your spouse/partner coverage, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. If any coverage above the guaranteed amount is not approved, your spouse/partner will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled your spouse/partner for only the guaranteed amount when you were first eligible.

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PART-TIME TRUCK DRIVER TRANSFERRING TO FULL-TIME HOURLY ASSOCIATE (CONTINUED)

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Full-time hourly associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a part-time truck driver, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your part-time truck driver classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Short-term disability

As a full-time hourly associate, you are eligible for short-term disability coverage.

You are automatically enrolled in the basic and maternity benefits under the **full-time hourly short-term disability basic plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York will be enrolled in the **New York short-term disability basic plan**. Coverage is effective on the later of: 1) the first day of the pay period in which your transfer occurs, or 2) the 12-month anniversary of your date of hire.

You may enroll in the **full-time hourly short-term disability enhanced plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York may enroll in the **New York short-term disability enhanced plan**.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll online, coverage is effective the later of 1) the date you enroll or 2) the 12-month anniversary of your date of hire.
- If you enroll by calling People Services, coverage is effective the later of:
  - the 12-month anniversary of your date of hire or
  - your choice of either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs.

Long-term disability

As a full-time hourly associate, you are eligible for long-term disability coverage under the **full-time hourly and salaried long-term disability plan**.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll online, coverage is effective the later of 1) the first day of the pay period in which your transfer occurs or 2) the 12-month anniversary of your date of hire.
- If you enroll by calling People Services, coverage is effective the later of:
  - the 12-month anniversary of your date of hire or
  - your choice of either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs. If the effective date is any date other than the date you enroll, any retroactive premiums back to that effective date will be deducted from your pay.

PART-TIME TRUCK DRIVER TRANSFERRING TO FULL-TIME HOURLY VISION CENTER MANAGER

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Full-time hourly Vision Center managers*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a part-time truck driver, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your part-time truck driver classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance

As a full-time hourly Vision Center manager, you are eligible for medical, dental, vision, AD&D, critical illness and accident insurance coverage and may cover your eligible dependent children and spouse/partner. You may not enroll in associate-only or associate + children coverage as a result of the transfer because you already had the opportunity to enroll yourself and your children in coverage as a part-time truck driver. However, you may enroll in associate + spouse/partner or associate + family coverage to add your spouse/partner to coverage.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll online, coverage is effective on the date you enroll.
- If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive premiums back to that effective date will be deducted from your pay on an after-tax basis.

Company-paid life insurance

As a full-time hourly Vision Center manager, you are automatically enrolled in company-paid life insurance coverage, effective the first day of the pay period in which your transfer occurs.

Optional associate life insurance, optional dependent life insurance

As a full-time hourly Vision Center manager, you remain eligible for optional associate life insurance and optional dependent life insurance for your eligible dependent children. You may also cover your spouse/partner under dependent life insurance coverage. Proof of Good Health requirements may apply.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll in dependent life insurance coverage for your spouse/partner, they may be subject to Proof of Good Health requirements:
  - If you enroll for the guaranteed amount for your spouse/partner, or any amount for your child, coverage is effective the date you enroll.
  - If you enroll for more than the guaranteed amount for your spouse/partner, coverage is subject to Prudential's approval. Your spouse/partner will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the date Prudential approves your spouse/partner coverage. If any coverage above the guaranteed amount is not approved, your spouse/partner will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled your spouse/partner for only the guaranteed amount when you were first eligible.

Short-term disability

As a full-time hourly Vision Center manager, you are eligible for short-term disability coverage.

You are automatically enrolled in the basic and maternity benefits under the **full-time hourly short-term disability basic plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York will be enrolled in the **New York short-term disability basic plan**. Coverage is effective the first day of the pay period in which your transfer occurs.

You may enroll in the **full-time hourly short-term disability enhanced plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York may enroll in the **New York short-term disability enhanced plan**.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs.
- If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.

Long-term disability

As a full-time hourly Vision Center manager, you are eligible for long-term disability coverage under the **full-time hourly and salaried long-term disability plan**.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs.
- If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.

PART-TIME TRUCK DRIVER TRANSFERRING TO MANAGEMENT ASSOCIATE (INCLUDING FULL-TIME TRUCK DRIVER)

*You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a part-time truck driver, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your part-time truck driver classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance

As a management associate, you are eligible for medical, dental, vision, AD&D, critical illness and accident insurance coverage and may cover your eligible dependent children and spouse/partner. Additionally, the maximum coverage amount for AD&D insurance coverage increases to $1,000,000.

If you were eligible for coverage on the date of your transfer, you may not enroll in associate-only or associate + children coverage as a result of your transfer because you already had the opportunity to enroll yourself and your children. However, you may enroll in associate + spouse/partner or associate + family coverage to add your spouse/partner.

If you were not already eligible for coverage on the date of your transfer, you may enroll in any coverage level.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll online, coverage is effective the date you enroll.
- If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive premiums back to that effective date will be deducted from your pay on an after-tax basis.

Company-paid life insurance

As a management associate, you are automatically enrolled in company-paid life insurance coverage, effective the first day of the pay period in which your transfer occurs.

Optional associate life insurance, optional dependent life insurance

As a management associate, you remain eligible for optional associate life insurance coverage but the maximum coverage amount increases to $1,000,000. Proof of Good Health requirements apply if you increase your coverage. You also remain eligible for optional dependent life insurance for your eligible dependent children.

As a management associate, you may cover your spouse/partner under optional dependent life insurance coverage. Proof of Good Health requirements may apply.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll in dependent life insurance coverage for your spouse/partner, they may be subject to Proof of Good Health requirements:
  - If you enroll for the guaranteed amount for your spouse/partner, coverage is effective the date you enroll.
  - If you enroll for more than the guaranteed amount for your spouse/partner, coverage is subject to Prudential's approval. Your spouse/partner will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the date Prudential approves your spouse/partner coverage. If any coverage above the guaranteed amount is not approved, your spouse/partner will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled your spouse/partner for only the guaranteed amount when you were first eligible.
- See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply if you change coverage for yourself (including increasing the coverage amount) after your initial enrollment period.

Short-term disability

Management associate (non–truck driver): You are automatically enrolled in the basic and maternity benefits under the **salaried short-term disability plan**. Coverage is effective the first day of the pay period in which your transfer occurs.

Management associate (full-time truck driver): You are automatically enrolled in the basic and maternity benefits under the **truck driver short-term disability plan**. Coverage is effective the first day of the pay period in which your transfer occurs.

Long-term disability

Management associate (non–truck driver): You are eligible for long-term disability coverage under the **full-time hourly and salaried long-term disability plan**.

Management Associate (full-time truck driver): You are eligible for long-term disability coverage under the **truck driver long-term disability plan**.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you enroll online, coverage is effective on the first day of the pay period in which your transfer occurs.
- If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.

FULL-TIME HOURLY ASSOCIATE TRANSFERRING TO PART-TIME HOURLY ASSOCIATE OR TEMPORARY ASSOCIATE

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Part-time hourly associates and temporary associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a full-time hourly associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your full-time hourly associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance

As a part-time hourly associate or temporary associate transferring from a full-time hourly associate classification, you will be eligible for medical, dental, vision, AD&D, critical illness and accident insurance coverage and may cover your eligible dependent children. However, see **Your annual eligibility check** in the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in this chapter for important information about the period of time that you will remain eligible for medical benefits and future eligibility checks for medical benefits.

As a part-time hourly associate or temporary associate, you are not eligible for spouse/partner coverage. If you were enrolled in coverage on the date of your transfer and covered your spouse/partner, your coverage is automatically adjusted to associate-only or associate + child(ren) coverage (depending on whether you cover your eligible dependent children), effective as of the first day of the pay period beginning after the date your transfer occurs. Your spouse/partner may be eligible for continuation coverage. See the **COBRA** chapter of this 2025 *Associate Benefits Book*.

You may not make changes to your coverage as a result of your transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a full-time hourly associate.

Company-paid life insurance

As a part-time hourly associate or temporary associate, you are not eligible for company-paid life insurance coverage. Your coverage will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your company-paid life insurance coverage to an individual policy. See the **Company-paid life insurance** chapter of this 2025 *Associate Benefits Book* for information on how to request conversion to an individual policy.

Optional associate life insurance, optional dependent life insurance

As a part-time hourly associate or temporary associate, you remain eligible for optional associate and optional dependent life insurance coverage for your eligible dependent children.

As a part-time hourly associate or temporary associate, you are not eligible for spouse/partner coverage. If you have enrolled your spouse/partner in dependent life insurance coverage, it will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your spouse/partner dependent life insurance coverage to an individual policy. See the **Optional dependent life insurance** chapter of this 2025 *Associate Benefits Book* for information on how to request conversion to an individual policy.

Short-term disability

As a part-time hourly associate or temporary associate, you are not eligible for short-term disability coverage. Your prior full-time hourly short-term disability coverage will remain in effect through the last day of the pay period in which your transfer occurs and will not be effective after that date.

Long-term disability

As a part-time hourly associate or temporary associate, you are not eligible for long-term disability coverage. If you were enrolled in long-term disability insurance coverage on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date.

FULL-TIME HOURLY ASSOCIATE TRANSFERRING TO PART-TIME TRUCK DRIVER

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Part-time truck drivers*** *chart in the* ***Enrollment and effective dates by job classification*** *for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a full-time hourly associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your full-time hourly associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance
As a part-time truck driver transferring from the full-time hourly associate classification, you will remain eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children.

As a part-time truck driver, you are not eligible for spouse/partner coverage. If you were enrolled in coverage on the date of your transfer and covered your spouse/partner, your coverage is automatically adjusted to associate-only or associate + child(ren) coverage (depending on whether you cover your eligible dependent children), effective as of the first day of the pay period following the date of your transfer. Your spouse/partner may be eligible for continuation coverage. See the **COBRA** chapter of this 2024 *Associate Benefits Book*.

You may not make changes to your coverage as a result of your transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a full-time hourly associate.

Company-paid life insurance
As a part-time truck driver, you are not eligible for company-paid life insurance coverage. Your coverage will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your company-paid life insurance to an individual policy. See the **Company-paid life insurance** chapter of this 2025 *Associate Benefits Book* for information.

Optional associate life insurance, optional dependent life insurance
As a part-time truck driver, you remain eligible for optional associate life insurance and dependent life insurance for your eligible children.

As a part-time truck driver, you are not eligible for spouse/partner coverage. If you have enrolled your spouse/partner in dependent life insurance coverage, it will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your spouse/partner dependent life insurance coverage to an individual policy. See the **Optional dependent life insurance** chapter of this 2025 *Associate Benefits Book* for information on how to request conversion to an individual policy.

Short-term disability
As a part-time truck driver, you are not eligible for short-term disability coverage. Your prior full-time hourly short-term disability coverage will remain in effect through the last day of the pay period in which your transfer occurs and will not be effective after that date.

Long-term disability
As a part-time truck driver, you are not eligible for long-term disability coverage. If you were enrolled in long-term disability insurance coverage on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date.

FULL-TIME HOURLY ASSOCIATE TRANSFERRING TO FULL-TIME HOURLY VISION CENTER MANAGER

*You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the **Full-time hourly Vision Center managers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a full-time hourly associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your full-time hourly associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

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

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

FULL-TIME HOURLY ASSOCIATE TRANSFERRING TO MANAGEMENT ASSOCIATE (INCLUDING FULL-TIME TRUCK DRIVER)

*You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases, your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a full-time hourly associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your full-time hourly associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident, company-paid life insurance

As a management associate, you remain eligible for medical, dental, vision, AD&D, critical illness and accident insurance coverage and may cover your eligible dependent children and spouse/partner. Additionally, the maximum coverage amount for AD&D insurance coverage increases to $1,000,000. No changes are permitted as a result of the transfer other than changes to AD&D insurance coverage for increased coverage amounts.

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

Optional associate life insurance, optional dependent life insurance

As a management associate, you remain eligible for optional associate life insurance coverage but the maximum coverage amount increases to $1,000,000. Proof of Good Health requirements apply if you increase your coverage. You also remain eligible for optional dependent life insurance for your spouse/partner and eligible dependent children.

Short-term disability

Management associate (non–truck driver): You are eligible for short-term disability coverage. You are automatically enrolled in the basic and maternity benefits under the **salaried short-term disability plan**. Coverage is effective the first day of the pay period in which your transfer occurs. Your coverage under the **full-time hourly short-term disability plan** will continue through the day immediately preceding the first day of the pay period in which your transfer occurs.

Management associate (full-time truck driver): You are eligible for short-term disability coverage. You are automatically enrolled in the basic and maternity benefits under the **truck driver short-term disability plan**, effective the first day of the pay period in which your transfer occurs. Your coverage under the **full-time hourly short-term disability plan** will continue through the day immediately preceding the first day of the pay period in which your transfer occurs.

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FULL-TIME HOURLY ASSOCIATE TRANSFERRING TO MANAGEMENT ASSOCIATE (INCLUDING FULL-TIME TRUCK DRIVER) (CONTINUED)

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases, your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Management associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a full-time hourly associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your full-time hourly associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book.*

Long-term disability

Management associate (non–truck driver): You remain eligible for long-term disability insurance coverage under the **full-time hourly and salaried long-term disability plan**. Your coverage will not change as a result of the transfer and no changes are permitted as a result of the transfer.

Management associate (full-time truck driver): You are eligible for long-term disability insurance coverage under the **truck driver long-term disability plan**.

If you were enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs. You are automatically enrolled in the same level of coverage (50% or 60%) in the **truck driver long-term disability plan** at the five-year-duration option, effective the first day of the pay period in which your transfer occurs. ***This may result in increased premium deductions from your pay.***

If you were not enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer, you may enroll in the **truck driver long-term disability plan**. Proof of Good Health requirements apply.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you were automatically enrolled in the **truck driver long-term disability** plan because you were enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer:
  - If you drop your enrollment in the **truck driver long-term disability plan** or decrease your coverage, the change is effective the day after the online enrollment session. If you make your change by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs.
  - If you do not make changes to the coverage level (50% or 60%) that you were automatically enrolled in, but you change to the full-duration option, you will not be subject to Proof of Good Health requirements. Coverage will be effective the first day of the pay period in which the transfer occurs.
  - If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level but remain in the five-year duration option, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received. If the increase in coverage is not approved, you will remain enrolled at the 50% level and coverage will be effective the first day of the pay period in which your transfer occurs.
  - If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level and change to the full-duration option, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, the increase in coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received. If the increase in coverage is not approved, you will remain enrolled at the 50% level and coverage will be effective the first day of the pay period in which your transfer occurs. However, the change to the full-duration option is not subject to Proof of Good Health requirements and will be effective the first day of the pay period in which the transfer occurs.
- If you were not enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received.

FULL-TIME HOURLY VISION CENTER MANAGER TRANSFERRING TO PART-TIME HOURLY ASSOCIATE OR TEMPORARY ASSOCIATE

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Part-time hourly associates and temporary associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a full-time hourly Vision Center manager, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your full-time hourly Vision Center manager associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance

As a part-time hourly associate or temporary associate transferring from a full-time hourly Vision Center manager classification, you will be eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children. However, see **Your annual eligibility check** in the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in this chapter for important information about the period of time that you will remain eligible for medical benefits and future eligibility checks for medical benefits.

As a part-time hourly associate or temporary associate, you are not eligible for spouse/partner coverage. If you were enrolled in coverage on the date of your transfer and covered your spouse/partner, your coverage is automatically adjusted to associate-only or associate + child(ren) coverage (depending on whether you cover your eligible dependent children), effective as of the first day of the pay period beginning after your transfer occurs. Your spouse/partner may be eligible for continuation coverage. See the **COBRA** chapter of this 2025 *Associate Benefits Book*.

You may not make changes to your coverage as a result of the transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a full-time hourly associate.

Company-paid life insurance

As a part-time hourly associate or temporary associate, you are not eligible for company-paid life insurance coverage. Your coverage will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your company-paid life insurance coverage to an individual policy. See the **Company-paid life insurance** chapter of this 2025 *Associate Benefits Book* for information on requesting conversion to an individual policy.

Optional associate life insurance, optional dependent life insurance

As a part-time hourly associate or temporary associate, you remain eligible for optional associate and optional dependent life insurance coverage for your eligible dependent children.

As a part-time hourly associate or temporary associate, you are not eligible for spouse/partner coverage. If you have enrolled your spouse/partner in dependent life insurance coverage, it will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your spouse/partner dependent life insurance coverage to an individual policy. See the **Optional dependent life insurance** chapter of this 2025 *Associate Benefits Book* for information on how to request conversion to an individual policy.

Short-term disability

As a part-time hourly associate or temporary associate, you are not eligible for short-term disability coverage. Your prior full-time hourly short-term disability coverage as a vision center manager will remain in effect through the last day of the pay period in which your transfer occurs and will not be effective after that date.

Long-term disability

As a part-time hourly associate or temporary associate, you are not eligible for long-term disability coverage. Your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date.

FULL-TIME HOURLY VISION CENTER MANAGER TRANSFERRING TO PART-TIME TRUCK DRIVER

*You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the **Part-time truck drivers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a full-time hourly Vision Center manager, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your full-time hourly Vision Center classification through the end of your initial enrollment period.

The rules discussed below will apply after that initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance
As a part-time truck driver transferring from the full-time hourly Vision Center manager associate classification, you will remain eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children.

As a part-time truck driver, you are not eligible for spouse/partner coverage. If you were enrolled in coverage on the date of your transfer and covered your spouse/partner, your coverage is automatically adjusted to associate-only or associate + child(ren) coverage (depending on whether you cover your eligible dependent children), effective as of the first day of the pay period that begins after your transfer occurs. Your spouse/partner may be eligible for continuation coverage. See the **COBRA** chapter of this 2025 *Associate Benefits Book*.

You may not make changes to your coverage as a result of the transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a full-time hourly associate.

Company-paid life insurance
As a part-time truck driver, you are not eligible for company-paid life insurance coverage. Your coverage will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your company-paid life insurance to an individual policy. See the **Company-paid life insurance** chapter of this 2025 *Associate Benefits Book* for information on how to request conversion to an individual policy.

Optional associate life insurance, optional dependent life insurance
As a part-time truck driver, you remain eligible for optional associate life insurance and optional dependent life insurance for your eligible dependent children.

As a part-time truck driver, you are not eligible for spouse/partner coverage. If you have enrolled your spouse/partner in dependent life insurance coverage, it will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your spouse/partner dependent life insurance coverage to an individual policy. See the **Optional dependent life insurance** chapter of this 2025 *Associate Benefits Book* for information on how to request conversion to an individual policy.

Short-term disability
As a part-time truck driver, you are not eligible for short-term disability coverage. Your prior full-time hourly short-term disability coverage as a vision center manager will remain in effect through the last day of the pay period in which your transfer occurs and will not be effective after that date.

Long-term disability
As a part-time truck driver, you are not eligible for long-term disability coverage. If you were enrolled in long-term disability insurance coverage on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date.

FULL-TIME HOURLY VISION CENTER MANAGER TRANSFERRING TO FULL-TIME HOURLY ASSOCIATE

*You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a full-time hourly Vision Center manager, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your full-time hourly Vision Center manager classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book.*

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

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

FULL-TIME HOURLY VISION CENTER MANAGER TRANSFERRING TO MANAGEMENT ASSOCIATE (INCLUDING FULL-TIME TRUCK DRIVER)

*You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a full-time hourly Vision Center manager, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your full-time hourly Vision Center manager classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book.*

Medical, dental, vision, AD&D, critical illness, accident, company-paid life insurance
As a management associate, you remain eligible for medical, dental, vision, AD&D, critical illness and accident insurance coverage and may cover your eligible dependent children and spouse/partner. Additionally, the maximum coverage amount for AD&D insurance coverage increases to $1,000,000. No changes are permitted as a result of the transfer other than changes to AD&D insurance coverage for increased coverage amounts.

Optional associate life insurance, optional dependent life insurance
As a management associate, you remain eligible for optional associate life insurance coverage, but the maximum coverage amount increases to $1,000,000. Proof of Good Health requirements apply if you increase your coverage. You also remain eligible for optional dependent life insurance for your spouse/partner and your eligible dependent children.

Short-term disability
Management associate (non–truck driver): You are eligible for short-term disability coverage. You are automatically enrolled in the basic and maternity benefits under the **salaried short-term disability plan**. Coverage is effective the first day of the pay period in which your transfer occurs. Your coverage under the **full-time hourly short-term disability plan** will continue through the day immediately preceding the first day of the pay period in which your transfer occurs.

Management associate (full-time truck driver): You are eligible for short-term disability coverage. You are automatically enrolled in the basic and maternity benefits under the **truck driver short-term disability plan** effective the first day of the pay period in which your transfer occurs. Your coverage under the **full-time hourly short-term disability plan** will continue through the day immediately preceding the first day of the pay period in which your transfer occurs.

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FULL-TIME HOURLY VISION CENTER MANAGER TRANSFERRING TO MANAGEMENT ASSOCIATE (INCLUDING FULL-TIME TRUCK DRIVER) (CONTINUED)

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Management associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a full-time hourly Vision Center manager, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your full-time hourly Vision Center manager classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Long-term disability

Management associate (non–truck driver): You remain eligible for long-term disability insurance coverage under the **full-time hourly and salaried long-term disability plan**. Your coverage will not change as a result of the transfer and no changes are permitted as a result of the transfer.

Management associate (full-time truck driver): You are eligible for long-term disability insurance coverage under the **truck driver long-term disability plan**.

If you were enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs. You are automatically enrolled in the same level of coverage (50% or 60%) in the **truck driver long-term disability plan** at the five-year-duration option, effective the first day of the pay period in which your transfer occurs. ***This may result in increased premium deductions from your pay.***

If you were not enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer, you may enroll in the **truck driver long-term disability plan**. Proof of Good Health requirements apply.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you were automatically enrolled in the **truck driver long-term disability plan** because you were enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer:
  - If you drop your enrollment in the **truck driver long-term disability plan** or decrease your coverage, the change is effective the day after the online enrollment session. If you make your change by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs.
  - If you do not make changes to the coverage level (50% or 60%) that you were automatically enrolled in, but you change to the full-duration option, you will not be subject to Proof of Good Health requirements. Coverage will be effective the first day of the payroll period in which your transfer occurs
  - If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level but remain in the five-year duration option, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received. If the increase in coverage is not approved, you will remain enrolled at the 50% level and coverage will be effective the first day of the pay period in which your transfer occurs.
  - If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level and change to the full-duration option, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, the increase in coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received. If the increase in coverage is not approved, you will remain enrolled at the 50% level and coverage will be effective the first day of the pay period in which your transfer occurs. However, the change to the full-duration option is not subject to Proof of Good Health requirements and will be effective the first day of the pay period in which the transfer occurs.
- If you were not enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received.

MANAGEMENT ASSOCIATE (INCLUDING FULL-TIME TRUCK DRIVER) TRANSFERRING TO PART-TIME HOURLY OR TEMPORARY ASSOCIATE

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Part-time hourly associates and temporary associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a management associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your management associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance

As a part-time hourly associate or temporary associate transferring from a management associate classification, you will be eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children. However, see **Your annual eligibility check** in the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in this chapter for important information about the period of time that you will remain eligible for medical benefits and future eligibility checks for medical benefits.

As a part-time hourly associate or temporary associate, you are not eligible for spouse/partner coverage. If you were enrolled in coverage on the date of your transfer and covered your spouse/partner, your coverage is automatically adjusted to associate-only or associate + child(ren) coverage (depending on whether you cover your eligible dependent children), effective as of the first day of the first pay period in which your transfer occurs. Your spouse/partner may be eligible for continuation coverage. See the **COBRA** chapter of this 2025 *Associate Benefits Book*.

You may not make changes to your coverage as a result of the transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a management associate.

If you were enrolled in AD&D insurance coverage for amounts in excess of $200,000, your coverage will be reduced to $200,000.

Company-paid life insurance

As a part-time hourly associate or temporary associate, you are not eligible for company-paid life insurance coverage. Your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your company-paid life insurance coverage to an individual policy. See the **Company-paid life insurance** chapter of this 2025 *Associate Benefits Book* for information on how to request conversion to an individual policy.

Optional associate life insurance, optional dependent life insurance

As a part-time hourly associate or temporary associate, you remain eligible for optional associate life insurance coverage but the maximum available coverage amount is reduced to $200,000. If you are enrolled in a coverage amount in excess of $200,000 on the day *prior* to the first day of the pay period in which your transfer occurs, coverage will be reduced to $200,000 effective the first day of the pay period in which your transfer occurs.

As a part-time hourly associate or temporary associate, you remain eligible for optional dependent life insurance for your eligible dependent children, but you are not eligible for spouse/partner coverage. If you have enrolled your spouse/partner in dependent life insurance coverage, it will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your spouse/partner dependent life insurance coverage to an individual policy. See the **Optional dependent life insurance** chapter of this 2025 *Associate Benefits Book* for information on how to request conversion to an individual policy.

Short-term disability

As a part-time hourly associate or temporary associate, you are not eligible for short-term disability coverage. Your coverage will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date.

Long-term disability

As a part-time hourly associate or temporary associate, you are not eligible for long-term disability coverage. If you were enrolled in long-term disability insurance coverage on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date.

MANAGEMENT ASSOCIATE (INCLUDING FULL-TIME TRUCK DRIVER) TRANSFERRING TO PART-TIME TRUCK DRIVER

*You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the **Part-time truck drivers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a management associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your management associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident insurance
As a part-time truck driver transferring from the management associate classification, you will remain eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children.

As a part-time truck driver, you are not eligible for spouse/partner coverage. If you were enrolled in coverage on the date of your transfer and covered your spouse/partner, your coverage is automatically adjusted to associate-only or associate + child(ren) coverage (depending on whether you cover your eligible dependent children), effective as of the first day of the first pay period in which your transfer occurs. Your spouse/partner may be eligible for continuation coverage. See the **COBRA** chapter of this 2025 *Associate Benefits Book*.

You may not make changes to your coverage as a result of the transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a management (including truck driver) associate.

If you were enrolled in AD&D insurance coverage for amounts in excess of $200,000, your coverage will be reduced to $200,000.

Company-paid life insurance
As a part-time truck driver, you are not eligible for company-paid life insurance coverage. Your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your company-paid life insurance to an individual policy. See the **Company-paid life insurance** chapter of this 2025 *Associate Benefits Book* for information on how to request conversion to an individual policy.

Optional associate life insurance, optional dependent life insurance
As a part-time truck driver, you remain eligible for optional associate life insurance coverage, but the maximum available coverage amount is reduced to $200,000. If you are enrolled in a coverage amount in excess of $200,000 on the day prior to the first day of the pay period in which your transfer occurs, coverage will be reduced to $200,000 effective the first day of the pay period in which your transfer occurs.

As a part-time truck driver, you remain eligible for optional dependent life insurance for your eligible dependent children, but you are not eligible for spouse/partner coverage. If you have enrolled your spouse/partner in dependent coverage, it will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your spouse/partner dependent life insurance coverage to an individual policy. See the **Optional dependent life insurance** chapter of this 2025 *Associate Benefits Book* for information on how to request conversion to an individual policy.

Short-term disability
As a part-time truck driver, you are not eligible for short-term disability coverage. Your prior salaried short-term disability coverage will remain in effect through the last day of the pay period in which your transfer occurs, and will not be effective after that date.

Long-term disability
As a part-time truck driver, you are not eligible for long-term disability coverage. If you were enrolled in long-term disability insurance coverage on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date.

MANAGEMENT ASSOCIATE (INCLUDING FULL-TIME TRUCK DRIVER) TRANSFERRING TO FULL-TIME HOURLY ASSOCIATE

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Full-time hourly associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a management associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your management associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident, company-paid life insurance
Your benefits will not change as a result of your transfer, except that if you were enrolled in AD&D insurance coverage for amounts in excess of $200,000, your coverage will be reduced to $200,000. Otherwise, no changes are permitted as a result of your transfer.

Optional associate life insurance, optional dependent life insurance
As a full-time hourly associate, you remain eligible for optional associate life insurance coverage, but the maximum available coverage amount is reduced to $200,000. If you are enrolled in a coverage amount in excess of $200,000 on the day *prior* to the first day of the pay period in which your transfer occurs, coverage will be reduced to $200,000 effective the first day of the pay period in which your transfer occurs. You also remain eligible for optional dependent life insurance for your spouse/partner and your eligible dependent children.

Short-term disability
As a full-time hourly associate, you are eligible for short-term disability coverage. Your enrollment in the **salaried or truck driver short-term disability plan** continues through the day immediately preceding the first day of the pay period in which your transfer occurs. You are automatically enrolled in the **full-time hourly short-term disability enhanced plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York will be enrolled in the **New York short-term disability enhanced plan**. ***This will result in premium deductions from your pay.***

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- You may drop your enrollment in the **full-time hourly short-term disability enhanced plan** or, for associates in New York, the **New York short-term disability enhanced plan**. If you drop your enrollment in the **full-time hourly short-term disability enhanced plan** or, for associates in New York, the **New York short-term disability enhanced plan**, you will be automatically enrolled in the full-time hourly short-term disability basic plan or, for associates in New York, the **New York short-term disability basic plan** and your coverage is effective the day after the online enrollment session. If you drop coverage by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs.
- If you do not drop your enrollment in the **full-time hourly short-term disability enhanced plan** or, for associates in New York, the **New York short-term disability enhanced plan**, your coverage is effective the first day of the pay period in which your transfer occurs.

Long-term disability
Transferring from management associate (non–truck driver): No changes are permitted as a result of your transfer.

Transferring from management associate (full-time truck driver): As a full-time hourly associate, you are eligible for the **full-time hourly and salaried long-term disability plan**. If you were enrolled in the **truck driver long-term disability plan** on the date of your transfer, your coverage continues through the last day of the pay period in which your transfer occurs. You are automatically enrolled in the same level of coverage (50% or 60%) in the **full-time hourly and salaried long-term disability plan** effective the first day of the pay period in which your transfer occurs.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you were automatically enrolled in the **full-time hourly and salaried long-term disability plan** because you were enrolled in the **truck driver long-term disability** on the date of your transfer:
  - If you drop or decrease your automatic enrollment in the **full-time hourly and salaried long-term disability plan**, the change is effective the day after the online enrollment session. If you drop coverage by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs.
  - If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level, coverage will be effective the first day of the pay period following the date you enroll.
- If you were not enrolled in **truck driver long-term disability plan** prior to the date of your transfer and you choose to enroll in the **full-time hourly and salaried long-term disability plan**:
  - If you enroll online, coverage is effective the later of (1) the first day of the pay period in which your transfer occurs or 2) the 12-month anniversary of your date of hire.
  - If you enroll by calling People Services, coverage is effective the later of the 12-month anniversary of your date of hire, or your choice of either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs.

MANAGEMENT ASSOCIATE (INCLUDING FULL-TIME TRUCK DRIVER) TRANSFERRING TO FULL-TIME HOURLY VISION CENTER MANAGER ASSOCIATE

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Full-time hourly associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a management associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your management associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident, company-paid life insurance
Your benefits will not change as a result of your transfer. No changes are permitted as a result of your transfer.

Optional associate life insurance, optional dependent life insurance
As a full-time hourly Vision Center manager, you remain eligible for optional associate life insurance coverage, but the maximum available coverage amount is reduced to $200,000. If you are enrolled in a coverage amount in excess of $200,000 on the day *prior* to the first day of the pay period in which your transfer occurs, coverage will be reduced to $200,000 effective the first day of the pay period in which your transfer occurs. You also remain eligible for optional dependent life insurance for your spouse/partner and your eligible dependent children.

AD&D insurance
As a full-time hourly vision center manager, you remain eligible for AD&D coverage, but the maximum available coverage amount is reduced to $200,000. If you are enrolled in a coverage amount in excess of $200,000 on the day prior to the first day of the pay period in which your transfer occurs, coverage will be reduced to $200,000 effective the first day of the pay period in which your transfer occurs.

Short-term disability
As a full-time Vision Center manager, you are eligible for short-term disability coverage. Your enrollment in the salaried or **truck driver short-term disability plan** continues through the day immediately preceding the first day of the pay period in which your transfer occurs. You are automatically enrolled in the **full-time hourly short-term disability enhanced plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York will be enrolled in the **New York short-term disability enhanced plan**. ***This will result in premium deductions from your pay.***

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- You may drop your enrollment in the **full-time hourly short-term disability enhanced plan** or, for associates in New York, the **New York short-term disability enhanced plan**. If you drop your enrollment in the full-time hourly short-term disability enhanced plan or, for associates in New York, the New York short-term disability enhanced plan, you will be automatically enrolled in the full-time hourly short-term disability basic plan or, for associates in New York, the New York short-term disability basic plan and your coverage is effective the day after the online enrollment session. If you drop coverage by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs.
- If you do not drop your enrollment in the **full-time hourly short-term disability enhanced plan** or, for associates in New York, the **New York short-term disability enhanced plan**, your coverage is effective on the first day of the pay period in which your transfer occurs.

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MANAGEMENT ASSOCIATE (INCLUDING FULL-TIME TRUCK DRIVER) TRANSFERRING TO FULL-TIME HOURLY VISION CENTER MANAGER ASSOCIATE (CONTINUED)

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Full-time hourly associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a management associate, and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your management associate classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Long-term disability

Transferring from management associate (non–truck driver): No changes are permitted as a result of your transfer.

Transferring from management associate (full-time truck driver): As a full-time Vision Center manager associate, you are eligible for the **full-time hourly and salaried long-term disability plan**. If you were enrolled in the **truck driver long-term disability plan** on the date of your transfer, your coverage continues through the day immediately preceding the first day of the pay period in which your transfer occurs. You are automatically enrolled in the same level of coverage (50% or 60%) in the **full-time hourly and salaried long-term disability plan** effective the first day of the pay period in which your transfer occurs.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you were automatically enrolled in the **full-time hourly and salaried long-term disability plan** because you were enrolled in the **truck driver long-term disability** on the date of your transfer:
  - If you drop your enrollment in the full-time hourly and salaried long-term disability plan or decrease your coverage, the change is effective the day after the online enrollment session. If you make your change by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs.
  - If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level, coverage will be effective the first day of the pay period following the date you enroll.
- If you were not enrolled in **truck driver long-term disability plan** prior to the date of your transfer and you choose to enroll in the **full-time hourly and salaried long-term disability plan**:
  - If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs.
  - If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.

MANAGEMENT ASSOCIATE (FULL-TIME TRUCK DRIVER) TRANSFERRING TO MANAGEMENT ASSOCIATE (NON–TRUCK DRIVER)

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Management associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a management associate (full-time truck driver), and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your initial enrollment period will not change. You may make any election permitted as a result of your management associate (full-time truck driver) classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident, company-paid life insurance, optional associate and dependent life insurance
Your benefits will not change as a result of your transfer. No changes are permitted as a result of your transfer other than to optional associate and dependent life insurance coverage, which can be changed at any time.

Short-term disability
As a management associate (non–truck driver), you are automatically enrolled in the basic and maternity benefits under the **salaried short-term disability plan**, effective the first day of the pay period in which your transfer occurs. Your enrollment in the **truck driver short-term disability plan** continues through the day immediately preceding the first day of the pay period in which your transfer occurs.

Long-term disability
As a management associate (non–truck driver), you are eligible for the **full-time hourly and salaried long-term disability plan**.
If you were enrolled in the **truck driver long-term disability plan** on the date of your transfer, your coverage continues through the day immediately preceding the first day of the pay period in which your transfer occurs. You are automatically enrolled in the same level of coverage (50% or 60%) in the **full-time hourly and salaried long-term disability plan** effective the first day of the pay period in which your transfer occurs.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you were automatically enrolled in the **full-time hourly and salaried long-term disability plan** because you were enrolled in the **truck driver long-term disability** on the date of your transfer:
- If you drop your enrollment in the **full-time hourly and salaried long-term disability plan** or decrease your coverage, the change is effective the day after the online enrollment session. If you make your change by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs.
  - If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level, coverage will be effective the first day of the pay period following the date you enroll.
- If you were not enrolled in **truck driver long-term disability plan** prior to the date of your transfer and you choose to enroll in the **full-time hourly and salaried long-term disability plan**:
  - If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs.
  - If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.

MANAGEMENT ASSOCIATE (NON–TRUCK DRIVER) TRANSFERRING TO MANAGEMENT ASSOCIATE (FULL-TIME TRUCK DRIVER)

You must make permitted changes described below within 60 days from the first day of the pay period in which your transfer occurs. If you do not make changes, in most cases your next opportunity to do so will be during the next Annual Enrollment or when you experience a valid election change event. See the ***Management associates*** *chart in the* ***Enrollment and effective dates by job classification*** *section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.*

If you recently became eligible for benefits while classified as a management associate (non truck-driver), and the initial enrollment period communicated to you has not ended prior to the date of your transfer, your enrollment period will not change. You may make any election permitted as a result of your management associate (non–truck driver) classification through the end of your initial enrollment period.

The rules discussed below will apply after your initial enrollment period ends, through the date that is 60 days from the first day of the pay period in which your transfer occurs.

All benefits remain subject to the terms and conditions described in this 2025 *Associate Benefits Book*.

Medical, dental, vision, AD&D, critical illness, accident, company-paid life insurance, optional associate and dependent life insurance
Your benefits will not change as a result of your transfer. No changes are permitted as a result of your transfer other than to optional associate and dependent life insurance coverage, which can be changed at any time.

Short-term disability
As a management associate (full-time truck-driver), you are automatically enrolled in the basic and maternity benefits under the **truck driver short-term disability plan**, effective the last day of the pay period in which your transfer occurs. Your coverage under the **salaried short-term disability plan** continues through the day immediately preceding the first day of the pay period in which your transfer occurs.

Long-term disability
As a management associate (full-time truck driver), you are eligible for long-term disability coverage under the **truck driver long-term disability plan**.

If you were enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer, your coverage will continue through the day of the pay period in which your transfer occurs. You are automatically enrolled in the same level of coverage (50% or 60%) in the **truck driver long-term disability plan** at the five-year-duration option, effective the first day of the pay period in which your transfer occurs. ***This may result in increased premium deductions from your pay.***

If you were not enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer, you may enroll in the **truck driver long-term disability plan**. Proof of Good Health requirements apply.

If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:

- If you were automatically enrolled in the **truck driver long-term disability plan** because you were enrolled in the full-time hourly and **salaried long-term disability plan** on the date of your transfer:
  - If you drop your enrollment in the **truck driver long-term disability plan** or decrease your coverage, the change is effective the day after the online enrollment session. If you make your change by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs.
  - If you do not make changes to the coverage level (50% or 60%) that you were automatically enrolled in, but you change to the full-duration option, you will not be subject to Proof of Good Health requirements. Coverage will be effective the first day of the payroll period in which your transfer occurs.
  - If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level but remain in the five-year duration option, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received. If the increase in coverage is not approved, you will remain enrolled at the 50% level and coverage will be effective the first day of the pay period in which your transfer occurs.
  - If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level and change to the full-duration option, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, the increase in coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received. If the increase in coverage is not approved, you will remain enrolled at the 50% level and coverage will be effective the first day of the pay period in which your transfer occurs. However, the change to the full-duration option is not subject to Proof of Good Health requirements and will be effective the first day of the pay period in which the transfer occurs.
- If you were not enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received.

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. As used in this section, the term QMSCO also means an approved NMSN.

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

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

If you are in the state of Hawaii, the default plan is Health Plan Hawaii (HMSA). If you are in a location where the PPO Plan is offered, the default plan is the Saver Plan.

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

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

- If you are enrolled in an HMO plan or 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 your satisfying your initial waiting period for medical coverage, the order will be put into effect when your initial waiting period is satisfied, subject to applicable Plan terms.
- If you are ineligible for coverage when the Plan receives a QMCSO, the order will be rejected.
- If you are ineligible for coverage when the Plan receives a QMCSO but subsequently become eligible, the Plan requires a new QMCSO before coverage for your dependent can take effect.
- If you are eligible for coverage when the Plan receives a QMCSO, then become ineligible and subsequently regain eligibility, the Plan requires a new QMCSO before coverage for your dependent can take effect. This requirement will apply in the following situations:
  - If you become ineligible due to non-payment of 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 for the child(ren) identified in the QMCSO if the following applies:

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

  EXAMPLES:

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

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

  EXAMPLE:

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

- A child who is the subject of the court order reaches the age of emancipation in the state issuing the court order. Contact your state child support enforcement agency for details.

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

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

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

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

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

When your Plan coverage ends

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

- At termination of your employment
- On the last day of coverage for which 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 your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in this chapter for information on any impact to your coverage.

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

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

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

Eligibility, enrollment, and effective dates for associates in Hawaii

Eligibility, enrollment, and effective dates for associates in Hawaii

If you are an associate who works in Hawaii, the benefits described throughout this 2025 *Associates Benefits Book* apply to you, apply to you, with the exception of some slight differences in eligibility terms applicable to medical and short-term disability benefits. To the extent information discussed in this chapter conflicts with information in the **Eligibility, enrollment, and effective dates** chapter, information in this chapter will control.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Health Plan Hawaii (HMSA)	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 program, full-time hourly associates are generally not eligible to participate in a Walmart short-term disability plan. However, you may still be eligible for the maternity benefit under the Walmart short-term disability basic plan. See the **Full-time hourly short-term disability** chapter for details.
- Initial eligibility periods for coverage vary for Hawaii associates based on their employment status, as described in this chapter.

Eligibility waiting periods for medical coverage

MANAGEMENT ASSOCIATES

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

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

If you are a full-time hourly associate (including full-time hourly pharmacists and field supervisor positions in stores and clubs) or a part-time hourly or temporary associate in Hawaii, your eligibility for medical coverage is subject to special rules applicable to Hawaii associates. For benefits other than medical and disability, eligibility terms are described in the **Eligibility, enrollment, and effective dates** chapter. Eligibility for other benefits is also described in charts under **Enrollment and effective dates by job classification** 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 cost of the premium, but only up to 1.5% of their wages or 50% of the cost of the premium per pay period, whichever is less. For example: if your wages per pay period are $1,000 and you qualify for tobacco-free rates, you are not required to pay more than $15 for coverage per pay period (assuming that the entire premium is at least $30).

Enrollment and effective dates for Hawaii associates

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

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 payday 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 consecutive 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 payday and the day prior to your coverage effective date.</td></tr>
<tr><td>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>

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

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 and your coverage is effective on that date.
Associate assistance resources Business travel accident insurance	You are automatically enrolled on your date of hire and your coverage is effective on that date.
Hawaii Temporary Disability Insurance* (legally mandated program) 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 payday and the day *prior* to the first day of the calendar month during which your 89th day of continuous full-time employment falls. **When coverage is effective:*** **If you enroll during your initial enrollment period:** • If you enroll for the guaranteed amount, coverage is effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous full-time employment falls. • If you enroll for more than the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. If approved, 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 any coverage above the guaranteed amount is not approved, you (or your spouse) will be enrolled in coverage for the guaranteed amount and coverage will be effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous full-time employment falls. **If you enroll in or increase coverage after your initial enrollment period:** • Coverage for you and/or your spouse/partner (including an increase to previously elected coverage) is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. If approved, your coverage is effective on the date Prudential approves your coverage. • You are not required to provide Proof of Good Health for children you enroll in optional dependent coverage. 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 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).

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

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
• Long-term disability plan (including enhanced benefits)	**Initial enrollment period:** You must enroll in coverage between the date of your first payday and the day *prior* to first day of the calendar month during which your 89th day of continuous full-time employment falls. **When coverage is effective:** • **If you enroll in coverage during your initial enrollment period:** Coverage is effective on the 12-month anniversary of your date of hire. • **If you enroll in or increase coverage after your initial enrollment period:** – If you enroll in or increase coverage following an election change event, your coverage is effective on the later of 1) the first day of the pay period following the date you enroll, or 2) the 12-month anniversary of your date of hire. – If you enroll in or increase coverage during Annual Enrollment for the next Plan year, your coverage will be effective the later of 1) January 1 of that year, or 2) the 12-month anniversary of your date of hire. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of the **Eligibility, enrollment, and effective dates** chapter.

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

PART-TIME HOURLY AND TEMPORARY ASSOCIATES
NOTE: *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 payday and the day prior to your effective date.</td></tr>
<tr><td rowspan="2">*Part-time hourly and temporary associates in Hawaii are not subject to the requirements described under Part-time hourly associates and temporary associates: eligibility checks for medical benefits in the Eligibility, enrollment, and effective dates chapter.</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="2">If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the Permitted election changes outside Annual Enrollment section of the Eligibility, enrollment, and effective dates chapter.</td></tr>
<tr><td>Dental (enrollment is for two consecutive calendar years)
Vision
Critical illness insurance
Accident insurance
AD&D</td><td>Initial enrollment period:
You must enroll in coverage between the date of your first payday and the day prior to your coverage effective date.</td></tr>
<tr><td></td><td colspan="2">When coverage is effective:
Your coverage is effective the first day of the calendar month during which your 89th day of continuous employment falls.</td></tr>
<tr><td>Associate assistance resources
Business travel accident insurance</td><td colspan="2">You are automatically enrolled on your date of hire.</td></tr>
</table>

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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 Effective Dates
Hawaii Temporary Disability Insurance (legally mandated program)	For Hawaii Temporary Disability Insurance, see the **Resources** chart at the beginning of this chapter for contact information on eligibility and effective dates.
Optional associate life insurance Optional dependent life insurance	**Initial enrollment period:** You must enroll in coverage between the date of your first payday and the day *prior* to your coverage effective date. **When coverage is effective:*** **If you enroll during your initial enrollment period:** • If you enroll for the guaranteed amount, coverage is effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. • If you enroll for more than the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. If approved, coverage is effective on the later of 1) the date Prudential approves your coverage, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. If any coverage above the guaranteed amount is not approved, you will be enrolled in coverage for the guaranteed amount and coverage will be effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous full-time employment falls. **If you enroll in or increase coverage after your initial enrollment period:** • Coverage for you and/or your spouse/partner (including an increase to previously elected coverage) is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. If approved, your coverage is effective on the date Prudential approves your coverage. • You are not required to provide Proof of Good Health for children you enroll in optional dependent coverage. 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 spouses/partners. Company-paid life insurance is not available to part-time hourly and temporary associates.

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

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

The medical plan

The 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**
Important information to help you manage your health care costs and find TPA network providers	**Price comparison tool**: **IncludedHealth.com/Walmart**		
	Provider directory: **IncludedHealth.com/Walmart**		
Aetna Premier, Contribution, Saver, and Banner Local Plan	Go to **One.Walmart.com/Health** or **aetna.com**	**855-548-2387**	**Aetna** **151 Farmington Avenue** **Hartford, Connecticut 06156**
BlueAdvantage Administrators of Arkansas Premier, Contribution, and Saver Plan	Go to **One.Walmart.com/Health** 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/Health** or **UMR.com**	**855-870-9177**	**UMR** **P.O. Box 30541** **Salt Lake City, Utah 84130-0541**
Mercy Arkansas Local Plan		**800-804-1272**	
HealthSCOPE Benefits Cancer medical record review, heart surgery, kidney dialysis or ESRD medical record review, transplant, and related travel benefits (including family building)		**800-804-1289** Transplant: **479-621-2830**	
Contigo Health Hip and knee replacement, spine surgery, weight loss surgery programs, and related travel benefits		**877-230-7037**	
Kindbody Family building benefits	**Go to Kindbody.com/Walmart**	**855-454-7663**	Email: **Walmart@kindbody.com**
Request a paper copy of this 2025 *Associate Benefits Book*		Call People Services at **800-421-1362**	Scan the QR code below:

- This chapter describes the medical benefits offered under the self-insured AMP options in the Associates' Medical Plan. 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. If a fully insured option is available at your work location, coverage details are described in materials available online at **One.Walmart.com/Health** or provided separately by the HMO or PPO insurer. Terms of coverage for these options are not described in this chapter. However, the eligibility terms in the **Eligibility, enrollment, and effective dates** chapter override any inconsistent terms in any HMO and PPO documents. See the **Helping you manage your health** section in this chapter for some resources available to you, even if you are enrolled in an HMO or PPO option.
- 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.

The Associates' Medical Plan (AMP)

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

While every AMP option generally provides benefits for the same covered services, a specific option may have an alternative design. The information in this chapter will explain each self-insured AMP option, including alternative designs and tools and features to help you find care for you and your covered dependents.

For important resources to help you manage your health care:

- Provider directories can be found at **IncludedHealth.com/Walmart**
- A price comparison tool can be found at **IncludedHealth.com/Walmart**
- Information about covered services and claims can be found on your third-party administrator's website:
  - **aetna.com**
  - **blueadvantagearkansas.com**
  - **UMR.com**
- Other information about AMP options can be found on **One.Walmart.com/Health**

Associates who enroll in medical coverage through an HMO or PPO Plan option: HMO and PPO Plan options are available in 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 AMP as described in the **Eligibility, enrollment, and effective dates** chapter, eligibility terms in the **Eligibility, enrollment, and effective dates** chapter will control. However, terms related to covered benefits under an HMO or PPO option, other than some benefits discussed in the **Helping you manage your health** section, are described in materials provided separately by the HMO or PPO insurer or are available at **One.Walmart.com/Health**.

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 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 coverage effective date will vary depending on a number of factors, including your job classification. Refer to the **Eligibility, enrollment, and effective dates** chapter for more information. **Be sure to enroll by the enrollment deadline provided 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/Enroll**.

CHOOSING A COVERAGE TIER

When you enroll in the AMP, you will select your coverage tier, including any eligible dependents 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, whether you are eligible for tobacco-free rates and whether you are enrolled in the AMP through COBRA continuation coverage. See the **Paying for your benefits** section in the **Eligibility, enrollment, and effective dates** chapter for information about premiums. See also the **COBRA** chapter for more information about COBRA continuation coverage.

Role of third-party administrator (TPA)

The AMP provides medical benefits only for certain services, under the terms and conditions described in this chapter, which are referred to as "covered services." See the **What is covered by the AMP** section in this chapter for a definition of "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, your work location, and in some cases, the type of covered services you receive. If your work location changes during the year, the AMP options available to you and the TPA that administers your benefits may change. The primary TPA that administers the AMP option you elect is identified on your plan ID card. The Plan reserves the right to change the TPA that administers your benefits at any time.

For certain covered services, like those available through the Centers of Excellence program or the travel benefit for care, a TPA other than your primary TPA will administer the benefits. See the chart below.

Your TPA may also be an insurance company that issues health insurance policies in other areas of its business. This does not mean your medical benefits under the AMP are insured. Many insurance companies also provide TPA services to self-insured plans, which are plans that are funded by assets of the employers who sponsor them. 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. Each TPA will use its internal policies and procedures to make claims and appeals decisions on behalf of the AMP.

THIRD-PARTY ADMINISTRATORS (TPAS) DELEGATED BY PLAN ADMINISTRATOR	
• Premier Plan option • Contribution Plan option • Saver Plan option • Heart surgery under the Centers of Excellence program • 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	UMR
Centers of Excellence program for: • Cancer medical record review; on-site evaluation and treatment • Kidney dialysis (outpatient) or ESRD medical record review, on-site evaluation and treatment • Transplant services, and • Travel benefits related to these Centers of Excellence programs (including for heart surgery and family building)	HealthSCOPE Benefits
Centers of Excellence program • Hip and knee replacement • Spine surgery • Weight loss surgery, and • Travel benefits related to these Centers of Excellence programs	Contigo Health
Doula program	HealthSCOPE Benefits (in-person doula) Kindbody (virtual doula)

*For AMP participants in Alabama, Alaska, Arizona, Colorado, Illinois, Indiana, Iowa, Kentucky, Minnesota, Missouri, North Carolina, South Carolina, Tennessee, Texas, Virginia, West Virginia, or Wisconsin, preauthorization requests ("pre-service claims") are determined by American Health Holding, Inc. on behalf of Included Health.

In addition to administering your benefits, the TPA identified on your plan ID card also provides access to its provider network for most covered services. This is your "TPA network." See the **Network providers and non-network providers** section below for more information on network providers.

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 a specific facility. If you are a truck driver, the AMP options available to you may be determined by your home address on record rather than work location. Over the next few pages, you will find charts of the various AMP options that may be available to you. Each chart provides a summary of coverage for each AMP option. Following the charts is information to help you evaluate the best option for you. Remember that in some locations, you may also have access to an insured option through the AMP, but it will be described in materials provided by the insurer, which are also available at **One.Walmart.com/Health**.

PREMIER, CONTRIBUTION, SAVER PLAN OPTIONS

The three main options available nationwide are the Premier, Contribution, and Saver Plan options. The chart titled **Premier, Contribution, Saver Plan options** compares these options and provides coverage information for each option. However, if a local plan option is available in your work location (see below), it will generally replace the Contribution Plan option as a coverage option.

In some locations, there may be agreements between the AMP (or a TPA) and providers that include financial incentives to providers to manage care.

LOCAL PLAN OPTIONS

If available at your work location, the AMP options available to you may also include a "local plan," which provides access to groups of providers in a specific area. If a local plan option is available in your work location, the AMP options available to you will likely be the Premier, Saver, and the available local plan option, but not the Contribution Plan option. In other words, if 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.

Agreements between the AMP and these groups of providers may include financial incentives to manage care.

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**.

NETWORK PROVIDERS AND NON-NETWORK PROVIDERS

Your "TPA network" consists of providers who have contractually agreed with the TPA 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. **Providers in the TPA network are not permitted to bill you for an amount over that negotiated amount for covered services under the AMP.**

For some services, such as covered services provided through the Centers of Excellence program or advanced imaging services, the network of providers is different from, or a narrow subset of, your TPA network. These more narrow networks are referred to as "AMP networks" to indicate they are networks created by the AMP for specific covered services. For those covered services, the AMP may pay only a limited benefit, or no benefit, if you do not use one of the providers in the AMP network, even if you use a provider who is in the TPA network for other covered services.

"Non-network providers" are providers who are not in your TPA network or AMP network. This may also refer to providers in your TPA network that are treated as non-network providers when you receive services that are only covered services when received through the AMP network, such as under the Centers of Excellence program.

See the **Provider networks** section of this chapter for additional detail.

PREMIER, CONTRIBUTION, SAVER PLAN OPTIONS			
	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 office visits (in-person or telehealth) *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** • Network • Non-network	100% after $35 copay 50% after deductible	75% after deductible 50% after deductible	75% after deductible 50% after deductible
Specialist • Network • 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[1]
Urgent care[2] • 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*[3] • Network[4] • 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[2] **and other covered services** Inpatient & outpatient care *Including physician, surgeon, air ambulance, and other provider/facility services not listed* • 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 charges** • Network • Non-network	75% after deductible 50% after deductible	75% after deductible 50% after deductible	75% after deductible 50% after deductible
Outpatient office visits (in-person or telehealth) • Network • Non-network	100% after $35 copay 50% after deductible	75% after deductible 50% after deductible	75% after deductible 50% after deductible
Emergency services[2] **Ground ambulance**[5]	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[3]	See the **Centers of Excellence** section of this chapter		

[1] *The information indicating that the deductible applies is current as of December 15, 2024. If this changes, the AMP materials will be updated.*

[2] *For full details about surprise billing and cost sharing for urgent care, hospitalization, and emergency services, see the* **Emergency, ground ambulance, preventive, and telehealth services** *section later in chapter. May not apply to urgent care facilities in your state.*

[3] *This is an AMP network*

[4] *This refers to a provider in the TPA network.*

[5] *Covered only as described in the* **Emergency, ground ambulance, preventive, and telehealth services** *section and* **When limited benefits apply to the AMP** *to the AMP section later in this chapter.*

LOCAL PLAN OPTIONS—BANNER AND MERCY ARKANSAS		
	Banner	**Mercy Arkansas**
	In-Network Benefits Only *No benefits for services provided outside the network except for emergency services*	
Annual deductible (Individual/Family)	$3,000/$6,000	$1,750/$3,500
Walmart-provided funds (Individual/Family)	N/A	N/A
Annual out-of-pocket maximum (Individual/Family)	$6,850/$13,700	$6,850/$13,700
Eligible preventive care	100% (no deductible)	100% (no deductible)
Doctor office visits (in-person or telehealth) *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** **Specialist**	 100% after $35 copay 100% after $75 copay	 100% after $35 copay 100% after $75 copay
Telehealth video visits through Doctor On Demand by Included Health	$0 copay	$0 copay
Urgent care[1]	100% after $75 copay	100% after $75 copay
Diagnostic tests *Nonpreventive tests ordered or performed outside a doctor's office*	75% after deductible	75% after deductible
Hospitalization[1] **and other covered services** Inpatient & outpatient care *Including physician, surgeon, air ambulance, and other provider/facility services not listed*	75% after deductible	75% after deductible
Mental health **Inpatient & outpatient facility charges (in-person or telehealth)** **Outpatient office visits (in-person or telehealth)**	 75% after deductible 100% after $35 copay	 75% after deductible 100% after $35 copay
Emergency services[1] **Ground ambulance**[2]	100% after deductible and $300 copay	100% after deductible and $300 copay
Pharmacy	See **The pharmacy benefit** chapter	
Centers of Excellence[3]	See the **Centers of Excellence** 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.

[1] *For full details about surprise billing and cost sharing for urgent care, hospitalization, and emergency services, see the* ***Emergency, ground ambulance, preventive, and telehealth services*** *section later in chapter. May not apply to urgent care facilities in your state.*

[2] *Covered only as described in the* **Emergency, ground ambulance, preventive, and telehealth services** *section and* **When limited benefits apply to the AMP** *section later in this chapter.*

[3] *This is an AMP network.*

Evaluating your options

For important resources to help you manage your health care:

- Provider directories can be found at **IncludedHealth.com/Walmart**
- A price comparison tool can be found at **IncludedHealth.com/Walmart**
- Information about covered services and claims can be found on your third-party administrator's website:
  - **aetna.com**
  - **blueadvantagearkansas.com**
  - **UMR.com**
- Other information about AMP options can be found on **One.Walmart.com/Health**

WALMART-PROVIDED FUNDS

Contribution Plan option—health reimbursement account

The Contribution Plan option includes a health reimbursement account ("HRA"). Each year, Walmart 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 Walmart 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, Walmart 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 2024 and 2025, any HRA funds allocated in 2025 could be used only for eligible medical expenses for services received in 2025 but not those received prior to 2025 (such as an expense incurred in 2024 but not processed until 2025). However, any "rollover funds"—HRA funds that roll over from 2024 to 2025—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, Walmart 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, Walmart 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 your coverage under the Contribution Plan ended. 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 Walmart 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. Walmart 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 Walmart's) cannot exceed the 2025 annual IRS limit of $4,300 for associate-only coverage or $8,550 for all other coverage tiers, plus $1,000 if you turn 55 by the end of the 2025 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 summary charts on earlier pages show the percentage, or share, of the cost of covered services that the AMP will pay. See the **Coinsurance** section on the next page for information about the "maximum allowable charge," or the cost of covered service the AMP will use to determine benefits. The cost of covered services is shared between you and the AMP. You are responsible for paying the "coinsurance," which is the difference between 100% of the cost of covered services and the percentage, or share, the AMP pays, in addition to any applicable deductible and copayment (or copay). The portion of eligible medical expenses you are responsible for paying is referred to as "cost sharing," which includes the deductible, copayment (or copay), and coinsurance amounts. 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 AMP's 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 are enrolled in the Contribution plan, you have a $1,750 annual network deductible and 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).

The Premier, Contribution and Saver Plan 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 this case, 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 are enrolled in 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 you enroll in one of the local plans, which do 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, except when the out-of-network services are covered services for an emergency medical condition in an emergency department, certain covered services provided by a non-network provider in a network facility subject to notice and consent requirements that has not obtained your consent to bill you for amounts in excess of the AMP's maximum allowable charge, or services provided by a non-network provider of air ambulance services that would be covered by the AMP if provided by a network provider of air ambulance services.

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 all or a portion of 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 the entire cost for covered services and prescription drugs until you meet your network annual deductible. There are exceptions (including some preventive and over-the-counter drugs and preventive services), which are discussed under **Preventive care program** later in this chapter 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, including but not limited to those for pharmacy, in-person or telehealth doctor visits, urgent care, covered services for a non-emergency medical condition in an emergency department, or covered services for ground ambulance
- 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 AMP's 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 not covered by the AMP, including but not limited to amounts paid for out-of-network services if you are in a local plan option and 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.

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.

The portion that you and the AMP each pay for the cost of covered services 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." See **Maximum allowable charge** in the **What is covered by the AMP** section later in this chapter for important information about how the maximum allowable charge is calculated. The maximum allowable charge is the maximum charge for covered services that will be used to determine any AMP benefit, subject to any copayment, deductible, or coinsurance you are responsible for.

- **Premier, Contribution, and Saver Plan options:** 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, certain covered services provided by a non-network provider in a network facility subject to notice and consent requirements that has not obtained your consent to bill you for amounts in excess of the maximum allowable charge, or services provided by a non-network provider of air ambulance services that would be covered by the AMP if provided by a network provider of air ambulance services. 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 a TPA network provider who is an *Alternate Network Provider* in the AMP network than those received from a TPA network provider who is not an *Alternate Network Provider*. If no *Alternate Network Provider* is located within 30 miles of the provider ordering advanced imaging services, the AMP will pay the alternate network benefit amount for covered services if you use a TPA network provider. See **Advanced imaging network** in the **Provider networks** section for more information. See **Maximum allowable charge** in the **What is covered by the AMP** section later in this chapter for additional information. Find TPA 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, even if you or your dependents live outside the normal service area of the local plan. You will be responsible for paying the entire cost of services received from a non-network provider, except in the case of covered services for an emergency medical condition in an emergency department, certain covered services provided by a non-network provider in a network facility subject to notice and consent requirements that has not obtained your consent to bill you for amounts in excess of the maximum allowable charge, or services provided by a non-network provider of air ambulance services that would be covered by the AMP if provided by a network provider of air ambulance services. See **Maximum allowable charge** in the **What is covered by the AMP** section later in this chapter for additional information. Find network providers in the provider directory: **IncludedHealth.com/Walmart**.

Keep in mind that for some services, such as covered services provided through the Centers of Excellence program or advanced imaging services, the network of providers is different from, or a narrow subset of, your TPA network. These more narrow networks are referred to as "AMP networks" to indicate they are networks created by the AMP for specific covered services. For those covered services, the AMP may pay only a limited benefit, or no benefit, if you do not use one of the providers in the AMP network, even if you use a provider who is in the TPA network for other covered services.

"Non-network providers" include providers who are not in your TPA network or AMP network. This may also refer to providers in your TPA network that are treated as non-network providers when you receive services that are only covered services when received through the AMP network, such as under the Centers of Excellence program.

See the **Provider networks** section of this chapter for additional detail.

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 received from a network provider. Generally, only amounts you pay for covered services received from network providers count toward the out-of-pocket maximum. There are some exceptions, such as 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 TPA network provider when an *Alternate Network Provider* in the AMP network is located within 30 miles of the provider ordering advanced imaging services, or coinsurance for services received from a TPA network provider when a Blue Select network provider is available within 30 miles of your home (in applicable locations). See the **Advanced imaging network** sections in the **Provider networks** section of this chapter for more information. Generally, amounts you pay for covered services received from a non-network provider do not count toward your out-of-pocket maximum. See the lists below for expenses that do and do not count toward your out-of-pocket maximum.

After you meet the annual out-of-pocket maximum, the AMP pays 100% of the maximum allowable charge for covered services received from a network provider, excluding those that do not apply to the annual out-of-pocket maximum. You will be required to pay for the cost of covered services received from a non-network provider, excluding those that do count toward the annual out-of-pocket maximum.

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 dependents are subject to the individual out-of-pocket maximum. Once you or any of your covered dependents have paid for covered services up to the individual amount, that individual's eligible medical expenses for covered services are paid at 100% for the rest of the calendar year. The family out-of-pocket maximum is a combination of all covered individuals' eligible medical expenses. Any combination of two or more covered individuals 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 covered individual, even if each individual has not met the individual out-of-pocket maximum, except as otherwise provided in this section.

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, including but not limited to those for in-person or telehealth doctor visits, urgent care, or covered services that are emergency services for an emergency medical condition in an emergency department, or covered services for a ground ambulance
- Coinsurance for services provided by a network provider or by a non-network provider that the AMP pays as in-network or for certain covered services provided by a non-network provider in a network facility subject to notice and consent requirements that has not obtained your consent to bill you for amounts in excess of the maximum allowable charge, or for services provided by a non-network provider of air ambulance services that would be covered by the AMP if provided by a network provider of air ambulance services
- 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 for hip or knee replacement services outside of the Centers of Excellence program without an exception from a TPA network provider; advanced imaging services from a TPA network provider when an *Alternate Network Provider* is available within 30 miles of the provider ordering the advanced imaging services; or services from a TPA network provider when a Blue Select network provider is available within 30 miles from your home (in applicable locations). See the **Provider networks** section and **Centers of Excellence** section for more details.
- Charges for non-network preventive services
- Coinsurance for services received from a non-network provider
- Amounts in excess of the AMP's 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
- 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 enrolled in one of the local plans, which do 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

For important resources to help you manage your health care:

- Provider directories can be found at **IncludedHealth.com/Walmart**
- A price comparison tool can be found at **IncludedHealth.com/Walmart**
- Information about covered services and claims can be found on your third-party administrator's website:
  - **aetna.com**
  - **blueadvantagearkansas.com**
  - **UMR.com**
- Other information about AMP options can be found on **One.Walmart.com/Health**

As explained above, neither the AMP's portion of eligible medical expenses nor your portion (your coinsurance) is based on the amount billed by the provider, but rather on the "maximum allowable charge." How the maximum allowable charge is determined depends on whether a provider is a network provider or non-network provider.

A network provider is, generally, a provider who has agreed to accept a contracted amount as full payment for covered services at discounted prices and has agreed not to bill you for amounts in excess of the maximum allowable charge, which is the contracted amount.

There are different types of network providers and in some cases, whether a provider is a network provider will depend on the specific services you receive. A network provider for one covered service may not be a network provider for all covered services.

TPA network. Each AMP option provides access to a network that consists of a group of providers who have agreed with the TPA to accept a contracted amount for covered services. These network providers are in your "TPA network" and the TPA has agreed to make its TPA network available to the AMP. The contracted amount is the AMP's maximum allowable charge. Most covered services under the AMP are available though a TPA network provider. However, providers in the TPA's network are not network providers for all covered services. **See the AMP networks section on the following page for important information about services that will be covered services only if provided by a provider in a more narrow AMP network, even if you receive the services from a provider who is otherwise in the TPA network for other covered services.**

AMP network. Each AMP option also provides access to a network of providers and facilities the AMP has contracted with, either directly or through a third party, who have agreed to accept a contracted amount for specific covered services. These network providers are in an "AMP network," which is different from the TPA network. The contracted amount is the AMP's maximum allowable charge. The AMP will generally pay the greatest benefit only when you receive specific covered services from a provider in an AMP network. **Not all providers in the TPA network are providers in an AMP network. See the AMP networks section below for important information about services that will be covered services only if provided by a provider in an AMP network, even if you receive the services from a provider who is otherwise in the TPA network for other covered services.**

A non-network provider is one who has not agreed to accept a contracted amount as full payment for covered services. This may include a provider who is otherwise in the TPA network for some covered services, but not for other covered services, which are only available through an AMP network. The maximum allowable charge for non-network providers is determined by each TPA. See the discussion of covered services available through the Centers of Excellence program and advanced imaging services in the **AMP networks** section for important information about when the AMP may pay a reduced benefit, or no benefit for certain covered services, even if the services are provided by a provider in the TPA network and your AMP option otherwise provides out-of-network coverage. With some exceptions, non-network providers can bill you for amounts in excess of the maximum allowable charge determined by the TPA. This is why you can generally expect to pay a greater share of the cost for services you receive from a non-network provider. See **Maximum allowable charge** in the **What is covered by the AMP** section later in this chapter for detailed information about how each TPA determines the maximum allowable charge for covered services received from non-network providers.

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, New Hampshire, Oklahoma, western Pennsylvania, Tennessee, northern Virginia, or Wisconsin, see important information on the following page in the section titled **Blue Select networks through BlueAdvantage Administrators of Arkansas**.
- UMR

Each TPA enters into contracts with various providers and a provider may be in all TPA networks or just one or two TPA networks.

If your provider is no longer in your TPA 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. In certain circumstances, you may be eligible for continued coverage, called "continuity of care," where your provider may continue to be treated as a TPA network provider for a period of time. See important information about continuity of care services described in the section titled **When network benefits are paid for out-of-network services** later in this chapter.

If you are enrolled in the Premier, Contribution, or Saver Plan option, which provide out-of-network coverage, and you receive services from a non-network provider, you will generally be responsible for any remaining deductible, coinsurance and the cost of services in excess of the AMP's maximum allowable charge. If you are enrolled in one of the local plan options, which do not provide out-of-network coverage, you will generally be responsible for the entire amount charged by the non-network provider.

With some exceptions, non-network providers can bill you for amounts in excess of the maximum allowable charge determined by the TPA. This is why you can generally expect to pay a greater share of the cost for services you receive from a non-network provider. See **Maximum allowable charge** in the **What is covered by the AMP** section later in this chapter for detailed information about how each TPA determines the maximum allowable charge for non-network providers.

For important resources to help you manage your health care:

- Provider directories can be found at **IncludedHealth.com/Walmart**
- A price comparison tool can be found at **IncludedHealth.com/Walmart**
- Information about covered services and claims can be found on your third-party administrator's website:
  - **aetna.com**
  - **blueadvantagearkansas.com**
  - **UMR.com**
- Other information about AMP options can be found on **One.Walmart.com/Health**

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 TPA 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 indicated in this **TPA networks** section, providers who are not in a Blue Select network will be considered non-network providers and services received from the providers will be treated as out-of-network services, except when the out-of-network services are covered services for an emergency medical condition in an emergency department, certain covered services provided by a non-network provider in a network facility subject to notice and consent requirements that has not obtained your consent to bill you for amounts in excess of the maximum allowable charge, or services provided by a non-network provider of air ambulance services that would be covered by the AMP if provided by a network provider of air ambulance services. Coinsurance paid for covered services from a TPA network provider when a Blue Select network provider is available within 30 miles from your home will not apply to your out-of-pocket maximum, except when the out-of-network services are covered services for an emergency medical condition in an emergency department, certain covered services provided by a non-network provider in a network facility subject to notice and consent requirements that has not obtained your consent to bill you for amounts in excess of the maximum allowable charge, or services provided by a non-network provider of air ambulance services that would be covered by the AMP if provided by a network provider of air ambulance services. 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 TPA network provider for covered services, including those not in the Blue Select networks, subject to all applicable AMP terms and conditions of coverage.

If BlueAdvantage Administrators of Arkansas is your TPA, 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
- New Hampshire: BlueChoice Open Access POS
- Oklahoma: BluePreferred
- Western 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.

AMP networks

For some services, the AMP will generally pay the greatest benefit, or the only benefit, when you receive specific covered services from a provider in an AMP network. If you receive those services from a provider not in an AMP network, the AMP may pay a reduced benefit, or no benefit for those services, even if you receive the services from a provider who is otherwise in a TPA network for other covered services. Each AMP network is described below.

CENTERS OF EXCELLENCE NETWORK

The covered services listed below are available through the Centers of Excellence program, and are described in detail in the **Centers of Excellence** section. In some cases, if you receive the services described below from a provider not in the AMP network, the AMP may pay a reduced benefit, or no benefit, even if you receive the services from a provider who is otherwise in a TPA network for other covered services, unless you request and receive an exception.

- Medical records review by Mayo Clinic for certain types of cancer, including on-site evaluation or treatment, when recommended by Mayo Clinic
- Family-building services (age 18 and up) at Kindbody Signature Clinics, including but not limited to in vitro fertilization (IVF) and intrauterine insemination (IUI)
- Medical record e-review by Cleveland Clinic for certain heart conditions (age 18 and up) including on-site heart surgery, when recommended by Cleveland Clinic
- Hip or knee replacement surgery
- Medical record review by Mayo Clinic for outpatient kidney dialysis or end-stage renal disease (ESRD) (all ages), including on-site evaluation or treatment, when recommended by Mayo Clinic
- Surgeries for certain spine conditions (age 18 and up, except for certain spine conditions, such as scoliosis)
- 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 (age 14 and up), including gastric bypass, gastric sleeve, and duodenal switch.

See the **Centers of Excellence** section for complete details regarding these services and Centers of Excellence eligibility conditions and requirements.

ADVANCED IMAGING NETWORK

If you are enrolled in the Premier, Contribution, or Saver Plan option (but not a local plan option), an alternate network of providers for advanced imaging services (MRI and CT scans) may be available to you. This alternate network of providers is an AMP network. All *Alternate Network Provider*s are also in your TPA network but not all providers in your TPA network are *Alternate Network Provider*s. The AMP benefit for advanced imaging services will depend on whether the provider is a TPA network provider who is an *Alternate Network Provider* in the AMP network, a TPA network provider who is not an *Alternate Network Provider* in the AMP network, 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 TPA network provider who is not an *Alternate Network Provider*, when an *Alternate Network Provider* is available within 30 miles of the provider ordering the advanced imaging services. The AMP will also pay a portion of the cost of covered services received from a non-network provider if you are enrolled in the Premier, Contribution, or Saver Plan option, in accordance with regular AMP terms applicable to covered services received from a non-network provider. **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.

See the discussion of the annual out-of-pocket maximum in the **Annual out-of-pocket maximum** section for important information about the application of the out-of-pocket maximum limit to your share of the covered cost for advanced imaging services.

TELEHEALTH VISITS

The cost of covered services for telehealth visits will be paid under the otherwise applicable AMP terms (for example, the same as outpatient doctor visits), unless the services are provided by Doctor On Demand by Included Health. For more details, please see the section titled **Telehealth video visits through Doctor On Demand by Included Health**.

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 the contracted amount used for network providers) or the amount that is determined by applicable law, subject to other applicable AMP terms. You will still be responsible for any amounts 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, covered services from a non-network provider subject to notice and consent requirements who has not obtained your consent to bill you for amounts in excess of the maximum allowable charge, and covered services from a non-network provider of air ambulance services that would be covered by the AMP if provided by a network provider of air ambulance services. 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 care). You will need to contact your TPA if you believe this exception applies to you.
- 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 amounts in excess of the maximum allowable charge, which is determined in accordance with applicable law:

- If you receive covered services for an emergency medical condition 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 who is subject to notice and consent requirement and who has not obtained your consent to bill you for amounts in excess of 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

To the extent the AMP covers air ambulance services provided by a network provider, out-of-network air ambulance services will be treated as network covered expenses. Your cost-sharing will be the same as for covered 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 maximum allowable charge 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.

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.

See the section titled **Ground ambulance** in the **Emergency, ground ambulance, preventive, and telehealth services** section for more details.

COVERAGE WHEN YOU TRAVEL TO A FOREIGN COUNTRY

If you travel abroad, follow these steps:

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

Emergency, ground ambulance, preventive, and telehealth services

EMERGENCY SERVICES

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

The AMP will pay the benefit described below for emergency services. 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 as an inpatient from the emergency department or pass away prior to admission, in which case the copay is waived). 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 you are enrolled in the Premier, Contribution, or Saver Plan option, 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 AMP's maximum allowable charge for medical services provided in the emergency department of a non-network facility. 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.

GROUND AMBULANCE

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

If you receive ground ambulance services that are not for an "emergency medical condition," but are covered by the AMP as described in the **When limited benefits apply to the AMP** section, the AMP will pay 100% of the covered services after you have met your network deductible and paid the $300 copay. The $300 copay applies to each ground ambulance service you receive but will be waived if you are admitted as an inpatient at a hospital to which you are transported or you pass away prior to admission. In instances where the ground ambulance transports you to a facility other than a hospital, the $300 copay will apply. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible.

If you receive ground ambulance services for a condition that is an "emergency medical condition," as described above, the AMP will pay 100% of the cost of covered services, even if the ground ambulance provider is a non-network provider, after you have met your deductible and paid a $300 copay. The $300 copay applies to each ground ambulance service you receive but will be waived if you are admitted as an inpatient at the facility to which the ground ambulance transports you, or you pass away prior to admission at that facility. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible.

For ground ambulance services provided for a condition that is an "emergency medical condition" by a non-network provider, the AMP's maximum allowable charge will be determined according to the following terms:

- If you are not admitted as an inpatient at a hospital to which the ground ambulance transports you and you do not pass away prior to admission to that hospital, the AMP's maximum allowable charge will be 125% of Medicare's maximum allowable charge.
- If you are admitted as an inpatient at a hospital to which the ground ambulance transports you or you pass away prior to admission at that hospital, the AMP's maximum allowable charge will be 200% of 125% of Medicare's maximum allowable charge.

For ground ambulance services that are covered services for a condition that is not an "emergency medical condition" provided by a non-network provider, the AMP's maximum allowable charge will be determined according to the following terms:

- If you are not admitted as an inpatient at a hospital to which the ground ambulance transports you and you do not pass away, the AMP's maximum allowable charge will be 125% of Medicare's maximum allowable charge.
- If you are admitted as an inpatient at a hospital to which the ground ambulance transports you or you pass away prior to admission at that hospital, the AMP's maximum allowable charge will be 200% of 125% of Medicare's maximum allowable charge.

- If you are currently admitted as an inpatient at a hospital and are transported by ground ambulance to a facility other than a hospital, the AMP's maximum allowable charge will be 125% of Medicare's maximum allowable charge.

A non-network provider will be permitted to bill you for amounts in excess of the maximum allowable charge.

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 the **Premier, Contribution**, or **Saver Plan option**: 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. In addition to the coinsurance, you are also responsible for any amount above the maximum allowable charge, and amounts you pay will not apply to your deductible or out-of-pocket maximum
- 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. These AMP options do not provide out-of-network coverage.

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 visits (including urgent care and primary 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 49 states and the District of Columbia, 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, before you have met your deductible, if you are enrolled in the Premier, Contribution, or local plan option. If you are enrolled in the Saver Plan option, you must meet your deductible first. 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 specialists at 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 the AMP and each Centers of Excellence facility may share information to determine eligibility for and administer the Centers of Excellence program, as permitted by HIPAA.

In performing evaluation services or determining Centers of Excellence care, the Centers of Excellence facility is not acting as agent for the AMP, but as your health care provider. The Centers of Excellence program covers:

- Medical records review by Mayo Clinic for certain types of cancer, including on-site evaluation or treatment, when recommended by Mayo Clinic
- Family-building services (age 18 and up) at Kindbody Signature Clinics, including but not limited to in vitro fertilization (IVF) and intrauterine insemination (IUI)
- Medical record e-review by Cleveland Clinic for certain heart conditions (age 18 and up) including on-site heart surgery, when recommended by Cleveland Clinic
- Hip or knee replacement surgery
- Medical record review by Mayo Clinic for outpatient kidney dialysis or end-stage renal disease (ESRD) (all ages), including on-site evaluation or treatment, when recommended by Mayo Clinic
- Surgeries for certain spine conditions (age 18 and up, except for certain spine conditions, such as scoliosis)
- 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 (age 14 and up), including gastric bypass, gastric sleeve, and duodenal switch

The chart below is a summary only. Read all 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	
Cancer medical record review, on-site evaluation and treatment May include on-site evaluation and treatment, when recommended by Mayo Clinic	**HealthSCOPE Benefits 800-804-1289**	100% No deductible[2]	Regular AMP terms and conditions apply
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 UMR 800-804-1289**	75% After network deductible	No coverage
Heart surgery eReview by Cleveland Clinic and on-site surgery when recommended by Cleveland Clinic	**Your medical plan administrator (see plan ID card** **Travel by HealthSCOPE Benefits 800-804-1289**	100% No deductible[2]	Regular AMP terms and conditions apply
Hip and knee replacement	**Contigo Health 877-230-7037**	100% No deductible[2]	**Premier, Contribution, and Saver Plan options:** 50% after out-of-network deductible Coinsurance will not apply to out-of-pocket maximum **Local plans:** No coverage[3]
Kidney dialysis (outpatient) or ESRD medical records review, on-site evaluation and treatment May include on-site kidney transplant evaluation or treatment when recommended by Mayo Clinic	**HealthSCOPE Benefits** **479-621-2830**	100% No deductible[2]	Regular AMP terms and conditions apply
Spine surgery	**Contigo Health 877-230-7037**	100% No deductible[2]	No coverage[3]
Transplant Mayo Clinic only. Excludes cornea and intestinal transplant	**HealthSCOPE Benefits 479-621-2830**	100% No deductible[2]	No coverage[3]
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] Exceptions may apply. See the specific program details in this section.

As shown in the chart above, 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.

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:

- All services must be coordinated and approved by the applicable Centers of Excellence program administrator. The specific administrator or facility from whom approval 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.
- The AMP covers some services outside the Centers of Excellence program under regular AMP terms and conditions. However, there are some services the AMP does not cover outside the Centers of Excellence program, unless you have requested and received an exception. See the **Centers of Excellence** chart on the previous page. These services must be "preauthorized."
- 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.
- 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 the indicated service.
- For most services offered under the Centers of Excellence program, you must supply contact information for a local provider who has agreed to manage your follow-up care after you return home from the 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.
- In performing evaluation services or in making determinations about Centers of Excellence treatment and care, including whether to treat you or continue to treat you, the Centers of Excellence facility is not acting as agent for the AMP, but as your health care provider. The AMP cannot require a provider in the Center of Excellence program to treat you. A provider may refuse to treat you if your behavior disrupts the provider-patient relationship or if you fail to follow the provider's instructions.
- You, your caregiver, and any visitors must abide by all rules and policies of the Centers of Excellence facility, hotel, and transport service, including those that apply to communications and on-site conduct. Failure to do so may result in loss of eligibility for benefits under the Centers of Excellence program. Any communications or interactions with Centers of Excellence facilities or staff that are abusive or disruptive may also result in loss of eligibility for benefits under the Centers of Excellence program.
- Covered services performed at a Centers of Excellence facility outside the scope of services covered by the Centers of Excellence program are subject to regular AMP terms and conditions of coverage, even if provided by an AMP network provider.
- 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 your 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 are covered services under the Centers of Excellence program, from: 1) a provider or facility that is not an AMP network provider under the Centers of Excellence program, or 2) a provider or facility that is otherwise an AMP network provider under the Centers of Excellence program, but you do not work through the Centers of Excellence program administrator or have not been approved for the Centers of Excellence program, you will be subject to terms summarized in the right-hand column of the **Centers of Excellence** chart earlier in this chapter, 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 TPA network provider.

Under limited circumstances, the AMP provides out-of-network coverage for hip or knee replacement as described later in the **Hip or knee replacement and spine surgery** section and summarized in the **Centers of Excellence** chart earlier in this chapter.

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.

CANCER MEDICAL RECORD REVIEW, ON-SITE EVALUATION, AND TREATMENT

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

- **Review of medical records.** Mayo Clinic will review your medical records and will make a recommendation, based on medical records provided, about whether an on-site evaluation is appropriate. Mayo Clinic's determination is not subject to the AMP's claims and appeals procedures.
- **On-site evaluation at Mayo Clinic for possible treatment at Mayo Clinic.** Based on Mayo Clinic's review of your medical records, Mayo Clinic may recommend that you travel to Mayo Clinic for an on-site evaluation regarding possible treatment at Mayo Clinic. Your travel will be provided through the Centers of Excellence program. Mayo Clinic's determination is not subject to the AMP's claims and appeals procedures.
- **Treatment at Mayo Clinic.** If Mayo Clinic recommends treatment at Mayo Clinic, this treatment will be covered under the Centers of Excellence program, which will pay 100% of the cost of covered services received from Mayo Clinic. Eligible medical expenses will be paid before you meet your annual network 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 Mayo Clinic does not recommend treatment at Mayo Clinic or 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, even if you receive care at Mayo Clinic outside of the Centers of Excellence program.

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. Unless otherwise provided, 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 terms applicable to your deductible, coinsurance, and 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 cover any benefits after you have reached the $20,000 maximum lifetime benefit. The $20,000 maximum is the amount of paid benefits 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 (FET)
- Frozen oocyte thaw and fertilization
- Preimplantation genetic testing (PGT-A; PGT-M, PGT-SR, etc.)
- Male infertility treatments due to azoospermia or history of vasectomy (TESE; PESE)
- Donor eggs, embryos, and sperm (considered taxable)
- Cryopreservation (freezing) of oocyte (egg)/embryo/sperm (if the patient is under age 18, Kindbody may recommend for medical reasons, such as for tissue storage following a cancer diagnosis or other medical condition). Payment for Kindbody's storage of cryopreserved oocyte/embryo/sperm will be provided for one year. Payment for additional years of storage by Kindbody 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.

HEART SURGERY E-REVIEW AND TREATMENT

Before receiving non-emergency heart surgery, 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 for eReview of your medical records, Cleveland Clinic recommends on-site heart surgery, and you choose to participate in the Centers of Excellence program for heart surgery, you will be connected with HealthSCOPE Benefits to arrange your travel benefits.

If you are eligible to participate in the Centers of Excellence program for eReview, including on-site heart surgery if recommended by Cleveland Clinic, 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.

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 if you request and receive a network exception. 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 choose not to participate in the Centers of Excellence program for hip or knee replacement, and do not receive an exception, the AMP may pay only limited benefits for covered services, subject to terms described in the **Centers of Excellence** chart earlier in this chapter and in the **Hip or knee replacement** section on the next page.

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.

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 the AMP network or TPA 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, or Saver Plan option**, 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 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 virtual 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, before you meet your deductible, 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.

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 network exception process is summarized below and discussed in more detail in the section in the **Claims and appeals** chapter referenced immediately above.

Pre-service exception request: If you 1) have not yet received a hip or knee replacement but are considering receiving services from a non-Centers of Excellence provider or facility, or 2) have not yet received spine surgery, you may request a pre-service network exception request to receive services at a non-Centers of Excellence provider or facility and have the AMP pay the cost of covered services, subject to the AMP's regular terms and conditions of coverage 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 section in the **Claims and appeals** chapter titled **External appeal process for medical, pharmacy, or Centers of Excellence benefits**.

Post-service exception request: If you already have received services from a non-Centers of Excellence provider or facility, you may request a post-service network 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**.

A decision by a Centers of Excellence provider to not perform hip or knee replacement or spine surgery is not subject to review under the network exception request process if the Centers of Excellence provider's decision is based on your refusal to 1) follow the terms and conditions of the Centers of Excellence Program, including the rules and policies listed elsewhere in this **Centers of Excellence** section, or 2) comply with medical restrictions or requirements including but not limited to weight loss, smoking cessation, alcohol cessation, social support, conduct, or similar factors.

KIDNEY DIALYSIS OR ESRD MEDICAL RECORD REVIEW

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

- **Review of medical records.** Mayo Clinic will review your medical records and will make a recommendation, based on medical records provided, about whether an on-site evaluation is appropriate. Mayo Clinic's determination is not subject to the AMP's claims and appeals procedures.
- **On-site evaluation at Mayo Clinic.** Based on Mayo Clinic's review of your medical records, Mayo Clinic may recommend that you travel to Mayo Clinic for an on-site evaluation regarding possible treatment at Mayo Clinic. Your travel will be provided through the Centers of Excellence program. In performing evaluation services, including whether to recommend an in-person evaluation or further treatment at Mayo Clinic, Mayo Clinic is acting as a health care provider, not as an agent for the AMP. Mayo Clinic's determination is not subject to the AMP's claims and appeals procedures.
- **Treatment at Mayo Clinic.** If Mayo Clinic recommends treatment at Mayo Clinic, this treatment will be covered under the Centers of Excellence program, which will pay 100% of the cost of covered services received from Mayo Clinic. Eligible medical expenses will be paid before you

meet your annual network 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 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 Mayo Clinic does not recommend treatment at Mayo Clinic or 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, even if you receive care at Mayo Clinic outside of the Centers of Excellence program.

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

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).

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.

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 are eligible for the Centers of Excellence transplant program and choose not to participate or if you are not eligible and choose to receive services elsewhere, 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, 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. The 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**.

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 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 pretransplant 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. You are responsible for providing contact information for the Centers of Excellence program administrator to the eligible transplant donor before appointments.

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

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 provider or facility other than Mayo Clinic and have the AMP pay the cost of covered services, subject to the AMP's regular terms and conditions of coverage if:

- There is significant risk that travel to Mayo Clinic could result in loss of life, or
- Mayo Clinic does not recommend a transplant because it is not the 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 **Centers of Excellence** section, 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.

Post-service exception request: If you have already received a transplant because your circumstances called for an immediate transplant, without which you would likely have suffered loss of life, you may request that the AMP pay benefits for a transplant received from a facility other than Mayo Clinic under otherwise applicable terms, by filing a post-service claim.

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 **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**.

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 14 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 weight loss surgery or procedure for weight loss purposes, and now need surgical revision 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 revision or a conversion to a covered weight loss surgery. You will be required to provide documentation demonstrating that you met the required clinical criteria for bariatric surgery prior to the original surgery or procedure. Contact 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 14 years of age; i.e., each covered individual must meet their own 12-month waiting period. Any time enrolled in the AMP prior to attaining age 14 counts toward the 12-month waiting period.

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

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

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

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.

Diabetes and Metabolic Management by Twin Health

If you have been diagnosed with type 2 diabetes, you may be eligible for the Diabetes and Metabolic Management by Twin Health program. The goals of this digital and telemedicine clinical program are to help you improve your health, lose weight, manage diabetes and other chronic metabolic conditions, and reduce your need for prescription drugs. Participation is voluntary, and Twin Health must determine that you meet the program's eligibility requirements. You must be at least age 18 to participate and have a compatible smart phone. The program is at no cost to you.

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

- **Education and intake process:** If you are interested in enrolling in the Twin Health program, you must first download the Twin Health app and agree to Twin's program terms, including privacy practices. You will then schedule a call with Twin Health to determine your initial eligibility.
- **Enrollment and medical appropriateness:** Twin Health will evaluate whether you are a medically appropriate candidate for the program services, including asking questions about your health and lifestyle behaviors like diet, exercise, sleep, and stress management, obtaining blood work, and reviewing your lab work. Note that certain conditions may mean that the Twin Health program is not medically appropriate for you, such as pregnancy, cancer, and end-stage renal disease. If Twin health finds that you are not a medically appropriate candidate, you may want to consider participation in an alternative program under the AMP, such as through Agile Health, to support your metabolic and diabetic health.
- **Wearable devices:** Upon enrollment, Twin Health will mail you one or more wearable devices for your use while enrolled in the program. These may include a continuous glucose monitor (CGM), digital body composition scale, digital blood pressure cuff, and an activity tracker. Twin will help you sync these devices to your Twin app, and the data will help build your Twin to provide personalized, daily recommendations. Some devices may be subject to applicable taxes if you do not return them upon request, at the end of your participation in the program.
- **Program engagement.** Your participation in the program will require you to actively engage with the Twin Health care team, which consists of physicians, advanced practice providers, and certified health coaches who will coordinate your care with your primary care provider and specialists. Your engagement includes talking or chatting with the Twin Health care team, logging your food intake, quarterly blood tests, adopting lifestyle recommendations (i.e., diet and exercise), and reviewing medications according to evidence-based protocols. If you need to pause the program, there is a 60-day grace period coordinated by Twin Health. If you do not resume participation at 60 days, you will be discharged and must complete the initial evaluation again to determine eligibility to rejoin.
- **Program goals.** The program aims to help you build a healthy lifestyle that promotes activity, nutrition, flexibility, strength, healthy weight, improved glycemic control, reduced A1C, and decreased dependence on medications for metabolic conditions like diabetes. Improved physical health, mood, energy levels, and sleep may also enhance mental health and overall well-being.
- **Copay assistance:** If you actively engage in the program, you will receive reduced copays for specific diabetes-related medications. If Twin Health determines that you are not a medically appropriate candidate or you cease participation in Twin Health, you may earn the same copay assistance through engagement in an alternative program under the AMP, such as through Agile Health, provided you actively participate. (See **Diabetes self-care** in the **Navigating your benefits** section that follows.)

Helping you manage your health

In addition to the specific covered services discussed in the prior sections, there are a number of services offered under the AMP that help you put all the AMP's benefits to work for you. The chart below and on the following pages outlines these programs and services. Note that some services are located only 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

EMBOLD HEALTH PROVIDER GUIDE

The Embold Health Provider Guide is available to assist you in selecting a provider by including Embold Health's evaluation of how well a provider follows evidence-based medical standards of care. The information in the Embold Health Provider Guide is intended to provide you with additional information you can consider as you choose the appropriate provider for your unique health care needs. Embold Health's evaluation is provided only for those providers who have entered into contracts with your TPA to be included in the TPA network. The Embold Health evaluations are based on historical clinical performance data for previous patient visits. The evaluations do not take your specific health care needs or medical conditions into consideration and are not a guarantee of the quality of care you will receive in the future from a provider that Embold Health has evaluated. Other factors may also be relevant in selecting a provider, including geographic convenience and appointment wait times. The evaluations of providers are created solely by Embold Health—not by Walmart or the Plan.

Embold Health is a doctor-led health care analytics company that uses objective clinical performance data at the individual-provider level to benchmark the provider's use of diagnostic tests, recommendation of appropriate treatments, and overall patient outcomes against national peers. Individual providers are evaluated using specific quality measures that indicate how well they follow evidence-based medical standards of care. Only providers in the following specialties are reviewed: bariatric surgery; cardiology; dermatology; endocrinology; gastroenterology; general surgery; lung surgery; neurology; obstetrics; ophthalmology; ortho-joint; pediatrics; podiatry; primary care; pulmonology; spine surgery; and urology. Other specialties may be added from time to time. You can see the complete list of performance quality measures Embold Health uses for its evaluation of all specialties by visiting the Embold Health Provider Guide and selecting "Performance Quality Measures" from the "Support" menu at the top of the page.

Embold Health uses a dataset that covers a four-year period and 200 million lives. A performance score for an individual provider will be provided only if a provider has at least 10 observations in at least four quality measures applicable to their medical specialty where utilization and/or outcomes can be measured for that particular quality measure.

Embold Health will meet with any provider, upon request, to answer questions about their individual score and the data on which it is based.

To visit the Embold Health Provider Guide, which includes a provider directory and Embold Health's evaluation of individual providers, go to **IncludedHealth.com/Walmart**. Included Health will then route you to the Embold Health Provider Guide.

This service is available to you if the following applies:

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

PROVIDER DIRECTORIES AND PRICE COMPARISON TOOL

Provider directories can also be found on your third-party administrator's website:

- **aetna.com**
- **blueadvantagearkansas.com**
- **UMR.com**

These directories include a list of network providers but do not include Embold Health's evaluation of individual providers. To visit the Embold Health Provider Guide, which includes a provider directory and Embold Health's evaluation of individual providers, go to **IncludedHealth.com/Walmart** if you are enrolled in the Premier, Contribution, or Saver Plan option. Included Health will then route you to the Embold Health Provider Guide.

A price comparison tool can be found at **IncludedHealth.com/Walmart**.

Also, be sure to check out **One.Walmart.com/health**.

These services are available to you if the following applies:

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

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 applies:

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

INCLUDED HEALTH: PROVIDER SEARCH, SECOND OPINIONS, AND CLAIM ADVOCACY

Included Health offers a number of tools and services to help you navigate your benefits, including a self-service tool to help you find a TPA network provider, an expert second opinion service, and a claims advocacy service to help you understand the financial aspect of your claims for benefits. 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 regular AMP terms and conditions.

Included Health self-service tool: If you are enrolled in the Premier, Contribution, or Saver Plan option, Included Health will route you to the Embold Health Provider Guide. If you are enrolled in a local plan or the PPO plan, you can use the self-service tool to find TPA network providers.

This service is available to you if the following applies:

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

Included Health live support: Call Included Health at **800-941-1384** for help scheduling, and preparing for an appointment.

This service is available to you if the following applies:

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

Expert second opinions

Participants and dependents enrolled in the AMP can 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.

This service is available to you if the following applies:

- You are enrolled in the Premier, Contribution, or Saver Plan, Banner or Mercy Arkansas Local Plan, or PPO 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 the following applies:

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

NAVIGATING YOUR BENEFITS

INCLUDED HEALTH: TRAVEL BENEFIT FOR 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 care where an in-person visit is required. You may be eligible for the benefit if:

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

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

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

- Services that are not covered by the AMP
- Services that are covered under the Centers of Excellence program
- 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
- Podiatry for purposes of insoles, bunions, etc.
- Reconstructive surgery (not breast cancer-related)
- Vision services related to routine vision checks

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

The travel benefit for care provides a travel benefit only for travel to the provider identified by Included Health. If Included Health 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 identified provider at the travel destination, which are subject to all applicable AMP terms and conditions of coverage, including any limitations and exclusions.

If you choose not to travel to the identified provider to receive services, or travel is not 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 identified 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 identified provider. Decisions about medical care from the identified provider are between you and that provider.

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

This service is available to you if the following applies:

- You are enrolled in the Premier, Contribution, or Saver Plan, or Banner or Mercy Arkansas Local Plan option.

NAVIGATING YOUR BENEFITS

INCLUSIVE HEALTH

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

This service is available to you if the following applies:

- You are enrolled in the Premier, Contribution, or Saver Plan, Banner or Mercy Arkansas Local Plan, or PPO Plan options.

CARE MANAGEMENT

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

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

- You are sick or injured and hospitalized
- You are scheduled for surgery
- You find out you have a chronic illness or are dealing with an ongoing chronic illness
- You have a mental health/substance use disorder
- You are prescribed multiple prescription drugs with potential interactions
- You simply have a question about your health
- You are home from the hospital and need help understanding your discharge plan, 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 review medical costs for "involuntary" out-of-network services. In some cases, out-of-network benefits may be paid as network benefits (see **When network benefits are paid for out-of-network services** earlier in this chapter). In other cases, your TPA may negotiate with non-network providers before or after services are rendered to reduce the billed charges for which you are responsible under the AMP's out-of-network benefit. There are no guarantees that any reduction in your out-of-network costs will occur.

When you communicate with your health care advisor or 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 enrolled in the Premier, Contribution, or Saver Plan, Banner or Mercy Arkansas Local Plan, or PPO Plan option.

CARE NAVIGATION

You may be offered voluntary care navigation services, including a personal, specialized, medical team. Care navigation extends beyond the care management benefit; providing you with high-touch support for the full range of covered services provided under the AMP. The goal of care navigation is to provide you with enhanced services, which may include scheduling of appointments, accompaniment to medical appointments, in-home visits, remote monitoring, and collaboration with local community resources.

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

- You are sick or injured and hospitalized
- You are scheduled for surgery
- You are at risk of developing a health condition
- You find out you have a chronic illness or are dealing with an ongoing chronic illness
- You have a mental health/substance use disorder

If you are eligible, your care navigator will reach out to you to invite you to participate in the program or to assist you in locating certain resources and services in your community. Participation in the program is voluntary.

This service may be available to you if all the following apply:

- You live in select areas in Arizona, Florida, Georgia, Illinois, Oklahoma, or Texas;
- You are enrolled in the Premier, Contribution, or Saver Plan option; and
- Your TPA is Aetna or BlueAdvantage Administrators of Arkansas

NAVIGATING YOUR BENEFITS

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. If your virtual primary care provider orders labs, you may be able to do some of those from the comfort of your home through Quest Diagnostics. Not all labs can be done at home. Lab tests that can be done from home are at no cost to you, before you meet your deductible if you are in the Premier, Contribution, or Banner or Mercy Arkansas Local Plan option. If you are enrolled in the Saver Plan option, the lab tests will be at no cost to you after you meet your deductible. Visit Doctor On Demand online at **DoctorOnDemand.com/WalmartCare** or call **800-941-1384**.

This service is available to you if the following applies:

- You are enrolled in the Premier, Contribution, or Saver Plan, or Banner or Mercy Arkansas Local Plan option.

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 quit smoking, chewing tobacco, or vaping, the AMP offers a Quit Tobacco program called Kick Buts and administered by Agile Health for you and your covered dependents age 18 and older, at no cost to you.

If you or your spouse uses tobacco, and during initial enrollment or Annual Enrollment you agree to enroll and participate in the Quit Tobacco program or a program of your choice by the end of the Plan year for which you are enrolling, you will receive lower tobacco-free rates for medical and prescription drug coverage, optional associate life insurance, optional dependent life insurance for a spouse, and critical illness insurance throughout the Plan year for which you are enrolling. Your eligibility for tobacco-free rates can be established only at your initial enrollment and each year during Annual Enrollment.

To give you the resources and support needed to help kick the habit, the program includes:

- Daily text messaging support (up to three texts a day) to help you prepare for your quit date both mentally and physically.
- Practical skills to help manage cravings and avoid temptations
- In-the-moment support for craving, slip-ups, and relapses
- A personal health coach available via text Monday–Friday 9 a.m.–6 p.m. Central Time
- Up to two $50 gift cards to be used toward the purchase of nicotine replacement therapy (patches, gum, or lozenges) at Walmart, Sam's Club or **Walmart.com**

To enroll, call Kick Buts at **855-955-1905** or go to **Kickbuts.com/kbewmt**. Learn more about the Quit Tobacco program at **One.Walmart.com/QuitTobacco**.

You are eligible for this program if the following applies:

- You are enrolled in the Premier, Contribution, or Saver Plan, Banner or Mercy Arkansas 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 dependents. The program is available to you if you are enrolled in the AMP options listed below, all of 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, the Life with Baby Maternity Program can help you have a safe, successful pregnancy. The program assists with preconception, pregnancy, delivery (including three lactation support visits), and child development education. 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. Participation in the program is voluntary and does not affect your eligibility to participate in the AMP.

You are eligible for this program if the following applies:

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

Additional programs

If you are enrolled in the Premier, Contribution, Saver Plan, or Banner Local Plan option, you also have access to:

- Pregnancy and parenting apps through Ovia Health.
- A digital payment card issued by IQPay to purchase breastfeeding supplies, including a breast pump, storage bags, etc., online at **One.Walmart.com** or in a Walmart store.
- Doula services are available. See **When limited benefits apply to the AMP** later in this chapter for more details

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 enrolled in the Premier, Contribution, or Saver Plan, or Banner or Mercy Arkansas Local Plan option.

NAVIGATING YOUR BENEFITS

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.

To enroll or for more information, call myAgileLife at **855-955-1905**.

You are eligible for this program if the following apply:

- You are enrolled in the Premier, Contribution, or Saver Plan, Banner or Mercy Arkansas Local Plan, or PPO Plan option.
- You do not participate in the Diabetes and Metabolic Management program by Twin Health.

If you have been diagnosed with type 2 diabetes, additional resources may be available to you. See **Diabetes and Metabolic Management by Twin Health** earlier in this chapter.

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

You are not required to utilize the services of 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 applies:

- You are enrolled in the Premier, Contribution, or Saver Plan, or Banner or Mercy Arkansas 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 at no cost, before you meet your deductible, for the Premier, Contribution, or Banner or Mercy Arkansas Local Plan options. If you are enrolled in the Saver Plan, it is at no cost to you after you meet your deductible. Join today at **OmadaHealth.com/Walmart**.

You are eligible for this program if the following applies:

- You are enrolled in the Premier, Contribution, or Saver Plan, or Banner or Mercy Arkansas Local Plan option. State law may not permit virtual physical therapy.

DIGESTIVE HEALTH CARE THROUGH CYLINDER

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

You are eligible for this service if the following apply:

- You are enrolled in the Premier, Contribution, or Saver Plan, or Banner or Mercy Arkansas 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 TPA 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 non-network provider.

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/Health** 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
- **Anxiety screening** for adults age 64 years or younger
- **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 adults at high risk
- **Hepatitis C** screening for all adults age 18 to 79
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults—doses, recommended ages and recommended populations vary:
  - COVID-19
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Herpes zoster
  - Human papillomavirus
  - Influenza (flu shot)
  - Measles, mumps, rubella
  - Meningococcal
  - Mpox
  - Pneumococcal
  - Respiratory syncytial virus (RSV)
  - Tetanus, diphtheria, pertussis
  - Varicella

  Learn more about immunizations and see the latest vaccine schedules at: **cdc.gov/vaccines/imz-schedules**.
- **Latent tuberculosis infection (LTBI)** screening in populations at increased risk
- **Lung cancer** screening for certain adults age 50–80 who have a smoking history
- **Obesity** screening and counseling for all adults
- **Preexposure prophylaxis ("PrEP")** with effective antiretroviral therapy to persons who are at increased risk of HIV acquisition
- **Sexually transmitted infection (STI)** prevention counseling for adults at higher risk
- **Skin cancer** counseling for young adults to age 24
- **Statin** for the primary prevention of cardiovascular disease for adults aged 40 to 75 years who have one or more cardiovascular disease risk factors and an estimated 10-year risk of a cardiovascular event of 10% or greater (prescription required). See **The pharmacy benefit** for more information.
- **Syphilis** screening for all adults at higher risk
- **Tobacco** use screening for all adults and cessation interventions for tobacco users
- **Unhealthy drug use** screening (i.e., asking questions) for adults age 18 and older

COVERED PREVENTIVE SERVICES FOR WOMEN, INCLUDING PREGNANT WOMEN

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

COVERED PREVENTIVE SERVICES FOR CHILDREN

- **Anemia** screening for children at 12 months
- **Anxiety** screening in children and adolescents aged 8 to 18 years
- **Autism** screening for children at 18 and 24 months
- **Behavioral/social/emotional** screening for children of all ages
- **Bilirubin** screening for newborns
- **Blood pressure** screening for children of all ages
- **Blood** screening for newborns
- **Cervical dysplasia** screening for sexually active females
- **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:
  - COVID-19
  - Dengue
  - Diphtheria, tetanus, pertussis (DTaP and Tdap)
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human papillomavirus
  - Inactivated poliovirus
  - Influenza (flu shot)
  - Measles, mumps, rubella
  - Meningococcal
  - Mpox
  - Pneumococcal
  - Rotavirus
  - Respiratory syncytial virus (RSV)
  - Varicella

  Learn more about immunizations and see the latest vaccine schedules at **cdc.gov/vaccines/imz-schedules**.
- **Lead** screening for children at risk of exposure
- **Medical history** for all children throughout development
- **Obesity** 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 VACCINE PROGRAM

An annual COVID-19 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.

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 AMP's 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, or the provider's contract with the AMP, as applicable. 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) that sets the amount the AMP will pay for an item or service. In these cases, the MAC will be the amount established in the agreement with the non-network provider.

For ground ambulance services, each TPA will determine the MAC as described in the **Ground ambulance** section in the **Emergency, ground ambulance, preventive, and telehealth services** section.

For covered services for an emergency medical condition in an emergency department, certain covered services provided by a non-network provider in a network facility subject to notice and consent requirements that has not obtained your consent to bill you for amounts in excess of the maximum allowable charge, or services provided by a non-network provider of air ambulance services that would be covered by the AMP if provided by a TPA network provider of air ambulance services, each TPA will determine the MAC as described in the **When network benefits are paid for out-of-network services** section.

For all other covered out-of-network services, the MAC is determined by each TPA, as described below. 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 (Premier, Contribution, Saver, and Banner Local Plan options): There is no benefit for out-of-network services sought voluntarily by participants in the Banner Local Plan option. For the Premier, Contribution, and Saver Plan options, the MAC is 125% of Medicare's maximum allowable charge for voluntary out-of-network services. For the Premier, Contribution, Saver, and Banner Local Plan options, the MAC also is 125% of Medicare's maximum allowable charge for involuntarily out-of-network services, 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 Medicare's maximum allowable charge. Medicare's maximum allowable charge 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 delivered by individual providers, the MAC is 125% of Medicare's maximum allowable charge for such services on the date administered. If no Medicare maximum allowable charge exists, the MAC is 70% of billed charges.

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 pricing or allowance offered by the Blue Cross and Blue Shield Plan in the state where services are provided. If the Blue Cross and Blue Shield Plan in the state where services are provided does not have its own method or benchmark in a given case, the MAC for covered out-of-network services is limited to the allowance set by BlueAdvantage Administrators of Arkansas based on its local provider pricing methodology.

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.

UMR (Mercy Arkansas Local Plan): There is no benefit for out-of-network services sought voluntarily by participants in the Mercy Arkansas Local Plan option administered by UMR. For approved involuntary or emergency out-of-network services, 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.

UMR (Premier, Contribution, and Saver Plan options): 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") 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 on the following page.

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, although prenotification is not a guarantee that services will be covered. 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
- The following services provided under the Centers of Excellence program:
  - 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 care (see the **Filing a claim for travel benefits for 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 TPA 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 ground ambulance or air ambulance transportation is limited to the nearest hospital or nearest treatment facility capable of providing care, and only if such transportation is medically necessary as compared to other transportation methods of lower cost and safety.

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

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

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

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

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

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

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

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

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

- Abortion, except as provided under **Termination of pregnancy** in this section
- Prescription abortifacient medication, including but not limited to RU-486
- Over-the-counter birth control methods that are not prescribed, including but not limited to Plan B, spermicides, condoms, vaginal sponges, basal thermometers, and ovulation predictor kits.

Clinical trials: Approved clinical trials are covered under limited circumstances. Routine patient costs associated with participation in Phases I–IV of approved clinical trials to treat cancer or other life-threatening conditions, as

determined by the TPA and required by law. 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 the Premier, Contribution, or Saver Plan, or Mercy Arkansas or Banner Local Plan option, 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 benefit is part of the Life with Baby Program. To get started, call the TPA at the number on your plan ID card and the care manager who supports the Life with Baby program will guide you in accessing doula services. You may also access a virtual doula through Kindbody. This virtual doula program provides virtual doula care, education, and resources to support you through pregnancy, birth, and postpartum, all with a goal to facilitate optimal outcomes for you and your baby. Learn more at **Kindbody.com/Walmart**. In-person doulas must be credentialed through DONA International or the National Black Doula Association, or agree to sign an attestation form indicating that they have completed professional doula training if affiliated with another doula organization. Amounts for doula services are taxable to you.

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

DME is equipment that:

- Can withstand repeated use
- Is used mainly for a medical purpose rather than for comfort or convenience
- Generally is not useful in the absence of an illness or injury
- Is related to a medical condition and prescribed by a physician
- Is appropriate for use in the home, 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, home ultraviolet light therapy system, whirlpool bath equipment, bed pan, portable paraffin bath, heating pad, heat lamp, steam/hot/cold packs, devices that measure or record blood pressure (except when provided in conjunction with Virtual Primary Care through Doctor On Demand by Included Health), and other such medical equipment or items determined to be investigational or not medically necessary.

Family-building treatment: Fertility services such as IVF and IUI may be covered under the Centers of Excellence program. Such covered services are subject to a $20,000 maximum lifetime benefit per individual participant, and only when services are provided by Kindbody. 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 a maximum of three provider visits per calendar year. Orthopedic shoes prescribed by a doctor are limited to two shoes per calendar year.

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

- Gender reassignment surgery, including both male-to-female surgery and female-to-male surgery
- Hormone replacement therapy, including laboratory testing to monitor hormone therapy, 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. This maximum does not apply to mental health conditions.

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

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

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

International business travel medical coverage: Walmart provides international business medical insurance through an insurance policy from 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.

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

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. This visit limit does not apply to mental health conditions. 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, including those that are not covered under the pharmacy benefit
- Emergency department services for mouth pain
- Treatment of fractures/dislocations of the jaw resulting from an accidental injury
- Accidental injury to natural teeth up to one year from the date of the accident (does not include injuries resulting from biting or chewing; those may be covered under the dental plan)
- Dental procedures necessitated by either severe disease (including but not limited to cancer) or traumatic event, if the dental service is medically necessary and the service is incidental to and an integral part of service covered under AMP medical benefits. Examples of services include but are not limited to the extraction of teeth prior to or following chemotherapy or radiation therapy of the head and neck. Treatment of oral tissues related to chemotherapy must be supported by documentation of a direct link between the destroyed bone or gums and the chemotherapy.
- Non-dental cutting procedures in the oral cavity
- Medical complications that are the result of a dental procedure, 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. (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: Telehealth visits with Doctor On Demand by Included Health are at no cost, 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 deductible first. Telehealth visits outside of Doctor On Demand by Included Health 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 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. 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. Prescription drugs prescribed solely for weight loss are also not covered under the pharmacy benefit. See **The pharmacy benefit** chapter for detailed information about other prescription drugs not covered by the pharmacy benefit.

What is not covered by the AMP

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

If you are enrolled in the Saver 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), medically necessary gender dysphoria treatment, or conditions resulting from accidental injuries, tumors or diseases.

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

Drugs, items, and equipment not FDA-approved: The fact that a drug, item, or piece of equipment is FDA-approved does not guarantee that it is a covered item or service.

Educational services: Including any services for learning and educational disorders (which include but are not limited to reading disorders, alexia, developmental dyslexia, dyscalculia, spelling disorders, and other learning difficulties), but excluding services that are preventive services described in the **Preventive care 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: Claims received more than 12 months past the date of service. See **Filing a medical claim (other than travel benefits for care)** later in this chapter for information about coordination of benefits.

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

Neurofeedback

Nonaccredited/nonlicensed providers or institutions

Non-covered services:

- Services not included as a benefit in this Associate Benefits Book
- Services provided after exceeding the benefit or visit maximum for specified services
- Services for which you are responsible for payment, such as non-covered charges
- Services delivered in a jurisdiction where such services may not be legally provided
- Services that are not medically necessary (unless otherwise indicated)
- Charges for services in excess of the AMP's maximum allowable charge
- Charges for completion of leave of absence certification paperwork, 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 a participant otherwise covered under the AMP), whether paying for another's services or serving as a surrogate.

Travel and lodging, except as specified under Centers of Excellence or travel benefits for care: See **Travel benefit for 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.

Work hardening or similar vocational programs Workers' compensation: Treatment of any compensable injury, as defined by applicable workers' compensation law, regardless of whether you file a timely claim for workers' compensation benefits.

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

The information in this section is a summary only. Refer to the **Claims and appeals** chapter for instructions to file a claim for benefits. Failure to follow the instructions in the **Claims and appeals** chapter could result in a claim being denied.

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 12 months from date of service.

NOTE: The deadline for filing claims that arose prior to January 1, 2025 is 18 months.

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 care

If Included Health does not pre-approve your travel benefits for care and you disagree with that determination, you may file a written pre-service claim for benefits. Claim forms are located on **One.Walmart.com/Medical** or you can call Included Health at **800-941-1384** to request a paper copy.

Claims for travel benefits for care will be decided under the general procedures and time frames for pre-service 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 for the AMP to pay as secondary payer. These rules apply whether or not a claim is made under the other plan. If a claim is not made under the other plan and the other plan is the primary plan, benefits under the AMP will be delayed or denied until an explanation of benefits is received showing a claim was made with the primary plan.

The AMP does not coordinate as a secondary payer for any copays you pay with respect to another plan or with respect to prescription drug claims or transplants (except where the other plan is Medicare).

If you reside in a state where automobile no-fault coverage, personal injury protection coverage, or medical payment

coverage is mandatory, that coverage is primary and the AMP is secondary. The AMP reduces benefits for an amount equal to the state's mandatory minimum requirement.

Other rules:

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

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

DETERMINING WHICH PLAN IS PRIMARY

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

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

IF YOU OR A DEPENDENT IS COVERED UNDER MEDICAID

If you or your dependent is a participant in the AMP and covered under Medicaid, the AMP pays before Medicaid. The AMP does not take the Medicaid coverage into account for purposes of enrollment or payment of benefits.

If, while you are covered under Medicaid, benefits are required to be paid by the AMP, but are first paid by the state plan, payment by the AMP will be made as required by any applicable state law which provides that payment will be made to the state.

IF YOU OR A DEPENDENT IS ELIGIBLE FOR OR ENROLLED IN MEDICARE

If you are enrolled in a Medicare prescription drug plan, you are not eligible to enroll in the AMP. If your dependent is enrolled in a Medicare prescription drug plan and you are not, you are eligible to enroll in the AMP, but your dependent would not be eligible for such coverage.

In general, the Social Security Act requires that AMP be the primary payer if you or your dependent is eligible for or enrolled in Medicare Part A, or Parts A and B, and meet one of the following criteria:

- You are employed by Walmart and are age 65 or older
- You are employed by Walmart and your spouse/ partner is age 65 or older
- You are an active participant or COBRA participant entitled to Medicare on the basis of end-stage renal disease, but only for the first 30-month period of eligibility for Medicare coverage (whether actually enrolled in Medicare throughout this period)

- You are under age 65 and are entitled to Medicare due to disability and are covered under the AMP due to being employed by Walmart, 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 Walmart.

The AMP is secondary if you or your dependent is enrolled in Medicare and meets one of the following criteria:

- You or your dependent is a COBRA participant, except in the case of Medicare enrollment due to end-stage renal disease, for which the AMP is primary for the first 30-month period of eligibility for Medicare coverage, 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 Walmart, you may continue your coverage under the AMP. If you also have Medicare, the AMP is generally primary and Medicare is secondary. File your claim with the AMP first.

You may also elect to end your coverage under the AMP and choose Medicare as your primary coverage. If you choose Medicare as your primary coverage, you may not elect the AMP as your secondary plan.

LEGALLY MANDATED AUTOMOBILE PERSONAL INJURY OR MEDICAL PAYMENT COVERAGE

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

Break in coverage

There may be occasions in which you must make special arrangements to pay your 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 your medical coverage ends

Your coverage ends on your last day of employment, or when you are no longer eligible under AMP terms. Dependent coverage ends when your coverage ends or when a dependent is no longer an eligible dependent (as defined in the **Eligibility, enrollment, and effective dates** chapter). You and/or your covered dependents may be eligible for continued coverage through the Consolidated Omnibus Reconciliation Act of 1985, as amended (COBRA). See the **COBRA** chapter for details.

If your coverage is canceled due to your failure to pay 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 your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

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

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

If you leave Walmart and are rehired

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

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

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Find a Walmart or Sam's Club pharmacy	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.
- Any prescription drugs that are excluded under the terms of the AMP, including medications prescribed for weight loss, are not covered under the pharmacy benefit.
- 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 not currently available at a Walmart or Sam's Club pharmacy located within your work location ZIP code or through Walmart Home Delivery or Walmart Specialty, if applicable.
- 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.

See **What is not covered by the pharmacy benefit** for information about what prescription drugs are not covered.

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

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.

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

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. All specialty medications

must be filled through Walmart Specialty Pharmacy. For questions concerning your specialty medication prescriptions, call Walmart Specialty Pharmacy at **800-284-9770**.

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. 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.

DIABETES MANAGEMENT

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.

See **The medical plan** chapter for more information about myAgileLife and other resources to manage type 2 diabetes.

FERTILITY MEDICATION

The AMP medical benefit covers FDA-approved fertility medications, when prescribed by Kindbody, your family-building Centers of Excellence provider. These medications are unique to fertility treatment and will be filled through Kindbody's specialty pharmacy, Schraft's Pharmacy, and processed under the terms and conditions as described in **The medical plan** chapter.

MEDICATIONS 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. If the prescription drug requires prior authorization, 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. Requests for prescription drugs that are not covered under the AMP, including the pharmacy benefit, are not requests for prior authorization and will not be eligible for appeal.

For questions about prior authorizations, call OptumRx at **844-705-7493**.

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 increased 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** below.

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
Statin	By prescription for the primary prevention of cardiovascular disease for adults aged 40 to 75 years who have one or more cardiovascular disease risk factors and an estimated 10-year risk of a cardiovascular event of 10% or greater.
Bowel prep agents	By prescription when appropriate for a screening colonoscopy for adults age 45 and over

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:

- Any prescription drugs that are excluded under the terms of the AMP, including medications prescribed for weight loss.
- 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 medications 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 12 months of the date you had the prescription filled (or attempted to have it filled). If the prescription is an eligible prescription, it will be paid in accordance with the terms of the pharmacy benefit.

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 Walmart will match them dollar-for-dollar, up to set limits. Your account balance earnings are also tax-free and, as the money grows from year to year, you can use it to pay for current or future medical expenses.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Establish an account or change your contribution amount	Log on to **One.Walmart.com**	Call People Services at **800-421-1362**
Access your HSA	Log on to **MyHealthEquity.com** If you are logging in for the first time as a member and have not already established a user ID and password, click "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.
- Walmart will match pretax dollars you contribute through payroll deduction, dollar-for-dollar up to the matching limit.
- The HSA allows you to pay for qualified medical expenses (as defined by the IRS) with tax-free dollars.
- The HSA accepts rollover contributions from other eligible HSAs.
- You are not eligible to make HSA contributions for any month in which you travel on company business outside the U.S. and are covered under 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 Walmart has contracted to receive HSA contributions made through payroll deductions and matching contributions from Walmart. To receive company matching contributions to your HSA or make pretax contributions through payroll deductions, you must maintain an open account with HealthEquity and continue to be enrolled in the Saver Plan. If you have an HSA with another custodian, Walmart will not allow you to make pretax contributions through payroll deductions for that HSA or make matching contributions to that HSA. You may move your funds to another HSA custodian at any time, but Walmart will support ongoing payroll deductions and provide company matching contributions only for HSAs established with HealthEquity.

Interest earnings and capital gains on the balance in your account are not taxed during the period in which the funds remain in your account. In addition, all HSA funds withdrawn for qualified medical expenses are tax-free.

You will have the opportunity to invest your account balance once that balance reaches a certain amount. Investments are not guaranteed or FDIC-insured.

The balance in your HSA rolls over from year to year, increasing your savings for future medical expenses. You own the balance in your account, and can save it, invest it in funds offered through HealthEquity, or spend it on qualified medical expenses.

NOTE: State tax law with respect to HSAs may differ from federal tax law in certain states, including California and New Jersey, which do not exempt HSA contributions from state income tax. Please consult your tax advisor or HealthEquity if you have questions about either the federal or state tax implications of a health savings account.

HSA eligibility

You must be enrolled in the Saver 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. Walmart does not, however, insure the HSA described in this chapter. It is Walmart's intention to comply with U.S. Department of Labor guidance specifying that an HSA is not subject to ERISA when the employer's involvement with the HSA is limited. Accordingly, the HSA is not established or administered by Walmart or the Plan. Instead, the HSA is established by you during the benefits enrollment process and administered by HealthEquity.

Even if you are enrolled in the Saver 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 dental, vision, or preventive care, or a service-connected disability. Mere eligibility for Veterans Affairs benefits does not disqualify you from contributing to an HSA.
- You have received medical services at an Indian Health Service (IHS) facility during the preceding three months, other than services for dental, vision, or preventive care.
- You can be claimed as a dependent on another person's tax return.

You are also not eligible to make HSA contributions for any month in which you are traveling on company business outside the U.S. and are covered under 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 Walmart has in its records directly from HealthEquity, generally within the following time frames:

- By the end of December if you enroll during Annual Enrollment, 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 company 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 Walmart's matching contributions will begin the following pay period. If any pretax contributions or company matching contributions are made before your HSA is open, HealthEquity will hold those contributions and deposit them into your HSA when it is open. If your account is not opened within a reasonable amount of time, the funds withheld from your pay will be refunded to you through your payroll check (less applicable payroll taxes) and reported as wages on your Form W-2. The employer contribution, if any, will be returned to Walmart.

Your right to receive company matching contributions to your HSA is contingent upon your opening your HSA in a timely manner, and company matching contributions will not be earned or available unless you have opened your HSA in a timely manner. If you do not open your HSA by December 1 of the Plan year, you will forfeit your right to Walmart's matching contributions for that year, even if you are enrolled in the Saver Plan during that year.

For questions about your account status, welcome kit, or debit card, call HealthEquity at **866-296-2860** or go online to **MyHealthEquity.com**.

To transfer funds from a prior HSA, contact HealthEquity at **866-296-2860**.

HSA FEES

Walmart pays the monthly HSA maintenance fees if you are enrolled in the Saver Plan and your HSA custodian is HealthEquity. However, if you are enrolled in COBRA, terminate employment with Walmart, otherwise become ineligible for AMP coverage, or are no longer enrolled in the Saver Plan, you will be responsible for paying the monthly maintenance fees. These fees will be deducted automatically from your HSA balance if any of these events occur. Call HealthEquity at **866-296-2860** to learn about the fees for various HSA services. It is your responsibility to check your HSA balance prior to using funds to pay for services. Current rate and fee schedules are available online at **MyHealthEquity.com**. The fee schedule is also included in the welcome kit.

Walmart does not pay overdraft fees, excess contribution fees, or lost card fees. Walmart also does not contribute funds or pay any fees associated with an HSA for your spouse or partner enrolled in the Saver Plan through your family coverage.

HSA STATEMENTS AND INFORMATION

Your right to receive a statement regarding your HealthEquity HSA balance and other information regarding your HealthEquity HSA is governed by the terms of the HealthEquity custodial agreement. To review information regarding your HSA, including the HealthEquity custodial agreement, please go to **MyHealthEquity.com.**

Naming a beneficiary

To ensure that your HSA is distributed according to your wishes in the event of your death, you may designate one or more beneficiaries. You may do this through the HealthEquity member portal in the HealthEquity app or at **MyHealthEquity.com**. For assistance and information call HealthEquity at **866-296-2860**.

If you do not name a beneficiary, your surviving spouse (if any) will be deemed the beneficiary. If your spouse is the designated or deemed beneficiary, your HSA account balance can be transferred upon your death to a new HSA in the name of your spouse. If you do not name a beneficiary and there is no surviving spouse, your account will be distributed to your estate, successor in interest, or other party with authority to act on the account.

Beneficiary designation requirements vary by state. For example, if you are married and living in a community property state and want to designate a primary beneficiary other than your spouse, your spouse must agree in writing to your designation.

Properly completed designations are effective upon receipt by HealthEquity and cancel all previous HSA beneficiary designations on file.

You should consult your tax or legal advisor when naming a beneficiary, as there may be tax or legal consequences to your designation.

Contributions to your HSA

Once you open your HSA, contributions to your HSA will be made under the following terms (as long as your account is open and you are enrolled in the Saver Plan):

- You may make pretax contributions to your HSA through payroll deductions in any amount (of $5 or more each pay period) up to the legal limit, taking into account Walmart's contributions. Contributions are generally based annually on 26 pay periods.
- Walmart will match your pretax contributions dollar-for-dollar, up to the matching limit described in the chart on the following page.
- Pretax contributions and company matching contributions are deposited into your HSA shortly after each payroll deduction period ends.
- In addition to making pretax contributions by payroll deduction, you may contribute money directly to your HSA by mailing a check to HealthEquity, or by electronic funds transfer (EFT) once you have linked a personal bank account on the HealthEquity website. Any such contributions count toward the contribution limit stated in the chart on the following page. These personal contributions are made on an after-tax basis and are not eligible for Walmart matching contribution. Although you may be able to claim an income tax deduction for contributions made directly to your HSA, there is no corresponding deduction for Social Security or Medicare taxes that may have been imposed on the funds used to make the direct contributions. (By comparison, pretax contributions made through payroll deductions are exempt from Social Security and Medicare taxes, as well as federal income tax and, in many cases, state income tax.) Walmart does not track your after-tax HSA contributions; you bear the responsibility of making sure you do not exceed the annual contribution limit.
- If your requested HSA contribution for a specific pay period exceeds the amount of your paycheck after deductions, no pretax contribution or company match will be made to your HSA for that pay period.
- With respect to your final paycheck, your HSA pretax contributions and corresponding company match may be reduced because of state law restrictions on salary reduction or because your requested HSA contribution exceeds the net amount of your payroll check after deductions.

If you experience an election change event and switch from associate-only coverage to family coverage under the Saver Plan during the year, Walmart will increase its matching contribution to correspond with the matching contribution limit for family coverage. If you switch from family coverage to associate-only coverage during the year, the matching contributions that Walmart made prior to the change will not be reduced. If this results in your having contributions in your account above the annual contribution limit, the excess contributions must be withdrawn by the tax-filing deadline to avoid additional taxes.

ANNUAL CONTRIBUTION LIMITS

By law, there is a maximum amount that may be contributed to your HSA during the year. The annual maximum contribution is the total contribution from all sources (pretax and after-tax contributions made by you and any company matching contributions). For 2025, the maximum annual contribution that can be made to your HSA is:

- $4,300 for individual coverage, or
- $8,550 for family coverage.

These amounts are indexed annually by the federal government and are subject to change each year. You can consult IRS Publication 969 for the indexed amounts applicable to a particular year.

YOUR CONTRIBUTIONS AND WALMART'S CONTRIBUTIONS TO THE HSA		
Your Saver Plan network annual deductible	**Company matching contribution: $1 for $1 up to**	**2025 maximum annual contribution (associate and company contributions combined)***
$3,000 (associate-only coverage)	$350	$4,300
$6,000 (family coverage)	$700	$8,550
*If you are age 55 or over by December 31, 2025, you can contribute an additional $1,000 in 2025.		

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 2025, you can make additional "catch up" contributions to your HSA by payroll deduction, just like your regular contribution. For 2025, 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 2025 for both accounts combined is based on the maximum amount that can be contributed for a family: $8,550. 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 2025, the total combined contribution is increased by $1,000 for each participant age 55 or older. However, the extra $1,000 can only be contributed by each spouse to their own individual HSA. Walmart does not contribute funds or pay any fees associated with an HSA for your spouse.

If you cover an eligible partner under the Saver 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 $8,550 (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 2025, the maximum contribution is increased by $1,000 for each participant age 55 or older, but this extra $1,000 can only be contributed by each partner to their own individual HSA. Walmart does not contribute funds or pay any fees associated with an HSA for your partner.

Call HealthEquity at **866-296-2860** for information on opening an HSA for your eligible spouse/partner.

EARNING INTEREST ON YOUR HEALTH SAVINGS ACCOUNT

The uninvested balance in your HSA earns interest. For interest rate information on your account, contact HealthEquity at **866-296-2860** or go online to **MyHealthEquity.com/Enroll**. Your current interest earned, along with the interest rate schedule, is available on your monthly statements.

SETTING UP OR CHANGING YOUR CONTRIBUTION AMOUNT

You may change your contribution amount online at any time during the year on a prospective basis.

To set up or change your contribution amount, log on to **One.Walmart.com/Enroll**. Contact People Services at **800-421-1362** if you need help setting up your payroll deductions.

NOTE: Once you make the maximum annual contribution (as stated in the chart above), your payroll contributions automatically cease. It is your responsibility to make a new contribution decision at the next Annual Enrollment for the following calendar year.

Paying qualified medical expenses through your HSA

When you have an eligible medical expense, you can decide whether to pay out of your pocket or use the funds in your HSA. Some people use their HSA for current expenses, while others prefer to use the HSA as an account for future health care expenses. Eligible medical expenses include health plan deductibles and coinsurance, most medical care and services, dental and vision care, prescription drugs, and over-the-counter drugs. In addition, amounts paid for certain menstrual care products such as tampons and pads are eligible medical expenses. These expenses must not already be covered by your medical plan, and health insurance premiums generally do not qualify. Only medical expenses incurred after you have established an HSA are eligible for payment or reimbursement through an HSA. Refer to IRS Publications 969 and 502 at **irs.gov** for information about qualified medical expenses. You can also find information about qualified medical expenses on **One.Walmart.com** and **MyHealthEquity.com**.

THE HSA AND YOUR INCOME TAX RETURN

The funds in your HSA belong to you, but any money used for nonqualified medical expenses is subject to federal income tax as well as a 20% penalty if you are under age 65. Make sure you save your receipts and other records to show that you used your HSA funds for eligible medical expenses. Remember that you are responsible for the tax consequences associated with contributions to and withdrawals from your HSA. Consult your tax advisor if you have questions about your HSA and taxes.

Investing your HSA

Once your HSA reaches a minimum balance of $1,000, you can invest any amount over that balance in a selection of over 20 investment funds available through HealthEquity. Review the funds and learn more at **MyHealthEquity.com** under "Investments." You are responsible for your own investment decisions. Amounts that are invested are not guaranteed or FDIC-insured and may lose value.

If you leave Walmart or are no longer enrolled in the Saver Plan

The funds in your HSA belong to you as the account holder, even if you enroll in COBRA, change medical plans, change jobs, or leave Walmart. In these events, all fees associated with the account become your responsibility.

Closing your HSA

All funds in your HSA belong to you. You may use these funds for qualified medical expenses on a tax-free basis now and in the future. If you do not choose to maintain the account, call HealthEquity at **866-296-2860** for information on closing your account. If you withdraw funds from your HSA upon closing the HSA, you may be subject to taxes on the withdrawn amounts.

The dental plan

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, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

The dental plan

The dental plan covers a wide range of services, with no deductible for preventive care or orthodontics. Plus, when you use network dentists, you'll save money while protecting one of your biggest assets—your smile.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get a listing of Delta Dental network dentists	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 consecutive calendar years.
- Orthodontia is covered after a 12-month waiting period.
- If you have medical coverage with the Associates' Medical Plan (AMP), both the dental and medical information are on your plan ID card. If you are enrolled in an HMO or if you have dental-only coverage, you will receive a Delta Dental ID card. Your ID cards will be mailed to your home address on record at Walmart.

Your dental plan

The dental plan is available to you if you are an hourly or management associate. Coverage is also available to your eligible dependents, with the exception of spouses/partners of part-time hourly associates, temporary associates, and part-time truck drivers. The dental plan is administered through Delta Dental.

The dental plan benefit is self-insured, which means benefits are not paid by an insurance company.

Delta Dental administers the dental plan and has been delegated the fiduciary authority to make determinations with respect to claims for benefits and the first-level appeal of a claim that has been denied.

Once you enroll in the dental plan, your coverage must remain in effect for two consecutive calendar years. You can add or remove a dependent during Annual Enrollment or due to an election change event, but you must maintain a minimum of associate-only coverage for two consecutive calendar years.

CHOOSING A COVERAGE TIER

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

- Associate only
- Associate + spouse/partner (except for part-time hourly associates, temporary associates, or part-time 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 preventive and diagnostic care, basic care, and major care.

For covered network services, the MPA is that portion of a provider's charges covered by the dental plan as determined by the provider's contract with Delta Dental of Arkansas. Network providers agree to accept an amount negotiated by Delta Dental for covered services as payment in full, subject to applicable deductible and coinsurance amounts.

For covered out-of-network services, the MPA can differ by state and is derived from a variety of factors, including data from fees on claims and fee filings submitted by the dentist. If you see a non-network dental provider, the dental plan pays a percentage based on the lesser of the MPA or the provider's actual billed charges for a covered procedure. If the provider's billed charges exceed the Plan's MPA, you are responsible for paying 100% of the difference. For additional information, call Delta Dental at **800-462-5410**.

KNOW WHAT YOU'LL OWE: GET A PRETREATMENT ESTIMATE

You are not required to get pre-approval of any dental treatments. But by having your dentist submit a proposed treatment plan, you can learn how much you can expect the dental plan to pay for a procedure or course of treatment before the work is done. It is recommended that a proposed treatment plan be submitted for treatment expected to cost $800 or more. Delta Dental will provide a pretreatment estimate of the amount that will be covered and may suggest an alternate treatment plan if part of your dentist's treatment plan is ineligible for coverage.

To get a pretreatment estimate, ask your dentist to complete a regular dental claim form and check the "predetermination" box. The form should be mailed to:

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, Arkansas 72231-5965

Delta Dental's pretreatment estimate is not a guarantee of payment. You still must file a claim for the services rendered, as set out in the **Claims and appeals** chapter.

SAVE MONEY BY USING NETWORK DENTISTS

As a dental plan participant, you can use any dentist and receive benefits for covered expenses under the Plan.

You will save money, however, when you use Delta Dental PPO and Premier dentists. Providers contracted with Delta Dental agree to accept the dental plan's maximum plan allowance as payment in full for a covered procedure, so you pay no more than the dental plan's applicable coinsurance percentage (after you meet any applicable annual deductible). In addition, you may save time when you use Delta Dental PPO or Premier dentists because they will file your claims for you.

The Delta Dental PPO network is an extensive nationwide network of dentists, but is not as widely available as the Delta Dental Premier network. Refer to the chart entitled **Coverage under the Dental Plan** earlier in this chapter for details on how coverage terms for preventive and diagnostic care may differ based on the availability of PPO dentists in your area. To find a Delta Dental PPO or Delta Dental Premier dentist, see the **Resources** chart at the beginning of this chapter.

IT PAYS TO USE NETWORK DENTISTS		
	Delta Dental Premier dentists and PPO dentists	**Non-network dentists**
Dentist files claim forms for you	Yes	No
Dentist accepts maximum plan allowance as payment in full, subject to annual deductible and coinsurance	Yes	No
Dentist offers discounted prices on services covered by the dental plan for Delta Dental participants	Yes	No

Filing a dental claim

If you use a Delta Dental PPO or Premier dentist, your dentist will file the claim for you. If you use a non-network dentist, you may need to file a claim. The dentist may be paid directly from the dental plan if the dentist is a Delta Dental PPO or Premier dentist. If you use a non-network dentist, the payment will be made to you.

Mail your claim to:

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, Arkansas 72231-5965

You or your dental provider must file a claim in accordance with the claims procedure within 12 months from date of service, or your claim will be denied. Not following the

claims procedure described in the **Claims and appeals** chapter, such as failure to mail your claim to the correct address, may result in the denial of your claim.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial.

IF YOU HAVE COVERAGE UNDER MORE THAN ONE DENTAL PLAN

If you or an eligible dependent have coverage under the dental plan and are also covered under another dental plan (for example, your spouse/partner's company plan), coordination of benefits may apply. The dental plan has the right to coordinate with other plans you are covered under so the total dental benefits payable will not exceed the level of benefits otherwise payable under the dental plan.

When you are covered by more than one plan, one of the plans is designated the primary plan. The primary plan pays first and ignores benefits payable under other plans when determining benefits. Any other plan is designated as a secondary plan that pays benefits after the primary plan. A secondary plan reduces its benefits by the amount of benefits payable under "other plans" and may limit the benefits it pays.

You must follow the primary insurance terms in order for the dental plan to pay as secondary payer.

These rules apply whether or not a claim is made under the other plan. If a claim is not made, benefits under the dental plan will be delayed or denied until an explanation of benefits is received showing a claim made with the primary plan.

HOW THE DENTAL PLAN COORDINATES WITH OTHER PLANS

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

DETERMINING WHICH PLAN IS PRIMARY

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

- The plan covering the participant for whom the claim is made, other than as a dependent, pays first and the other plan pays second.
- For dependent children's claims, the plan of the parent whose birthday occurs earlier in the calendar year is primary.
- When the birthdays of both parents are on the same day, the plan that has covered the dependent for the longer period of time is primary.
- When the parents of a dependent child are divorced or separated, or the domestic partnership or legal relationship is terminated, and the parent with custody has not remarried, that parent's plan is primary.
- When the parent with custody has remarried, or entered into a domestic partnership with another individual, that parent's plan is primary, the stepparent's plan pays second, and the plan of the parent without custody pays last.
- When there is a court decree that establishes financial responsibility for the health care expenses of the child, the plan that covers the parent with financial responsibility is primary.
- If these rules do not establish an order of benefit determination, the plan that has covered the participant for whom the claim is made for the longest period of time is primary.

If you are covered under a right of continuation coverage pursuant to federal or state law (for example, COBRA), and you are also covered under another plan that covers you as an employee, member subscriber, or retiree (or as that person's dependent), the latter plan is primary and the continuation coverage is secondary. If the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule does not apply.

What is covered under the dental plan

The dental plan covers the services listed in this section, subject to some limitations. If you have questions about what is covered under the dental plan, call Delta Dental at **800-462-5410**.

PREVENTIVE AND DIAGNOSTIC CARE

Preventive and diagnostic care are covered without having to meet the annual deductible.

Bitewing X-rays: Covered every year as required by dentist. Combined with panoramic X-ray if done by same provider on same day and processed as a full mouth series. Limited to two films per visit for children under age 10.

Cleaning (dental prophylaxis): 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 every calendar year for participants under age 19. One additional application per calendar year is covered for eligible dependents under age 19 who are identified at moderate or high risk (as defined by the American Dental Association's Dental Procedure Codes) for developing caries. Application of silver diamine fluoride is covered two times per calendar year per tooth. Restorations within two months of a silver diamine fluoride application are not covered. Sealants and preventive restorations are not covered if silver diamine fluoride has been applied to the tooth. Silver diamine fluoride is not covered on the same day as a restoration of the same tooth.

Full-mouth debridement: Limited to once per lifetime.

Full-mouth series or panoramic X-rays: Limited to one procedure in any consecutive 60-month period. 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 evaluations time limitations. Subsequent oral evaluations submitted by the same provider within three years are processed as routine oral evaluations.

Emergency evaluations performed by dentists are not subject to the calendar year restriction.

Periapical X-rays: Covered as needed.

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

To be eligible for orthodontia assistance, you must be enrolled in the AMP dental plan for at least 12 months. The 12-month waiting period applies to you and, separately, to each of your covered dependents. The 12-month waiting period is waived for localized associates and their covered dependents. If you were previously enrolled in the dental plan and coverage terminated for any reason after you or your covered dependent had met the 12-month waiting period (e.g., you terminated employment and were rehired or you voluntarily dropped coverage), you or your covered dependent's prior period of enrollment in the dental plan will count toward your 12-month waiting period. However, if you or your covered dependent had not met the 12-month waiting period prior to termination of coverage, prior time enrolled in the dental plan will not count toward the 12-month waiting period, and you or your covered dependent must meet a new 12-month waiting period following your reenrollment.

If the dentist submits a statement at the beginning of a period of orthodontic treatment showing a single charge for the entire treatment, benefits are paid in the following manner:

- The dentist receives an initial payment of up to $150
- A prorated portion of the remainder is paid monthly based on the estimated period for treatment and on continued eligibility, 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 how to make premium 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 your dental coverage ends

Your coverage ends on your last day of employment or when you are no longer eligible under the terms of the Plan. Dependent coverage ends when your coverage ends or when a dependent is no longer an eligible dependent (as defined in the **Eligibility, enrollment, and effective dates** chapter). All benefits cease on the date coverage ends, except for completion of operative procedures in progress at the time coverage ends. "Operative procedures" are limited to individual crowns, dentures, bridges, and implants, and are considered "in progress" only if all procedures for commencement of lab work are completed and all operative procedures are completed within 45 days of termination. The dental plan does not pay benefits if you or a covered dependent receive benefits for these post-termination expenses from another plan. You and/or your enrolled dependents may be eligible for continued coverage through the Consolidated Omnibus 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 your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

If you voluntarily drop coverage after an election change event or at Annual Enrollment (after completing two consecutive calendar years of coverage), coverage ends as follows:

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

If you leave Walmart and are rehired

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

details regarding the impact to your required minimum enrollment period, deductible, and waiting period for orthodontia assistance, see below.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work. For details regarding the impact to your required minimum enrollment period, deductible, and waiting period for orthodontia assistance, see below.

Impact to required minimum enrollment period, deductible, and waiting period for orthodontia assistance:

- If you terminate and then return to work within 30 days of your termination date, your deductible will not reset unless you terminate in one calendar year and return to work in the following calendar year. Your waiting period for orthodontia assistance will also not reset.
- If you terminate and then return to work more than 30 days but less than 13 weeks from your termination date, your deductible will not reset when you return to work in the same calendar year in which you terminated. Your deductible will reset when you terminate in one calendar year and return to work in the following calendar year. You or your covered dependent's waiting period for orthodontia assistance will reset unless the 12-month waiting period has already been met. If you have already maintained the required minimum enrollment period of two years, you may drop dental coverage within 60 days after returning.
- If you terminate and then return to work 13 weeks or more from your termination date, you will be considered a new associate and will be required to complete any applicable eligibility waiting period or other requirements. You or your covered dependent's waiting period for orthodontia assistance will reset unless the 12-month waiting period has already been met. See the **Eligibility, enrollment, and effective dates** chapter for details.

The vision plan

The 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, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

The vision plan

The vision plan helps you pay for routine eye exams, lenses, frames, and contact lenses, so you can see clearly for years to come.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Locate a Walmart Vision Center or Sam's Club Optical provider	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 part-time hourly 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 dependents 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	$45		
Lenses • Single vision • Lined bifocal • Lined trifocal • Lenticular	100% covered after copay The following options are also covered at 100%: • Scratch coating • Polycarbonate lenses • UV (ultraviolet) protected *Standard lenses are covered after applicable copay. Check with your optical team for lenses offered under benefit.*		
Frames Once every calendar year	$130 allowance *Charges above the frame allowance are your responsibility.*		
Elective contact lenses Once every calendar year in lieu of all other lenses and frame benefits	$130 contact lens allowance *Charges above the contact lens allowance are your responsibility.* *You may be charged an additional fee of up to $60 for fitting and evaluation.*		
Necessary contact lenses Once every calendar year in lieu of all other lenses and frame benefits	100% covered after copay once every calendar year. Includes professional fees and materials. *Non-elective contact lenses are a Plan benefit when specific criteria are met and when prescribed by a VSP network provider. Call VSP for more information on eligibility criteria.*		
NOTE: Sales taxes may apply and will reduce the vision benefit.			

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 an eligible dependent have coverage under the vision plan and are also covered under another vision plan (for example, your spouse/partner's company vision plan), coordination of benefits may apply. The vision plan has the right to coordinate with other plans under which you are covered so the total vision benefits payable will not exceed the level of benefits otherwise payable under the vision plan. Under the vision plan, "other plans" refers only to other plans administered by VSP. There is no coordination-of-benefits provision with vision coverage providers other than VSP. Plans referred to as "other plans" are described in **If you have coverage under more than one medical plan** in **The medical plan** chapter.

Break in coverage

There may be occasions in which you must make special arrangements to pay 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 how to make premium 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 your vision coverage ends

Your coverage ends on your last day of employment or when you are no longer eligible under the terms of the Plan. Dependent coverage ends when your coverage ends or when a dependent is no longer an eligible dependent (as defined in the **Eligibility, enrollment, and effective dates** chapter). You and/or your enrolled dependents may be eligible for continued coverage through the Consolidated Omnibus 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 your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

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

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

If you leave Walmart and are rehired

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

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

Associate assistance resources

What is Help Now?

What is My Mental Health Resources?

Help Now is not a benefit offered under the Walmart Inc. Associates' Health and Welfare Plan and is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Associate assistance resources

Walmart offers a variety of associate assistance services to help you address a wide range of issues you and your eligible dependents may face. **Help Now** services are offered by AiRCare and **My Mental Health Resources** services are offered by Lyra.

RESOURCES: HELP NOW		
Find What You Need	**Online**	**Other Resources**
Immediate access to a Help Now resource specialist		Call **855-4HLPNOW (855-445-7669)**
Access more information about how you can get Help Now	Go to **One.Walmart.com/HelpNow**	
RESOURCES: MY MENTAL HEALTH RESOURCES		
Quickly match with a mental health therapist or coach for up to 20 free sessions each year	Get started at **Walmart.LyraHealth.com**	Call **800-825-3555**
Speak with a Lyra Care Navigator to access Lyra resources, find a mental health provider, and get immediate support in times of crisis, self-harm, or suicidal thoughts	Chat with a Care Navigator at: **Walmart.LyraHealth.com**	Call **800-825-3555**
Tap into Lyra Essentials to access articles, activities, self-guided tools, and resources across a wide range of mental health topics	Go to **Walmart.LyraHealth.com**	
Explore on-demand work-related mental health knowledge courses, live monthly workshops, and small-group facilitated Gatherings.	Go to **Walmart.LyraHealth.com**	

What you need to know about associate assistance resources

Help Now

- Help Now services are provided by AiRCare, whose resource specialists are ready to assist you with your well-being needs.
- Help Now services are confidential, except as required by law.
- This service is optional.
- There is no cost to you for Help Now services. You are automatically enrolled in Help Now as of your date of hire.

My Mental Health Resources

- My Mental Health Resources is available 24 hours a day, seven days a week, 365 days a year.
- You and your eligible dependents can find mental health therapy and coaching, self-guided tools, and work-life assistance.
- There is no cost to you for My Mental Health Resources benefits. You and your eligible dependents are automatically enrolled in the program as of your date of hire, regardless of whether you enroll in a Walmart medical plan. Eligible dependents can utilize My Mental Health Resources benefits even if you are enrolled in a Walmart medical plan and your dependents are not. You will need to set up a free account with Lyra to access on-demand courses or start care with a provider.

What is Help Now?

Help Now provides associates and their eligible dependents with on-demand support for a variety of life challenges. Whether you need assistance navigating your Walmart benefits, paying bills, finding food or housing, or taking care of a sick family member, help is just a phone call (or email) away. Help Now services are provided by AiRCare, whose resource specialists understand Walmart well-being benefits and community resources. From your date of hire, it's available at no cost to you and your eligible dependents.

Using Help Now

If you are an associate in the United States or Puerto Rico, you and your eligible dependents are automatically enrolled in Help Now through AiRCare as of your first day of employment. Eligible dependents include your spouse/partner and children up to age 26. You do not need to take any steps to enroll. You can contact AiRCare any time by calling **855-4HLPNOW** (**855-445-7669**) during the hours of 7:00 a.m. CT to 7:00 p.m. CT or emailing **helpnowwalmart@aircarehealth.com**. See **Dependent eligibility** in the **Eligibility, enrollment, and effective dates** chapter.

Help Now support services by AiRCare

AiRCare provides personalized support by phone.

AiRCare can help you navigate to resources to support the following areas, which may be updated or modified from time to time:

- Financial concerns*
- Food/meals
- Veteran assistance
- Community support groups
- Foreclosure/eviction prevention resources
- Repair services
- Housing
- Education
- Transportation
- Childcare/eldercare
- And others.

*AiRCare's services are limited to helping you find and navigate available resources. AiRCare does not provide direct financial assistance, including monetary distributions or loans.

Help Now resource specialists educate you on the well-being programs available to you through the Plan and help you access those programs. If the Plan does not have a well-being program to support your individual need, the Help Now resource specialist will research, identify, vet, and connect you to resources available to you in your community. The resource specialist will notify you of any fees charged by the community resources, if known.

For more information on support categories, go to **One.Walmart.com/HelpNow**.

If you would like support, you can call **855-4HLPNOW** (**855-445-7669**). Calls are confidential, except as required by law.

When Help Now benefits end

Benefits end on your last day of employment, or when you are no longer eligible under the terms of the Plan.

Help Now is a resource navigation benefit that does not provide medical care. Help Now support services are exempt from ERISA and are not COBRA-eligible.

What is My Mental Health Resources?

My Mental Health Resources is Walmart's employee assistance program. Provided by Lyra, this program provides confidential emotional wellness and mental health support. Mental health coaching and therapy services and learning resources are available at no cost to you and your eligible dependents from your date of hire. Initial consultations for work-life services are available at no cost to you. Additional work-life services are available at a discounted fee. You can call Lyra's Care Navigator Team or visit Lyra's online platform to connect with therapists and mental health coaches, access digital wellness tools for managing stress, sleep, and relationships, and tap into work-life services.

Using My Mental Health Resources

If you are an associate in the United States or Puerto Rico, you and your eligible dependents are automatically enrolled in My Mental Health Resources as of your first day of employment. You will need to register with Lyra to access on-demand resources or start care with a provider. Eligible dependents include your spouse/domestic partner, and your children, stepchildren, or foster children under the age of 26. See **Dependent eligibility** in the **Eligibility, enrollment, and effective dates** chapter. You and your eligible dependents are required to provide your WIN and date of birth to confirm eligibility for services. All services provided are confidential, except as required by law.

Associates of any age (minors included) can set up their own accounts with Lyra. Dependents can set up accounts starting at age 13. Parental consent is not required to set up an account with Lyra.

Depending on state law, associates and dependents aged 13-17 may need parental consent for care. For those in Lyra's teen program, Lyra Care for Teens, parental consent, when required, will be obtained verbally during the first session, along with a completed "consent for care" form for virtual sessions and digital engagement.

Dependents under 13 can receive care through their parent's account. Parents can register and find care for their children age 12 and younger. If a minor who is 12 years old lives in a state that allows them to seek mental health care without parental consent, the minor can contact Lyra's Care Navigator Team for assistance in finding a provider and scheduling an appointment without involving their parents/guardians.

You can access My Mental Health Resources any time at **Walmart.LyraHealth.com** or call Lyra any time at **800-825-3555** to find tools for:

- Identifying a mental health provider
- Building strong mental health and resiliency
- Stress management
- Improving sleep
- Strengthening relationships at home and in the workplace

Many Lyra resources are accessible online and by telephone. Lyra's counseling services are available as face-to-face or live video sessions.

Mental health coaching and therapy services

You and your eligible dependents may receive up to 20 mental health coaching or therapy sessions, per person, per year, at no cost, as long as you access therapy or coaching through a Lyra provider. You can find your Lyra provider at **Walmart.LyraHealth.com** or by calling **800-825-3555** where a Care Navigator can help you register and search for care.

Through Lyra coaching, you can work with a coach through regularly scheduled sessions to better understand what's challenging you, decide what you want to work on, and plan a path forward. Choose to connect with your coach via live messaging through your mobile device or from your computer, or meet "face-to-face" over live video on a recurring basis. You can also select a more hands-off experience through Lyra's Guided Self-Care program.

Lyra therapy offers access to mental health providers that only use evidence-based treatments, with appointments generally available within two weeks. Lyra's therapists can diagnose mental health conditions and identify thoughts, behaviors, and strong emotions that may be symptoms of depression, anxiety, PTSD, or other conditions. During your sessions, your therapist will introduce new skills and may assign exercises for you to practice between sessions. Therapy sessions are available through both virtual and in-person appointments, depending on individual provider availability.

Areas you can address with a mental health provider include:

- Managing stress and burnout
- Coping with depression, anxiety, or substance use
- Building healthy relationships with family, friends, and co-workers
- Parent-child conflict
- Balancing the demands of work and home life
- Grief and loss
- Working through emotionally difficult situations

Work-life services

Lyra, through its third-party partner, makes available access to legal and identity-theft support. Initial consultations are at no cost to you. Additional services are available at a discounted fee.

Work-life services include helping you:

- Explore your options related to legal issues
- Access a library of legal forms and documents for a variety of needs
- Recover from identity theft

You can receive a half-hour consultation for each legal issue or a one-hour consultation for each identity-theft issue, at no cost to you. Note that this service does not provide assistance in situations involving employment law. If you need more legal or identify-theft support beyond the initial consultation, you can continue for an additional discounted fee. Resources, documents, and self-help tools are all available 24/7 online at **Walmart.LyraHealth.com/Worklife**.

Learning resources

Lyra's learning resources can help you build strategies to help improve your well-being at work and home through on-demand courses and live events like webinars and discussion groups created and facilitated by Lyra.

ON-DEMAND COURSES

Explore unlimited on-demand courses taught by mental health professionals at your own pace. While some courses feature five to eight chapters of in-depth content, others take less than 15 minutes to complete.

Topics include:

- Leading with awareness and confidence
- Tackling mental health stigma
- Getting better sleep
- Managing your stress
- Race, injustice, and mental health
- Parenting in the real world
- Demystifying mental health
- Soaring past setbacks
- And more, with new topics regularly added

LIVE EVENTS: WEBINARS & DISCUSSION GROUPS

Each month, Lyra offers webinars and virtual discussion groups on topics related to mental health, led by a clinical expert. The webinars offer an opportunity for attendees to watch, listen, and learn, whereas the discussion groups provide a supportive space for participants to share their experiences in a small-group setting. Advance registration is required for both webinars and discussion groups.

To explore on-demand courses or register for a live event, visit **Walmart.LyraHealth.com** and navigate to the "Library" tab once you've logged into your Lyra account. You must be 18 years or older to register for and attend live events including workshops and Gather sessions.

Contacting My Mental Health Resources

LYRA ON THE WEB

Visit **Walmart.LyraHealth.com** to start care with a mental health care provider, and access self-guided mental health essentials tools. You may also download the Lyra Health app from the App Store or Google Play to access many of Lyra's services. Registering as a new user will require you to use your WIN and date of birth to confirm eligibility.

You can also access more information at **One.Walmart.com/MyMentalHealthResources**.

CALLING LYRA

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

When My Mental Health Resources benefits end

If you experience a qualifying event and become eligible for COBRA benefits, My Mental Health Resources will remain available to you and your eligible dependents for 18 months after your last day of employment (or the maximum duration for which you would be eligible for COBRA coverage) at no cost to you. If you enroll for COBRA coverage under the medical, vision or dental plan, the benefit will be available throughout the COBRA period. However, you do not have to enroll in COBRA coverage under the medical, vision, or dental plan to continue your My Mental Health Resources benefits.

Filing a claim for My Mental Health Resources benefits

You do not have to file a claim for My Mental Health Resources benefits. As long as you remain eligible, you may access the Lyra website or contact Lyra by phone at any time. However, if you have a question about your benefits, or disagree with the benefits provided, you may contact People Services at **800-421-1362** or file a claim by writing to the following address:

Mail Stop 3610–Benefits Total Rewards Team
Attn: Custodian of Records
508 SW 8th Street
Mail Stop #3610
Bentonville, Arkansas 72716-3610

Claims and appeals are determined under the time frames and requirements set out in the procedures for filing a claim for medical benefits, as described in the **Claims and appeals** chapter.

COBRA

COBRA

If you and/or your covered dependents lose medical, dental, or vision coverage because of a qualifying event, a federal law known as "COBRA" may allow you to continue that coverage for a set period of time at your own expense.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Contact People Services within 60 calendar days of a divorce, legal separation, termination of a relationship with a partner, or ineligibility of dependents		Call People Services at **800-421-1362** or provide notification in writing to: **Walmart People Services** **805 Moberly Lane** **Bentonville, Arkansas 72712-3501**
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 access to My Mental Health Resources, provided by Lyra, automatically continues for 18 months from the date of the qualifying event (or the maximum duration for which you would be eligible for COBRA coverage). You do not have to enroll in COBRA coverage to continue your access to My Mental Health Resources.
- 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 Walmart ends for any reason, or
- You are no longer eligible for medical coverage because the number of hours you regularly work for Walmart has decreased, making you ineligible for coverage under the Plan.

Your spouse or partner is eligible for COBRA if coverage for the spouse or partner ends for any of the following reasons:

- Your employment with Walmart ends for any reason
- Your spouse or partner is no longer eligible for medical, dental, or vision coverage because the number of hours you regularly work for Walmart has decreased, making them ineligible for coverage under the Plan
- You and your spouse divorce or legally separate
- You and your partner no longer meet the definition of having a "partnership" for purposes of the Plan (refer to the **Eligibility, enrollment, and effective dates** chapter for the definition of "partner")
- You enroll in Medicare benefits Part D, causing your medical coverage to terminate (you must contact People Services by calling **800-421-1362** within 60 days of enrolling in Medicare Part D), or
- You die.

Your eligible dependent other than a spouse or partner is eligible for COBRA if coverage for the dependent ends for any of the following reasons:

- Your employment with Walmart ends for any reason
- Your eligible dependent is no longer eligible for medical, dental, or vision coverage because the number of hours you regularly worked for Walmart has decreased, making them ineligible for coverage under the Plan
- You enroll in Medicare benefits Part D, causing your medical coverage to terminate. (You or your eligible dependent must contact People Services by calling **800-421-1362** within 60 days of enrolling in Medicare Part D.)
- Your dependent child no longer meets eligibility requirements, as described in the **Eligibility, enrollment, and effective dates** chapter (e.g., the end of the month in which a dependent turns age 26), or
- You die.

NOTIFICATION

In general, Walmart will notify WageWorks, the Plan's third-party administrator for COBRA, if you or your dependents become eligible for COBRA continuation coverage because of your death, termination of employment, a reduction in hours of employment that makes you ineligible for coverage under the Plan, or you enroll in Medicare Part D. You or your dependent must notify People Services if you enroll in Medicare Part D. Walmart will 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
805 Moberly Lane
Bentonville, Arkansas 72712-3501

The notice must include the following information:

- Name and address of the covered associate
- Type of qualifying event
- Date of qualifying event
- Name of dependent losing coverage, 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 covered dependents. You should keep a copy of any notices you send to People Services and/or WageWorks for your records.

Federal law places responsibility upon you or your eligible dependent to notify People Services within 60 calendar days after the later of the date of a divorce, legal separation, termination of your relationship with a partner, or a child becoming ineligible due to loss of dependent status, or the date on which coverage under the Plan is terminated as a result of one of these events. If you or your eligible dependent do not notify People Services within 60 days, your dependent will not be eligible for COBRA.

You or your eligible dependent must also notify the COBRA administrator by phone or in writing of a second qualifying event or Social Security disability in order to extend the period of COBRA coverage. Other forms of notice will not bind the Plan. If notice is not provided by phone or in writing of a second qualifying event or extension request within 60 days from the later of the date of the second qualifying event or the date on which you lost (or will lose) coverage as a result of a second qualifying event, COBRA continuation rights will expire on the date that your or your eligible dependent's initial COBRA coverage period expires.

COBRA ENROLLMENT

Within 14 days after the COBRA administrator receives notification that a qualifying event has occurred, the COBRA administrator, on behalf of the Plan, will send a COBRA election notice to you and your eligible dependent at your last known address. The election notice describes your right to continue medical, dental, or vision coverage under COBRA. (If you do not receive this notification, please contact People Services.) To receive COBRA continuation coverage, you must elect coverage through the COBRA administrator within 60 calendar days from the date you lose coverage or the date of the election notice, if later. To enroll, you must complete and mail your COBRA election form to the address on the election form or go online at **mybenefits.wageworks.com**. If you elect COBRA, notify the COBRA administrator of any change of address. Refer to **Paying for COBRA coverage** on the next page for information on making COBRA payments. If you need assistance, call **800-570-1863**.

NOTE: You may be asked to provide documentation of the qualifying event.

You and each of your eligible dependents have independent election rights. You may elect COBRA coverage for all of your dependents who lose coverage because of the qualifying event. A parent or legal guardian may elect

COBRA coverage on behalf of a minor eligible dependent. A child born to or placed for adoption with you while you are on COBRA also has COBRA rights.

COBRA is provided subject to the eligibility requirements for continuation coverage for you and your eligible dependents under the law and the terms of the Plan. To the extent permitted by law, the Plan Administrator will retroactively terminate your COBRA coverage if you are later determined to be ineligible.

Instead of electing COBRA coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, or Medicaid. You may also be eligible for a 30-day "special enrollment period" in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer). You may also have the same special enrollment right at the end of your COBRA coverage if you take COBRA coverage for the maximum time available to you. Some of these options may cost less than COBRA continuation coverage. You can learn more about your options at **healthcare.gov**.

ELECTION CHANGE EVENTS WHILE ON COBRA CONTINUATION COVERAGE

After the COBRA election period, you or your eligible dependent may not change the elected COBRA coverage without an election change event outside Annual Enrollment or a subsequent qualifying event. For information about election change events, see **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter. If an election change event occurs (such as if a child is born), you must notify the COBRA administrator within 60 calendar days of the event. Supporting documentation may be required. You will have the right to make changes to your coverage during any Annual Enrollment while you are on COBRA.

Unless otherwise provided in the Plan, if you add a spouse or partner or other eligible dependent due to an election change event while on COBRA, each person must individually meet any applicable benefit waiting period (for example, for weight loss surgery) and is subject to any applicable Plan limitations. If you change medical plans due to an election change event, your annual deductible and out-of-pocket maximum will reset, and you will be responsible for meeting the new deductible and out-of-pocket maximum in their entirety. If you change from the Contribution 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 applicable waiting periods.

In the event of an election change event, you or your eligible dependent may change benefit coverage to another benefit tier under the Plan only if the change in coverage is consistent with the election change event.

If you move to a new location and this affects your medical coverage (i.e., moving from an HMO area to a non-HMO area), you will have 60 calendar days from the date you notify the COBRA administrator of the address change to select a different plan. If you do not submit your selections within 60 days, you may automatically be enrolled in a predetermined plan.

Paying for COBRA coverage

The COBRA premium is the amount you were paying before the qualifying event, plus the amount Walmart was paying, plus a 2% administrative fee (50% administrative fee in cases of the 11-month disability extension, as described later in this chapter). The letter sent to you and your eligible dependents following notice of a qualifying event will include the monthly premium cost for COBRA coverage.

Initial COBRA premium: Your first premium payment is due 45 days after you elect COBRA and must cover the period from the time your coverage was lost because of a qualifying event up to the end of the month in which your election is made. (For example, assume your employment terminates on September 30, and you lose coverage on September 30. You elect COBRA on November 15. Your initial premium payment should equal the premiums for October and November and is due on or before December 30, which is the 45th day after the date of your COBRA election. Ongoing premiums are due the first day of each month, with a 30-day grace period. So your December payment must be received no later than December 31, the end of the 30-day grace period for the December coverage period.)

If your initial premium payment is not made in the allowed time frame, you will not be eligible for COBRA coverage.

Continuing premiums: Monthly premiums are due on the first day of each month following the due date of the initial premium. If you make your payment on or before the first day of each month, your COBRA coverage under the Plan will continue for that month. To eliminate any possible delay in the updating of your eligibility information, it is recommended that you pay your premiums 7-10 days in advance of the due date.

You are allowed a 30-day grace period from the premium due date before coverage is canceled. However, if you make your payment on the first day of the month or later, your coverage will be suspended and any claims incurred, including pharmacy benefits, will not be paid until coverage is paid through the current month. If you do not pay this premium, you will be responsible for claims incurred. If the 30th day falls on a weekend or holiday, you have until the first business day following to have your payment postmarked or paid.

As a courtesy, the COBRA administrator will send you a COBRA premium payment invoice, unless you make your payments by Automated Clearing House (ACH) debit, in which case you will not receive an invoice. To avoid interruption or cancellation of coverage, it is recommended that you pay your premiums 7-10 days in advance of the due date. Using the ACH debit through the COBRA administrator can cause eligibility delays since these drafts are taken on the first business day of the month. Premium payments are due regardless of your receipt of a payment invoice. If you pay by mail, attach your payment to the invoice and mail it to:

WageWorks
P.O. Box 660212
Dallas, Texas 75266-0212

To pay online, log on to **mybenefits.wageworks.com**. To pay by phone, call **800-570-1863**.

If your COBRA coverage is canceled due to nonpayment of premiums, your COBRA coverage will end on the last day for which you paid your full COBRA premium on time, and it will not be reinstated.

COBRA is month-to-month coverage, and if you do not want to continue coverage, it can be terminated in the following ways:

- Simply stop paying premiums, and your COBRA coverage will be terminated for nonpayment.
- Enter a support request in the WageWorks online message center.
- Send a letter to WageWorks requesting termination of your COBRA coverage, mailed to:

  WageWorks
  P.O. Box 14390
  Lexington, Kentucky 40512-4390

If you choose to cancel coverage, it cannot be reinstated. Coverage will be automatically canceled if your payment is not postmarked on or before the deadline date of the month your premium is due.

How long COBRA coverage may last

The maximum duration of your COBRA coverage depends on the qualifying event making you eligible for COBRA coverage, as shown in the chart below.

MAXIMUM DURATION OF COBRA COVERAGE

Event	Associate	Dependents
• Your employment with Walmart ends for any reason • You are no longer eligible for coverage under the Plan due to a reduction in hours	18 months from the date of the event	18 months from the date of the event
• Your death • Your marital (or partnership) status changes • Dependent no longer meets eligibility requirements (e.g., turns age 26)	Not applicable	36 months from the date of the event
You enroll in Medicare less than 18 months prior to your termination of employment or reduction in hours	18 months from the date of termination of employment or reduction in hours	Up to 36 months from the date you enrolled in Medicare
You enroll in Medicare Part D	Not applicable	36 months from the date you enrolled in Medicare Part D
Disability extension is obtained	29 months from the date of the original qualifying event	29 months from the date of the original qualifying event
Second qualifying event—you must notify the COBRA administrator within 60 days of the second qualifying event or the date of loss of coverage, if later	Not applicable	Up to 36 months from the date of the original qualifying event

IF YOU ARE ENTITLED TO MEDICARE

In general if you are eligible for Medicare Parts A and/or B and terminate employment with Walmart (or lose coverage under the Plan), you have an eight-month special enrollment period in which to enroll in Medicare Part A and/or B that runs from the date you are no longer employed by Walmart (or lose coverage under the Plan, whichever occurs first), even if you elect COBRA continuation coverage. You should be aware that if you do not enroll in Medicare Parts A and/or B during the Medicare special enrollment period, you may have to wait to enroll in Medicare Parts A and/or B (i.e., until the next Medicare annual enrollment period) and may have to pay a higher Medicare premium when you do enroll. For additional information, refer to Medicare's *Medicare & You* handbook, published annually. The handbook can be obtained directly from Medicare by calling **800-633-4227** or from the Medicare website at **medicare.gov**.

Entitlement to Medicare means you are eligible for and enrolled in Medicare. If you become entitled to Medicare less than 18 months before a qualifying event due to termination of employment or reduction in hours, your covered dependents may be eligible for extended COBRA coverage for up to 36 months from the date you became entitled to Medicare.

If you are entitled to Medicare prior to your COBRA election date, you or your covered dependents must notify the COBRA administrator at **800-570-1863** of your Medicare entitlement date in order to ensure that maximum coverage eligibility for your dependents is properly calculated.

IF YOU OR AN ELIGIBLE DEPENDENT IS DISABLED

If you are a qualified beneficiary who has COBRA coverage because of termination of employment or reduction in hours, you and each covered dependent may be entitled to an extra 11 months of COBRA coverage if you or your covered dependents become disabled. (That is, you can get up to a total of 29 months of COBRA coverage.) The 29-month COBRA coverage period begins on the date after your termination of employment or reduction in hours of employment that makes you ineligible for coverage under the Plan. The disability extension applies only if all of the following conditions are met:

- The Social Security Administration determines that you or your eligible dependent is disabled
- The disability exists at any time within the first 60 calendar days of COBRA coverage and lasts at least until the end of the 18-month period of COBRA continuation coverage, 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 Walmart was paying, plus a 50% administrative fee, or 150% of the full premium amount.

However, if the disability extension applies, but the disabled qualified beneficiary dependent is not enrolled in COBRA coverage, the COBRA premium for the covered dependents for the extended period is limited to 102% of the full premium amount. You or your eligible dependent must notify the COBRA administrator no later than 30 days after the Social Security Administration determines that you or your eligible dependent is no longer disabled.

IF YOU HAVE A SECOND QUALIFYING EVENT WHILE ON COBRA

While you (the associate) cannot receive an extension of COBRA coverage due to a second qualifying event, your eligible dependent who has COBRA coverage due to your termination of employment or reduction in hours may receive COBRA coverage for up to a total of 36 months if a second qualifying event occurs during the original 18-month continuation coverage period (or during the 29-month coverage period, in the event of a disability extension).

The following can be second qualifying events:

- Your death
- Your divorce, legal separation, or termination of a relationship with a partner
- Your child is no longer eligible for medical, dental, or vision coverage (e.g., a dependent turns age 26), 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 your COBRA coverage ends

COBRA coverage usually ends after the 18-month, 29-month, or 36-month maximum COBRA coverage period. See **How long COBRA coverage may last** in this chapter to find out which maximum COBRA coverage period applies to you.

COBRA coverage may be terminated before the end of the 18th, 29th, or 36th month if:

- Walmart no longer provides medical, dental, or vision coverage to any associates
- After the initial 45-day payment period you do not make a COBRA payment within 30 calendar days of the due date (if the 30th day falls on a weekend or non-postal delivery day, you have until the next business day to have your payment postmarked or paid)
- You or your eligible dependent becomes covered by another group health, dental, or vision plan after electing COBRA coverage
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, terminates as of the later of (a) the first day of the month that is more than 30 days after a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled, or (b) the end of the coverage period that applies without regard to the disability extension), 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, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

Full-time hourly short-term disability

If pregnancy, a scheduled surgery, or an unexpected illness or injury keeps you off the job for an extended period, this plan for full-time hourly associates can replace part of your pay. Options include the short-term disability basic plan and short-term disability enhanced plan.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
To request a leave or to file a claim for basic or enhanced benefits or maternity benefits, or to get more information	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**
Colorado	Go to **famli.colorado.gov**	Call **866-263-2654**
Connecticut	Go to **ctpaidleave.org**	Call **877-499-8606**
Massachusetts	Go to **paidleave.mass.gov**	Call **833-344-7365**
Oregon	Go to **paidleave.oregon.gov**	Call **833-854-0166**
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 options: the short-term disability basic plan and the short-term disability enhanced plan.
  - **The short-term disability basic plan**
    - The *short-term disability basic benefit* replaces 50% of your average weekly wage for up to 25 weeks after a waiting period of seven calendar days, with no weekly maximum (however, if you work in New York there is a maximum of $6,000 per week).
    - The *short-term disability maternity benefit* replaces 100% of your average weekly wage for up to nine weeks after a waiting period of seven calendar days.
  - **The short-term disability enhanced plan** replaces 60% of your average weekly wage for up to 25 weeks after a waiting period of seven calendar days, with no weekly maximum (however, the New York short-term disability enhanced plan has a maximum of $6,000 per week).
- Some states and localities provide legally mandated benefits. Variations in laws and administrative procedures may affect your eligibility to participate in a Walmart short-term disability plan, as well as the amount of any disability benefit.
  - If you work in California, Hawaii, New Jersey, or Rhode Island, you are not eligible for the Walmart short-term disability enhanced plan or the basic benefit under the short-term disability basic plan because the states in which you work provide legally mandated benefits. However, you are eligible for the maternity benefit under the Walmart short-term disability basic plan to supplement any legally mandated maternity benefits offered by the state.
  - If you work in Colorado, Connecticut, Massachusetts, New York, Oregon, Washington, D.C., or Washington state, you are eligible to participate in one of Walmart's short-term disability plans, but it will only supplement your state or locally mandated benefit.
  - Legally mandated benefits are not offered under the Associates' Health and Welfare Plan, and benefits paid under those legally mandated programs are not provided under a Walmart short-term disability plan. Legally mandated benefits are not discussed in detail in this chapter, except where relevant to help you understand benefits under a Walmart short-term disability plan.

Your short-term disability benefit

If the short-term disability plan is available at your location and you become disabled as defined in the **When you qualify for benefits** section later in this chapter, the short-term disability basic plan provides a basic weekly benefit of 50% of your average weekly wage for up to 25 weeks of an approved disability, after a waiting period of seven calendar days, with no maximum weekly benefit (however, if you work in New York there is a maximum weekly benefit of $6,000). For more information about your average weekly wage, see **Calculating your benefit** later in this chapter.

If the short-term disability plan is available at your location and you become disabled as defined in the **When you qualify for benefits** section later in this chapter, the short-term disability enhanced plan provides a weekly benefit of 60% of your average weekly wage for up to 25 weeks of an approved disability, after a waiting period of seven calendar days, with no maximum weekly benefit (however, if you work in New York, the New York short-term disability enhanced plan has a maximum weekly benefit of $6,000).

If your disability is due to pregnancy, the short-term disability basic plan provides a maternity benefit of 100% of your average weekly wage for up to the first nine weeks, after an initial waiting period of seven calendar days. If you are eligible for legally mandated short-term disability benefits, the maternity benefit supplements your state benefits. The combined total of the maternity benefit available to you under the short-term disability basic plan and the maternity benefit available to you under any state or locally mandated program will not exceed 100% of your average weekly wage for nine weeks. If you remain disabled and are eligible for benefits after the first nine weeks of 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** later in this chapter for more information.

How short-term disability benefits are funded

The short-term disability basic plan is provided by Walmart at no cost to you. However, if you enroll in the short-term disability enhanced plan, you and Walmart share the cost. If you participate in the short-term disability enhanced plan, your cost is based on your eligible earnings and your age. If you have no eligible 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. Walmart currently funds benefits under the self-insured short-term disability plan from Walmart's general assets.

For associates who work in New York, benefits provided under the short-term disability basic plan and the New York short-term disability enhanced plan are insured by Lincoln.

How 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 related appeals.

See the **Legally mandated benefits** chart on the following page for details regarding the administration of non-maternity disability coverage available for associates in states and localities with legally mandated benefits. For details regarding the administration of short-term disability plan maternity benefit, see **Maternity benefit** later in this chapter.

When you qualify for benefits

To be eligible to receive short-term disability benefits under either short-term disability plan, you must meet the following requirements:

- The short-term disability plan must be available at your location.
- Your coverage must be effective.
- Your disability must have occurred on or after the effective date of your coverage.
- You must be on active status on the date of your disability unless:
  - You are on leave of absence or layoff as described later in this chapter under **If you are on a leave of absence or experience a temporary layoff**, or
  - You are unable to work because you have experienced medical complications during pregnancy or post-partum and have exhausted the nine-week short-term disability maternity benefit, as described later in this chapter under **Maternity benefit**.

LEGALLY MANDATED BENEFITS

If you work in a state or locality with a legally mandated benefit, differences in laws and administrative procedures affect your eligibility to participate in a Walmart short-term disability plan, as well as the amount of your disability benefit. See below for general information. Call the number listed in the **Resources** chart for details about benefits in these states or localities. See **Maternity benefit** for information about the maternity benefit, including information about administration.

Legally mandated benefits administered by your state	If you work in **California** or **Rhode Island**, you are not eligible to participate in a Walmart short-term disability plan. Your disability benefit is administered by the state. You may still be eligible for the maternity benefit* under the Walmart short-term disability basic plan.
Legally mandated benefits administered by Lincoln	If you work in **Hawaii** or **New Jersey**, you are not eligible to participate in a Walmart short-term disability plan. Your disability benefit is provided in accordance with the state program and is insured and administered by Lincoln. You may still be eligible for the maternity benefit* 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 benefits administered by Sedgwick	If you work in **Colorado, Connecticut, Massachusetts, Oregon, Washington, D.C.**, or **Washington state**, you are eligible to participate in a Walmart short-term disability plan to supplement your legally mandated benefits, which are administered by Sedgwick.*

*The amount of any non-maternity or maternity benefit paid under a Walmart short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates you are eligible to receive from the state or locality, regardless of whether you apply for that legally mandated benefit. If the benefit available to you under any state or locally mandated program is less than the benefit available to you under a Walmart short-term disability plan, the combined total of the benefit available to you under a Walmart short-term disability plan and the benefit available to you under any state or locally mandated program will not exceed the benefits that would have been available under the Walmart short-term disability plan you are enrolled in, if you had not worked in a state with a legally mandated program. You will be required to provide your determination letter from the state or locality to Sedgwick. If Sedgwick overestimated what your legally mandated benefit would be, meaning that you were paid less under the short-term disability plan than you were entitled to, you will be paid the difference in a lump sum payment. If Sedgwick underestimated what your legally mandated benefit would be, meaning that you were paid more under the short-term disability plan than you were entitled to, you must repay any amount overpaid to you. See the **Right to recover overpayment** section later in this chapter.

- Except as otherwise provided in the **Maternity benefit** section, you must submit objective medical evidence provided by a qualified doctor that you are disabled as defined below (for purposes of this chapter, the term "doctor" includes legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors [M.D.], osteopaths [D.O.], nurse practitioners, physician's assistants, psychologists, or other medical practitioners whose services would be eligible for reimbursement if submitted for reimbursement under the Associates' Medical Plan).
- You must receive approval by Sedgwick or Lincoln (as applicable) of your claim.

These conditions apply whether you are enrolled in the short-term disability basic or enhanced plan or the New York short-term disability enhanced plan. Sedgwick or Lincoln may require written proof of your disability, as described below, or additional information before making a decision on your claim. A statement by your doctor that you are unable to work does not by itself prove that you are disabled. Approval of a leave of absence also does not constitute approval for short-term disability benefits.

Except as otherwise provided in the **Maternity benefit** section, for purposes of benefits provided under a short-term disability plan, as described in this chapter, "disabled" or "disability" means that (i) you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or

physical illness or injury, or pregnancy, and (ii) you are under the continuous care of a qualified doctor and are following the course of treatment prescribed by your doctor.

Disability benefits are payable during a loss of license only while you are disabled and pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria, and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. Loss of license by itself is not sufficient for meeting the definition of disability.

If you are employed as a pilot, copilot, or crewmember of an aircraft, "disability" or "disabled" means that, as a result of a mental or physical illness or injury, you are unable to perform the material and substantial duties of your own occupation under the applicable Federal Aviation Administration fitness standards.

The determination of whether you are disabled is made by Sedgwick (or Lincoln, as applicable) on the basis of objective medical evidence, which consists of facts and findings, including but not limited to X-rays, laboratory reports, tests, consulting physician reports, as well as reports and chart notes from your doctor.

If your disability is caused by a mental illness or substance use disorder, you are encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, licensed counselor, drug and alcohol counselor, or clinical social worker who specializes in mental health and/or substance use disorders, and is licensed pursuant to state law. See the **Associate assistance resources** chapter for information on resources that are available if you are experiencing the effects of a mental illness or substance use disorder.

If Sedgwick or Lincoln requests that you be examined by an independent doctor, you must attend the exam to be considered for benefits. Walmart will pay the cost of any such examination.

The maximum length of any one period of disability during which disability benefits are paid, even if the disability is the result of more than one cause, is 25 weeks, after the initial waiting period of seven calendar days. See also **If you return to work and become disabled again**.

See the **Maternity benefit** section for additional details regarding the maternity benefit.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that:

- Arose before your coverage became effective
- Is not under 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).

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 during which short-term disability benefits are approved, unless allowed by state law. If you are later found to be ineligible for short-term disability benefits, you may go back and use PTO for any time that was unpaid, subject to terms of the PTO policy. You may be required to repay any PTO used for days when disability benefits were approved. Upon repayment, any PTO balance will be restored.

The PTO policy is not a benefit offered under, or administered as part of, the Plan. For specific details about the PTO policy, refer to **One.Walmart.com**.

Calculating your benefit

The amount of your weekly short-term disability benefit is based on:

- Your average weekly wage, as defined below
- The duration of your disability, 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 eligible earnings for the 26 pay periods* immediately preceding your last day worked ÷ 52 weeks For example, the average weekly wage for an associate with eligible earnings of $36,400 for the prior 26 pay periods is $700 ($36,400 ÷ 52)
Employed less than 12 months	Eligible earnings since date of hire ÷ number of weeks worked For example, the average weekly wage for an associate with eligible earnings of $8,400 for 12 weeks of work is $700 ($8,400 ÷ 12)
*Any pay periods in which you have no eligible earnings are excluded, decreasing the number of pay periods used for the calculation. To the extent your eligible earnings were paid on a weekly basis during the 12-month period, the number of pay periods used to calculate your average weekly wage will be adjusted accordingly. Your short-term disability benefits are paid through Walmart payroll on a pay-period basis. If your disability benefit is payable for less than a week, your disability benefit for each day that you are disabled during that week will be 1/7 of the weekly benefit.	
Eligible earnings used to determine average weekly wage include: • Regular earnings for the 26 pay periods prior to your last day worked • Overtime • Regularly scheduled target incentive bonuses that you and associates in similarly situated job types or job levels are eligible to earn • Paid time off and similar pay that replaces regular earnings (e.g., bereavement leave, jury duty leave, and sick time) Eligible earnings used to determine average weekly wage exclude: • Any previously paid disability benefits • Commissions or any other extra compensation or fringe benefits not listed above	

A hypothetical benefit calculation is shown below, using an average weekly wage of $700.

YOUR SHORT-TERM DISABILITY BENEFIT: AN EXAMPLE	
If you have	**Your benefit is**
Short-term disability basic plan coverage	50% of your average weekly wage
	Average weekly wage: $700 50% of $700: $350
Short-term disability enhanced plan coverage	60% of your average weekly wage
	Average weekly wage: $700 60% of $700: $420 weekly benefit Benefits are paid through Walmart payroll on a pay-period basis.
NOTE: If you are eligible for legally mandated benefits as well as benefits under a Walmart short-term disability plan, the amount of the benefit under the Walmart short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates that you will receive. See **Legally mandated benefits** earlier in this chapter.	

MATERNITY BENEFIT

See the **When you qualify for benefits** section for general requirements applicable to all disability benefits under a short-term disability plan, including the maternity benefit. There are some exceptions to those general rules that apply to the maternity benefit. Those exceptions are discussed in this section. Also see the **Legally mandated benefits** chart earlier in this section.

The maternity benefit is 100% of your average weekly wage for up to the first nine weeks of leave, after an initial waiting period of seven calendar days. Disability benefits begin on the eighth calendar day after your disability begins.

If your disability is due to pregnancy, the date of your disability is generally on or up to two weeks prior to your expected date of delivery. If you begin your short-term disability leave during this time frame, you will be deemed to meet the definition of disability for purposes of the maternity benefit. If you begin your leave more than two weeks prior to your expected delivery date, you will be required to provide objective medical evidence to demonstrate you are disabled, as defined in the **When you qualify for benefits** section. If you are disabled, as defined in that section, you will begin your short-term disability maternity benefit on the date you are determined to be disabled. In no event will the maternity benefit exceed nine weeks.

If you begin your short-term disability leave after your delivery date, you must meet the Plan's definition of disabled, as defined in the **When you qualify for benefits**

section. In that case, any disability benefit will be subject to rules applicable to non-maternity disability benefits and depend on whether you are eligible for the short-term disability basic or enhanced benefit. You will not be eligible for the maternity benefit described in this section.

If you return to work before receiving your full maternity benefit and then go on leave again, you will not be able to resume your maternity benefit unless you provide objective medical evidence to Sedgwick to support a determination that you meet the definition of disability. If no medical evidence is provided, the remainder of the maternity benefit is forfeited.

The maternity benefit is summarized below. See the **Legally mandated benefits** chart earlier in this section for additional information about legally mandated benefits.

MATERNITY BENEFIT		
Your work location (state or locality)*	**Up to 9 weeks****	**Beyond 9 weeks** (up to 25 total weeks)**
If you work in a state or locality with no legally mandated benefit	100% of your average weekly wage after an initial waiting period of 7 calendar days.	If you experience medical complications during pregnancy or 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 benefit, (ii) *you are eligible* to receive the state benefit due to your pregnancy, and (iii) you work in a location eligible for the Walmart short-term basic or enhanced plan	100% of your average weekly wage, reduced by any legally mandated benefits that are payable at the applicable state or local government rate, after an initial waiting period of 7 calendar days.	Additional benefits may be available through your state or local government and benefits may be payable under the short-term disability basic or enhanced plan, as described above.
If (i) you work in a state or locality with a legally mandated benefit, (ii) *you are eligible* to receive the state benefit due to your pregnancy, and (iii) you do not work in a location eligible for the Walmart short-term disability basic or enhanced plan	100% of your average weekly wage, reduced by any legally mandated benefits that are payable at the applicable state or local government rate, after an initial waiting period of 7 calendar days.	Additional benefits may be available through your state or local government.
If (i) you work in a state or locality with a legally mandated benefit, (ii) *you are not eligible* to receive the state or local government benefit due to your pregnancy, and (iii) you work in a location eligible for the Walmart short-term disability basic or enhanced plan	100% of your average weekly wage after an initial waiting period of 7 calendar days.	If you experience medical complications during pregnancy or 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 benefit, (ii) *you are not eligible* to receive the state or local government benefit due to your pregnancy, and (iii) you do not work in a location eligible for the Walmart short-term disability basic or enhanced plan	100% of your average weekly wage after an initial waiting period of 7 calendar days.	The Walmart short-term disability basic and enhanced plans are not available; maternity benefits end after the first 9 weeks of benefit payments.
Benefits are typically paid through Walmart payroll on a pay-period basis. However, there may be some instances during the claim process where payments could be issued outside the normal payroll cycle.		

*If you work in California, Colorado, Connecticut, Hawaii, Massachusetts, New Jersey, New York, Oregon, Rhode Island, Washington D.C., or Washington state, Sedgwick will estimate the legally mandated benefit available to you under those programs, regardless of whether you have applied for the legally mandated 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. The Parental Pay Policy is not a benefit offered under, or administered as part of, the Plan. For specific details about the Parental Pay Policy, refer to **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's contribution and associate after-tax contributions. Walmart generally withholds federal, state, local, and Social Security taxes from the portion of your benefit that is taxable.

If you work in New York, please contact Lincoln for information regarding the taxation of your short-term disability plan basic or enhanced benefits. Associates in other states or localities with legally mandated benefits who are not eligible to participate in the short-term disability basic or enhanced plans should either contact Lincoln (if you work in 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 or tax advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

RIGHT TO RECOVER OVERPAYMENT

The Plan has the right to recover from you, and you must repay, any amount overpaid to you for short-term disability benefits under a Walmart short-term disability plan. See **The Plan's right to recover overpayment** and **The Plan's right to salary/wage deduction** in the **Claims and appeals** chapter. If you do not repay overpaid amounts in a timely manner, Walmart will first deduct these amounts from future disability payments (if any). If there is a remaining amount due after any deductions from future disability payments, then Walmart may, in its discretion, either (i) treat overpaid amounts as taxable wages to you (reportable on your Form W-2), or (ii) deduct overpaid amounts from your pay, to the extent permitted by law.

Filing a short-term disability claim

If you become disabled, you should file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption in your wages, or the denial of your claim. The timing and the process you need to follow when filing a claim for short-term disability benefits depend on whether the short-term disability plan is available at your location (i.e., whether you are in a state or locality that provides legally mandated benefits.) See the **Claim filing instructions** on the following page for information about filing your claim.

STEP 1: Contact Sedgwick to apply for a leave of absence. Regardless of the process you follow to file a short-term disability claim with the Plan, you will need to contact Sedgwick by going to **One.Walmart.com/LOA > mySedgwick** or by calling **800-492-5678** to apply for a leave of absence as soon as you know you will be absent from work due to an illness, injury, or pregnancy. Sedgwick will send you an initial packet providing the information you will need and describing any actions you will need to take.

The leave of absence policy is not a benefit offered under, or administered as part of, the Plan and is not discussed here in detail. For specific details about the leave of absence policy, refer to **One.Walmart.com**.

NOTE: The approval of a leave of absence under Walmart's leave of absence policy does not automatically mean your short-term disability claim is approved. See **When benefits begin** for details.

STEP 2: File a claim for short-term disability or legally mandated benefits. Your claim for short-term disability benefits cannot be fully processed until you have stopped working. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated.

NOTE: Your claim filing date is the date on which you submit your disability claim to Sedgwick. In order for Sedgwick to begin their review of your claim, you must have fully stopped working. If you file your claim prior to your first date of absence, Sedgwick will begin processing your claim as of your first date of absence. If you file your claim on or after your first date of absence, Sedgwick will begin their review as of your reported date.

See the chart on the following page for details on where and when to file your claim.

CLAIM FILING INSTRUCTIONS

Your state or locality may have unique filing periods, which could potentially exclude benefits for periods prior to the date of your benefits application. It is strongly advised that you promptly apply to your state or locality for any benefits that are mandated by law.

State or locality	Eligibility	Claim administrator	Filing instructions
CA, RI	Not eligible for Walmart short-term disability basic or enhanced Eligible for maternity, as a supplement to legally mandated benefits	State for legally mandated benefit Sedgwick for maternity	**CA:** Go to **edd.ca.gov** or call **800-480-3287** for instructions **RI:** Go to **www.dlt.ri.gov/tdi** or call **401-462-8420** for instructions For maternity benefit, file a claim with Sedgwick within 90 days of the date your disability begins; you will need to provide the determination letter from the state with benefit details. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
HI, NJ	Not eligible for Walmart short-term disability basic or enhanced Eligible for maternity, as a supplement to legally mandated benefits	Lincoln Sedgwick for maternity	**HI:** File a claim with Sedgwick within 90 days of the date your disability begins, and Sedgwick will forward to Lincoln. **NJ:** File a claim with Sedgwick within 30 days of the date your disability begins, and Sedgwick will forward to Lincoln. For maternity benefit, file a claim with Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
CO, CT, MA, OR, WA **Washington, D.C.**	Eligible for Walmart short-term disability plan as a supplement to legally mandated benefits	State or district for legally mandated benefit Sedgwick for supplemental benefits and maternity	**CO:** Go to **famli.colorado.gov** or call **866-263-2654** for instructions **CT:** Go to **ctpaidleave.org** or call **877-499-8606** for instructions **MA:** Go to **paidleave.mass.gov** or call **833-344-7365** for instructions **OR:** Go to **paidleave.oregon.gov** or call **833-854-0166** for instructions **WA:** Go to **paidleave.wa.gov** or call **833-717-2273** for instructions **D.C.:** Go to **dcpaidfamilyleave.dc.gov** or call **202-899-3700** for instructions **Sedgwick:** File a claim with Sedgwick within 90 days of the date your disability begins; you will need to provide the determination letter from the state or district with state or district benefit details. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
NY	Eligible for Walmart short-term disability plan as a supplement to legally mandated benefits	Lincoln Sedgwick for supplemental benefits and maternity	File a claim with Sedgwick within 30 days of the date your disability begins and Sedgwick will forward to Lincoln For maternity benefit, file a claim with Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
All others	Eligible for Walmart short-term disability plan	Sedgwick	File a claim with Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

STEP 3: Let your doctor's office know it will be contacted for information. Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide objective medical information, including:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, 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 4: Follow up with your doctor to ensure that the requested information is forwarded to Sedgwick. Any delay in sending information to Sedgwick could result in a delay, or denial, in the processing of your claim and the payment of benefits.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

You may be required to provide written proof of your disability or additional medical information before your claim is approved.

When short-term disability benefit payments end

If you are receiving short-term disability benefits under a Walmart short-term disability plan, your benefit payments will end on the earliest of:

- The date you no longer meet the short-term disability plan's definition of disabled
- The date you fail to furnish the required proof of disability when requested to do so by Sedgwick or Lincoln
- The date you are no longer under the continuous care and treatment of a qualified doctor
- The date you refuse to be examined, if Sedgwick or Lincoln requires you to be examined
- The last day of the maximum period for which benefits are payable
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart, 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 following a leave

Sedgwick will contact you before your expected return-to-work date and advise you of steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

To ensure a smooth transition back to work and avoid a potential impact to your pay, you will need to contact Sedgwick **up to seven days prior to your actual return-to-work date**. If your return-to-work date changes, you should notify Sedgwick immediately. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options, which include requesting an extension of your leave or voluntarily terminating your employment. Failure to request an extension may result in your employment being terminated.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less and you are classified as a full-time associate on active status (with or without medical restrictions) and become disabled again from the same or a related condition that caused the first period of disability, as determined by Sedgwick or Lincoln, known as a "relapse/recurrent claim," your short-term disability benefits will pick up where they left off before you came back to work. There will be no additional waiting period of seven calendar days. The combined benefit duration for both periods of disability will not exceed 25 weeks.

If you have returned as a full-time associate and are on active status for more than 30 calendar days and then become disabled from the same or a related condition, it will be considered a new disability, and you may be able to receive up to 25 weeks of benefits following your completion of a new seven-calendar-day benefit waiting period.

If you return as a full-time associate and are on active status for any number of calendar days and then become disabled from a new and unrelated condition, it will be considered a new disability, and you may qualify for up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

If you are on a leave of absence or experience a temporary layoff

If you are not on active status due to a leave of absence or temporary layoff, your eligibility for short-term disability benefits will continue for 90 days from the beginning of your leave or temporary layoff. Your eligibility for short-term disability coverage ends on the 91st day after the beginning of your leave of absence or temporary layoff, but is reinstated to your prior coverage if you return to active work status within one year (you will not be required to satisfy the 12-month waiting period again). See **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits while on leave.

When your short-term disability coverage ends

Your short-term disability basic plan and enhanced plan coverage ends on the earliest of:

- The date your employment terminates
- The last day of the pay period in which your job status changes from an eligible job status
- The date of your death
- The 91st day of a leave of absence or layoff (unless you return to work), or
- The date the short-term disability benefit is no longer offered by Walmart.

In addition, coverage under the short-term disability enhanced plan will end if you voluntarily drop your coverage. See the **Eligibility, enrollment, and effective dates** chapter for information.

If you leave Walmart and are rehired

If you are a full-time hourly associate, see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

Full-time hourly short-term disability

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, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

The salaried short term disability plan is not a benefit offered under the Walmart Inc. Associates' Health and Welfare Plan and is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

This information does not create an express or implied contract of employment or any other contractual commitment. Walmart may modify this information at its sole discretion without notice, at any time, consistent with applicable law.

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 replace part of your pay.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
To request a leave, file a claim for benefits, or get more information	Go to **One.Walmart.com/LOA > mySedgwick**	Call Sedgwick at **800-492-5678**
If you work in one of the states or localities listed below, file a claim with Sedgwick in addition to filing with your state or locality. For maternity benefit information, see the **Maternity benefit** section later in this chapter.		
Colorado	Go to **famli.colorado.gov**	Call **866-263-2654**
Connecticut	Go to **ctpaidleave.org**	Call **877-499-8606**
Massachusetts	Go to **paidleave.mass.gov**	Call **833-344-7365**
Oregon	Go to **dcpaidfamilyleave.dc.gov**	Call **833-854-0166**
Washington, D.C.	Go to **paidleave.oregon.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 after a waiting period of seven calendar days and 75% of your base pay for up to 19 additional weeks. (Disabilities that qualify for workers' compensation through Walmart are treated differently, as described in the chart titled **Your salaried short-term disability plan benefit**.)
- If your disability is due to pregnancy, the short-term disability plan replaces 100% of your base pay for up to nine weeks after a waiting period of seven calendar days. Additional benefits may be payable after the first nine weeks of benefits if you experience medical complications during pregnancy or post-partum. For details, see **Maternity benefit** later in this chapter.
- The salaried short-term disability plan is not subject to ERISA and is not offered under 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 benefits, the salaried short-term disability plan will pay 75% of your base pay for up to 19 additional weeks.

If your disability is due to pregnancy, the salaried short-term disability plan pays a maternity benefit of 100% of your base pay for up to the first nine weeks, after an initial waiting period of seven calendar days. If you 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 an additional 16 weeks.

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 Walmart at no cost to you.

LEGALLY MANDATED BENEFITS

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 work in Colorado, Connecticut, Massachusetts, Oregon, Washington, D.C., or Washington state. Rules applicable to these state and local programs can be found in the chart below.

When you qualify for benefits

To be eligible to receive short-term disability benefits, you must meet the following requirements:

- Your coverage must be effective.
- Your disability must have occurred on or after the effective date of your coverage.
- You must be on active status on the date of your disability unless:
  - You are on leave of absence or layoff as described later in this chapter under **If you 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 objective medical evidence provided by a qualified doctor that you are disabled as defined on the following page (for purposes of this chapter, the term "doctor" includes legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors [M.D.], osteopaths [D.O.], nurse practitioners, physician's assistants, psychologists, or other medical practitioners whose services would be eligible for reimbursement if submitted for reimbursement under the Associates' Medical Plan).
- You must receive approval by Sedgwick of your claim.

Sedgwick may require written proof of your disability, as described on the following page, 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.

LEGALLY MANDATED BENEFITS	
If you are a salaried associate who works in Colorado, Connecticut, Massachusetts, Oregon, Washington, D.C., or Washington state	You are eligible to participate in the Walmart salaried short-term disability plan to supplement your state benefits. The amount of the benefit under the salaried short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates that you are eligible to receive from the state or locality, regardless of whether you apply for that legally mandated benefit. If the benefit available to you under any state or locally mandated program is less than the benefit available to you under the Walmart short-term disability plan, the combined total of the benefit available to you under the Walmart short-term disability plan and the benefit available to you under any state or locally mandated program will not exceed the benefits that would have been available under the Walmart short-term disability plan if you had not worked in a state or locality with a legally mandated plan. You will be required to provide your determination letter from the state or locality to Sedgwick. If Sedgwick overestimated what your mandated benefit would be, meaning that you were paid less under the salaried short-term disability plan than you were entitled to, you will be paid the difference in a lump sum payment. If Sedgwick underestimated what your mandated benefit would be, meaning that you were paid more under the salaried short-term disability plan than you were entitled to, you must repay any amount overpaid to you. See the **Right to recover overpayment** section later in this chapter.

Approval of a leave of absence also does not constitute approval for short-term disability benefits.

Except as otherwise provided in the **Maternity benefit** section, for purposes of benefits provided under the short-term disability plan, "disabled" or "disability" means that (i) you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy, and (ii) you are under the continuous care of a qualified doctor and are following the course of treatment prescribed by your doctor.

Disability benefits are payable during a loss of license only while you are disabled and pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. Loss of license by itself is not sufficient for meeting the definition of disability.

If you are employed as a pilot, copilot, or crewmember of an aircraft, "disability" or "disabled" means that, as a result of a mental or physical illness or injury, you are unable to perform the material and substantial duties of your own occupation under the applicable Federal Aviation Administration fitness standards.

The determination of whether you are disabled is made by Sedgwick on the basis of objective medical evidence, which consists of facts and findings, including but not limited to X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician.

If your disability is caused by a mental illness or substance use disorder, you are encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, licensed counselor, drug and alcohol counselor, or clinical social worker who specializes in mental health and/or substance use disorders, and is licensed pursuant to state law. See the **Associate assistance resources** chapter for information on resources that are available if you are experiencing the effects of a mental illness or substance use disorder.

If Sedgwick requests that you be examined by an independent doctor, you must attend the exam to be considered for benefits. Walmart will pay the cost of any such examination.

The maximum length of any one period of disability during which disability benefits are paid, even if the disability is the result of more than one cause, is 25 weeks, after the initial waiting period of seven calendar days. See also **If you return to work and become disabled again**.

See the **Maternity benefit** section of this chapter for additional details regarding the maternity benefit.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that:

- Arose before your coverage became effective
- Is not under the 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 that is related to work outside of Walmart.

When benefits begin

If your short-term disability claim is approved, the benefit will begin after a waiting period of seven calendar days, on the eighth calendar day after your disability begins. (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, unless allowed by state law, while a claim decision is pending or for any period during which short-term disability benefits are approved (see **Your pay after filing a claim** later in this chapter for information regarding provisional pay that may apply after your initial waiting period of seven calendar days). If you are later found to be ineligible for short-term disability benefits, you may go back and use PTO for any time that was unpaid, subject to the terms of the PTO policy. You may be required to repay any PTO used for days when disability benefits were received. Upon repayment, any PTO balance will be restored.

For specific details about the PTO policy, refer to **One.Walmart.com**.

Calculating your benefit

The amount of your short-term disability benefit is based on:

- Your base pay, as defined below, as of your last day worked, 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 salary
Non-exempt associates	Hourly rate multiplied by normal hours scheduled per pay period

If you become disabled and eligible to receive short-term disability benefits, the salaried short-term disability plan pays benefits as described below:

YOUR SALARIED SHORT-TERM DISABILITY PLAN BENEFIT		
Duration of your disability	**Your benefit is:**	
	If your disability does not qualify for workers' compensation through Walmart	**If you have a work-related disability that qualifies for workers' compensation through Walmart**
Up to 7 weeks	After an initial waiting period of 7 calendar days, 100% of your base pay per pay period. Disability benefits begin on the 8th calendar day. You may use PTO during your first 7 calendar days of continuous disability.	100% of your base pay per pay period, with no initial waiting period.
More than 7 weeks, up to 26 weeks	75% of your base pay per pay period. For example, if your base pay per pay period (as defined above) is $1,000, 75% of $1,000 is a $750 benefit. Short-term benefits are paid through Walmart payroll on a pay-period basis.	Workers' compensation benefits are payable at the applicable state rate; short-term disability benefits make up the difference up to 75% of your base pay per pay period. For example, if your base pay per pay period is $1,000 and workers' compensation pays 66% for your disability, or $660, short-term disability will pay an additional $90, for a total benefit of $750. (If the legally mandated workers' compensation rate exceeds 75% of your base pay, you will not receive any short-term disability benefit.)
If a benefit is payable for less than a week, your disability benefit will be based on your base pay divided by your regular work schedule for each day you are disabled. If you are able to return to work after a period of short-term disability and need to miss work periodically for reasons related to your disability, notify Sedgwick and your facility of your situation. Your treatment may be covered under your prior short-term disability claim for up to 12 months from the date you return to work from your short-term disability claim. Salaried short-term disability generally pays 100% of your base pay for the duration of your approved intermittent leave. You will not need to use PTO for the absences.		
NOTE: For associates who are eligible for legally mandated benefits (as noted in **Legally mandated benefits** earlier in this chapter) as well as benefits under Walmart's salaried short-term disability plan, the amount of the benefit under Walmart's salaried short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates that you will receive.		

WORKERS' COMPENSATION AND YOUR SHORT-TERM DISABILITY BENEFITS

Workers' compensation and short-term disability benefits are made as separate payments, except in the states of Texas and Wyoming, where the entire benefit is included in the payment you receive from Walmart.

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 Colorado; Connecticut; Massachusetts; Oregon; 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 be reduced by any legally mandated benefits that you are eligible for.
	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 through Walmart payroll on a pay-period basis.	
*You may 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 benefits** earlier in this chapter) as well as benefits under the salaried short-term disability plan, the amount of the benefit under the salaried short-term disability plan will be reduced by the amount of the legally mandated benefit, regardless of whether you have applied for the legally mandated benefit.		

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 for purposes of the maternity benefit. If you begin your leave more than two weeks prior to your expected delivery date, you will be required to provide objective medical evidence to demonstrate you are disabled, as defined in the **When you qualify for benefits** section. If you are disabled, as defined in that section, you will begin your short-term disability maternity benefit on the date you are determined to be disabled. In no event will the maternity benefit exceed nine weeks.

If you begin your short-term disability leave after your delivery date, you must meet the plan's definition of disabled, as stated in the **When you qualify for benefits** section. In that case, any disability benefit will be subject to rules applicable to non-maternity disability benefits. To the extent you are eligible for a disability benefit, that benefit would be determined under the rules applicable to non-maternity short-term disability. You will not be eligible for the maternity benefit described in this section.

If you experience medical complications during pregnancy or post-partum and continue to meet the definition of disabled 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.

If you return to work before receiving your full maternity benefit and then go on leave again, you will not be able to resume your maternity benefit unless you provide objective medical evidence to Sedgwick to support a determination that you meet the definition of disability. If no medical evidence is provided, the remainder of the maternity benefit is forfeited.

NOTE: For associates in states or localities with legally mandated benefits, please refer to the **Legally mandated benefits** chart earlier in this chapter for information about coordination of benefits.

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

Benefits payable to you under the salaried short-term disability plan are company-provided, at no cost to you. Because you do not make any contributions to the salaried short-term disability plan and you do not pay any tax on the coverage that Walmart provides, any benefits payable to you are subject to taxes, Walmart generally withholds federal, state, local, and Social Security taxes from the amount of your benefit payments.

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 or tax advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

RIGHT TO RECOVER OVERPAYMENT

Walmart has the right to recover from you, and you must repay, any amount overpaid to you for short-term disability benefits under this plan. If you do not repay overpaid amounts in a timely manner, Walmart will first deduct such amounts from future disability payments (if any). If there is a remaining amount due after any deductions from future disability payments, then Walmart may, in its discretion, either (i) treat overpaid amounts as taxable wages to you (reportable on your Form W-2), or (ii) deduct overpaid amounts from your pay, to the extent permitted by law.

Filing a salaried short-term disability claim

If you become disabled, you should file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption in your wages, or the denial of your claim. The timing and the process you need to follow when filing a claim for short-term disability benefits depend on whether the short-term disability plan is available at your location (i.e., whether you are in a state or locality that provides legally mandated benefits). See the **Claim filing instructions** below for information about filing your claim.

STEP 1: Contact Sedgwick to apply for a leave of absence. Regardless of the process you follow to file a short-term disability claim with the Plan, you will need to contact Sedgwick by going to **One.Walmart.com/LOA > mySedgwick** or by calling **800-492-5678** to apply for a leave of absence as soon as you know you will be absent from work due to an illness, injury, or pregnancy. Sedgwick will send you an initial packet providing the information you will need and describing any actions you will need to take.

The leave of absence policy is not a benefit offered, or administered as part of, the salaried short-term disability benefit and is not discussed here in detail. For specific details about the leave of absence policy refer to **One.Walmart.com**.

NOTE: The approval of a leave of absence under Walmart's leave of absence policy does not automatically mean your short-term disability claim is approved. See **When benefits begin** for details.

STEP 2: File a claim for short-term disability or legally mandated benefits. Your claim for short-term disability benefits cannot be fully processed until you have stopped working. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated.

NOTE: Your claim filing date is the date on which you submit your disability claim to Sedgwick. In order for Sedgwick to begin their review of your claim, you must have fully stopped working. If you file your claim prior to your first date of absence, Sedgwick will begin processing your claim as of your first date of absence. If you file your claim on or after your first date of absence, Sedgwick will begin their review as of your reported date.

See the chart below for details on where and when to file your claim.

CLAIM FILING INSTRUCTIONS

Your state or locality may have unique filing periods, which could potentially exclude benefits for periods prior to the date of your benefits application. It is strongly advised that you promptly apply to your state or locality for any benefits that are mandated by law.

State or locality	Eligibility	Claim administrator	Filing instructions
CO, CT, MA, OR, WA **Washington, D.C.**	Eligible for Walmart short-term disability plan as a supplement to legally mandated benefits	State or district for legally mandated benefit Sedgwick for supplemental benefits and maternity	**CO:** Go to **famli.colorado.gov** or call **866-263-2654** for instructions **CT:** Go to **ctpaidleave.org** or call **877-499-8606** for instructions **MA:** Go to **paidleave.mass.gov** or call **833-344-7365** for instructions **OR:** Go to **paidleave.oregon.gov** or call **833-854-0166** for instructions **WA:** Go to **paidleave.wa.gov** or call **833-717-2273** for instructions **D.C.:** Go to **dcpaidfamilyleave.dc.gov** or call **202-899-3700** for instructions **Sedgwick:** File a claim with Sedgwick within 90 days of the date your disability begins; you will need to provide the determination letter from the state or district with state or district benefit details. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
All others	Eligible for Walmart-short-term disability plan	Sedgwick	File a claim with Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

STEP 3: Let your doctor's office know it will be contacted for information. Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide objective medical information, including:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, 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 4: Follow up with your doctor to ensure that the requested information is forwarded to Sedgwick. Any delay in sending information to Sedgwick could result in a delay, or denial, in the processing of your claim and the payment of benefits.

You may be required to provide written proof of your disability or additional medical information before your benefit payments begin.

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.

If your claim is approved, the approval will be effective as of the date of your disability, and the provisional pay you received after your seven-day waiting period and while your claim was pending will count toward your disability benefit.

If your claim is denied before the Medical Due Date because you are not disabled, as defined by the plan, your provisional pay will be stopped and Walmart will commence efforts to recover the provisional pay that was paid to you while your claim was pending.

You will not receive provisional pay during any period when a determination is being made regarding a relapse/recurrent claim (see **If you return to work and become disabled again** later in this chapter).

For specific details about the PTO policy, refer to **One.Walmart.com**.

Benefits determination

Sedgwick will make 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.

For associates in states or localities with legally mandated plans (Colorado, Connecticut, Massachusetts, Oregon, Washington, D.C., and Washington state), your state or locality will specify its process and timeline for making a decision. Additional information can be found on your state or district's website. For contact information, refer to the **Resources** chart at the beginning of this chapter.

APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for short-term disability benefits is denied because Sedgwick did not receive objective medical documentation supporting your claim, or the documentation provided did not support your claim, you will have a grace period of 30 calendar days from the date of your denial letter to submit medical information to Sedgwick for review without the need to file an appeal. Once your grace period has ended, if your claim remains denied and you would like to appeal, you must follow the procedure described in this section.

If your claim for short-term disability 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.

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 decide 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 of your first appeal. 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

For associates in states or localities with legally mandated plans (Colorado, Connecticut, Massachusetts, Oregon, Washington, D.C., and Washington state), your state or locality will specify its process and timeline for deciding an appeal, if any. Additional information can be found on your state or district's website. For contact information, refer to the **Resources** chart at the beginning of this chapter.

When short-term disability benefit payments end

If you are receiving short-term disability benefit payments from the salaried short-term disability plan, your benefit payments will end on the earliest of:

- The date you no longer meet the short-term disability plan's definition of disabled
- The date you fail to furnish the required proof of disability when requested to do so by Sedgwick
- 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.

If your short-term disability benefits end and you do not return to work for any reason, you must request an extension of your leave (refer to the **Resources** chart at the beginning of the chapter for contact information). Failure to do so may result in your employment being terminated.

Benefits provided under a state or locally mandated program may have different end dates from Walmart's short-term disability plan.

Returning to work following a leave

Sedgwick will contact you before your expected return-to-work date and advise you of steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

To ensure a smooth transition back to work and avoid a potential impact to your pay, you will need to contact Sedgwick **up to seven days prior to your actual return-to-work date.** If your return-to-work date changes, you should notify Sedgwick immediately. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options, which include requesting an extension of your leave or voluntarily terminating your employment. Failure to request an extension may result in your employment being terminated.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less and you are classified as a 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 are on a leave of absence or experience a temporary layoff

If you are not on active status due to a leave of absence or temporary layoff, your eligibility for short-term disability benefits will continue for 90 days from the beginning of your leave or temporary layoff. Your eligibility for short-term disability coverage ends on the 91st day after the beginning of your leave of absence or temporary layoff, but is reinstated if you return to work within one year. See **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits while on leave.

When your salaried short-term disability coverage ends

Your short-term disability coverage ends on the earliest of:

- The date your employment terminates
- The last day of the pay period in which your job status changes from an eligible job status
- The date of your death
- The 91st day of a leave of absence or layoff (unless you return to work), or
- The date the benefit is no longer offered by Walmart.

If you leave Walmart and are rehired

If you leave Walmart and return to work for Walmart as a salaried associate, you will automatically be reenrolled in the salaried short-term disability plan.

Truck driver short-term disability 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, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

The truck driver short-term disability plan is not a benefit offered under the Walmart Inc. Associates' Health and Welfare Plan and is not subject to the Employee Retirement Income Security Act of 1974 ("ERISA").

This information does not create an express or implied contract of employment or any other contractual commitment. Walmart may modify this information at its sole discretion without notice, at any time, consistent with applicable law.

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 replace part of your pay. 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 request a leave, file a claim for benefits, 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 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		
Colorado	Go to **famli.colorado.gov**	Call **866-263-2654**
Connecticut	Go to **ctpaidleave.org**	Call **877-499-8606**
Massachusetts	Go to **paidleave.mass.gov**	Call **833-344-7365**
Oregon	Go to **paidleave.oregon.gov**	Call **833-854-0166**
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. (Disabilities that qualify for workers' compensation through Walmart are treated differently, as described in the chart titled **Your truck driver short-term disability plan benefit**.)
- If your disability is due to pregnancy, the short-term disability plan replaces 100% of your average day's pay for up to nine weeks. Additional benefits may be payable after the first nine weeks of benefits if you experience medical complications during pregnancy or post-partum. For details, see **Maternity benefit** later in this chapter.
- The truck driver short-term disability plan is not subject to ERISA and is not offered under 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 up to 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 an additional 16 weeks.

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 Walmart at no cost to you.

LEGALLY MANDATED BENEFITS

Short-term disability benefits provided by individual states and local governments generally have no impact on your eligibility for the truck driver short-term disability benefit plan through Walmart, unless you are an associate who works in Colorado, Connecticut, Massachusetts, Oregon, Washington, D.C., or Washington state. Rules applicable to these state and local plans can be found in the following chart.

LEGALLY MANDATED BENEFITS	
If you are an associate who works in Colorado, Connecticut, Massachusetts, Oregon, Washington, D.C., or Washington state	You are eligible to participate in the truck driver short-term disability plan to supplement your state benefits. The amount of the benefit under the truck driver short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates that you are eligible to receive from the state or locality, regardless of whether you apply for that legally mandated benefit. If the benefit available to you under any state or locally mandated program is less than the benefit available to you under a Walmart short-term disability plan, the combined total of the benefit available to you under a Walmart short-term disability plan and the benefit available to you under any state or locally mandated program will not exceed the benefits that would have been available under the short-term disability plan if you had not worked in a state with a legally mandated program. You are responsible for providing your determination letter from the state or locality to Sedgwick. If Sedgwick overestimated what your mandated benefit would be, meaning that you were paid less under the 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 on the date of your disability unless:
  - You are on leave of absence or layoff as described later in this chapter under **If you are on a leave of absence or experience a temporary layoff**, or
  - You are unable to work because you have experienced medical complications during pregnancy or 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 objective medical evidence provided by a qualified doctor that you are disabled as defined below (for purposes of this chapter, the term "doctor" includes legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors [M.D.], osteopaths [D.O.], nurse practitioners, physician's assistants, psychologists, or other medical practitioners whose services would be eligible for reimbursement under the Associates' Medical Plan).
- You must receive approval by Sedgwick of your claim.

Sedgwick may require written proof of your disability, as defined later in this chapter, or additional information before making a decision on your claim. A statement by your doctor that you are unable to work does not by itself prove that you are disabled. Approval of a leave of absence also does not constitute approval for short-term disability benefits.

Except as otherwise provided in the **Maternity benefit** section, for purposes of benefits provided under the short-term disability plan, "disabled" or "disability" means that (i) you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, in accordance with the Federal Motor Carrier Safety Administration regulations, or pregnancy, and (ii) you are under the continuous care of a qualified doctor and are following the course of treatment prescribed by your doctor. 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 your disability is caused by a mental illness or substance use disorder, you are encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, licensed counselor, drug and alcohol counselor, or clinical social worker who specializes in mental health and/or substance use disorders, and is licensed pursuant to state law. See the **Associate assistance resources** chapter for information on resources that are available if you are experiencing the effects of a mental illness or substance use disorder.

If Sedgwick requests that you be examined by an independent doctor, you must attend the exam to be considered for benefits. Walmart will pay the cost of any such examination.

The maximum length of any one period of disability during which disability benefits are paid, even if the disability is the result of more than one cause, is 25 weeks, after the initial waiting period of seven calendar days. See also **If you return to work and become disabled again**.

See the **Maternity benefit** section for additional details regarding the maternity benefit.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that:

- Arose before your coverage became effective
- Is not under the 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 that is related to work outside of Walmart.

When benefits begin

If your short-term disability claim is approved, the benefit will begin after a waiting period of seven calendar days. The waiting period begins on your next scheduled 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 during which short-term disability benefits are approved, unless allowed by state law (see **Your pay after filing a claim** later in this chapter for information regarding provisional pay that may apply after your initial waiting period of seven calendar days). If you are later found to be ineligible for short-term disability benefits, you may go back and use PTO for any time that was unpaid, subject to the terms of the PTO policy. You may be required to repay any PTO used for days when disability benefits were received. Upon repayment, any PTO balance will be restored.

For specific details about the PTO policy, refer to **One.Walmart.com**.

Calculating your benefit

The amount of your short-term disability benefit is based on:

- Your average day's pay as of your last day worked.
- The duration of your disability.

If you become disabled and are eligible to receive short-term disability benefits, the truck driver short-term disability plan replaces 75% of your average day's pay as of your last day before your disability for up to 25 weeks, after an initial waiting period of seven calendar days. There is no maximum weekly benefit under the truck driver short-term disability plan.

If you become disabled and are eligible to receive short-term disability benefits, the truck-driver short-term disability plan pays benefits as described below.

YOUR TRUCK DRIVER SHORT-TERM DISABILITY PLAN BENEFIT

Duration of your disability	Your benefit is:	
	If your disability does not qualify for workers' compensation through Walmart	If you have a work-related disability that qualifies for workers' compensation through Walmart
Up to 26 weeks	After an initial waiting period of 7 calendar days, 75% of your average day's pay. The waiting period begins on your next scheduled workday after your total disability begins. You may use 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 through Walmart payroll on a pay-period basis.	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 through Walmart payroll on a pay-period basis, while workers' compensation is paid through a separate check except in the states of Texas and Wyoming, where the entire benefit is included in the payment you receive from Walmart.
If a benefit is payable for less than a week, your disability benefit will be based on 75% of your average day's pay multiplied by your regular 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 benefits** earlier in this chapter) as well as benefits under the truck driver short-term disability plan, the amount of the benefit under the truck driver short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates that they will receive.		

WORKERS' COMPENSATION AND YOUR SHORT-TERM DISABILITY BENEFITS

Workers' compensation and short-term disability benefits are made as separate payments except in the states of Texas and Wyoming, where the entire benefit is included in the payment you receive from Walmart.

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 Colorado; Connecticut; Massachusetts; Oregon; 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 be reduced by any legally mandated benefits that you are eligible for.
	Maternity benefits under the truck driver short-term disability plan begin on the 8th calendar day after your eligible disability begins. You may use PTO during your first 7 calendar days of continuous disability. Benefits are paid through Walmart payroll on a pay-period basis.	
*You may be eligible for parental pay 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 benefits** earlier in this chapter) as well as benefits under the truck driver short-term disability plan, the amount of the benefit under the truck driver short-term disability plan will be reduced by the amount of the legally mandated benefit, regardless of whether you have applied for the legally mandated benefits.		

See the **When you qualify for benefits** section for general requirements applicable to all disability benefits under the 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 for purposes of the maternity benefit. If you begin your leave more than two weeks prior to your expected delivery date, you will be required to provide objective medical evidence to demonstrate you are disabled, as defined in the **When you qualify for benefits** section. If you are disabled, as defined in that section, you will begin your short-term disability maternity benefit on the date you are determined to be disabled. In no event will the maternity benefit exceed nine weeks.

If you begin your short-term disability leave after your delivery date, you must meet the plan's definition of disabled, as stated in the **When you qualify for benefits** section. In that case, any disability benefit will be subject to rules applicable to non-maternity disability benefits.

If you experience medical complications during pregnancy or post-partum and continue to meet the definition of disabled 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.

If you return to work before receiving your full maternity benefit and then go on leave again, you will not be able to resume your maternity benefit unless you provide objective medical evidence to Sedgwick to support a determination that you meet the definition of disability. If no medical evidence is provided, the remainder of the maternity benefit is forfeited.

NOTE: For associates in states or localities with legally mandated benefits, please refer to the **Legally mandated benefits** chart earlier in this chapter for coordination of benefits.

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

Benefits payable to you under the truck driver short-term disability plan are company-provided at no cost to you. Because you do not make any contributions to the truck driver short-term disability plan, and you do not pay any tax on the coverage that Walmart provides, any benefits payable to you are subject to taxes. Walmart generally withholds federal, state, local, and Social Security taxes from the amount of your benefit payments.

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

Walmart has the right to recover from you, and you must repay, any amount overpaid to you for short-term disability benefits under this plan. If you do not repay overpaid amounts in a timely manner, Walmart will first deduct such amounts from future disability payments (if any). If there is a remaining amount due after any deductions from future disability payments, then Walmart may, in its discretion, either (i) treat overpaid amounts as taxable wages to you (reportable on your Form W-2), or (ii) deduct overpaid amounts from your pay, to the extent permitted by law.

Filing a truck driver short-term disability claim

If you become disabled, you should file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption in your wages, or the denial of your claim. The timing and the process you need to follow when filing a claim for short-term disability benefits depend on whether the short-term disability plan is available at your location (i.e., whether you are in a state or locality that provides legally mandated benefits.) See **Claim filing instructions** below for information about filing your claim.

STEP 1: Contact Sedgwick to apply for a leave of absence. Regardless of the process you follow to file a short-term disability claim with the Plan, you will need to contact Sedgwick by going to **One.Walmart.com/LOA > mySedgwick** or by calling **800-492-5678** to apply for a leave of absence as soon as you know you will be absent from work due to an illness, injury, or pregnancy. Sedgwick will send you an initial packet providing the information you will need and describing any actions you will need to take.

The leave of absence policy is not a benefit offered under, or administered as part of, the truck driver short-term disability benefit and is not discussed here. For specific details about the leave of absence policy, refer to **One.Walmart.com**.

NOTE: The approval of a leave of absence under Walmart's leave of absence policy does not automatically mean your short-term disability claim is approved. See **When benefits begin** for details.

STEP 2: File a claim for short-term disability or legally mandated benefits. Your claim for short-term disability benefits cannot be fully processed until you have stopped working. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated.

NOTE: Your claim filing date is the date on which you submit your disability claim to Sedgwick. In order for Sedgwick to begin their review of your claim, you must have fully stopped working. If you file your claim prior to your first date of absence, Sedgwick will begin processing your claim as of your first date of absence. If you file your claim on or after your first date of absence, Sedgwick will begin their review as of your reported date.

See the chart below for details on where and when to file your claim.

CLAIM FILING INSTRUCTIONS

Your state or locality may have unique filing periods, which could potentially exclude benefits for periods prior to the date of your benefits application. It is strongly advised that you promptly apply to your state or locality for any benefits that are mandated by law.

State or locality	Eligibility	Claim administrator	Filing instructions
CO, CT, MA, OR, WA **Washington, D.C.**	Eligible for Walmart short-term disability plan as a supplement to legally mandated benefits	State or district for legally mandated benefit Sedgwick for supplemental benefits and maternity	**CO:** Go to **famli.colorado.gov** or call **866-263-2654** for instructions **CT:** Go to **ctpaidleave.org** or call **877-499-8606** for instructions **MA:** Go to **paidleave.mass.gov** or call **833-344-7365** for instructions **OR:** Go to **paidleave.oregon.gov** or call **833-854-0166** for instructions **WA:** Go to **paidleave.wa.gov** or call **833-717-2273** for instructions **D.C.:** Go to **dcpaidfamilyleave.dc.gov** or call **202-899-3700** for instructions **Sedgwick:** File a claim with Sedgwick within 90 days of the date your disability begins; you will need to provide the determination letter from the state or district with state or district benefit details. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
All others	Eligible for Walmart short-term disability plan	Sedgwick	File a claim with Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

STEP 3: Let your doctor's office know it will be contacted for information. Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide objective medical information, including:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, 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 4: Follow up with your doctor to ensure that the requested information is forwarded to Sedgwick. Any delay in sending information to Sedgwick could result in a delay, or denial, in the processing of your claim and the payment of benefits.

You may be required to provide written proof of your disability or additional medical information before your benefit payments begin.

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.

If your claim is approved, the approval will be effective as of the date of your disability, and the provisional pay you received after your seven-day waiting period and while your claim was pending will count toward your disability benefit.

If your claim is denied before the Medical Due Date because you are not disabled, as defined by the plan, your provisional pay will be stopped and Walmart will commence efforts to recover the provisional pay that was paid to you while your claim was pending.

You will not receive provisional pay during any period when a determination is being made regarding a relapse/recurrent claim (see **If you return to work and become disabled again** later in this chapter).

For specific details about the PTO policy, refer to **One.Walmart.com**.

Benefits determination

Sedgwick will make 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.

For associates in states or localities with legally mandated plans (Colorado, Connecticut, Massachusetts, Oregon, Washington, D.C., and Washington state), your state or locality will specify their process and timeline for making a decision. Additional information can be found on your state or district's website. For contact information, refer to the **Resources** chart at the beginning of this chapter.

APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for short-term disability benefits is denied because Sedgwick did not receive objective medical documentation supporting your claim, or the documentation provided did not support your claim, you will have a grace period of 30 calendar days from the date of your denial letter to submit medical information to Sedgwick for review without the need to file an appeal. Once your grace period has ended, if your claim remains denied and you would like to appeal, you must follow the procedure described in this section.

If your Sedgwick 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.

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 decide 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 of your first appeal. 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

For associates in states or localities with legally mandated plans (Colorado, Connecticut, Massachusetts, Oregon, Washington, D.C., and Washington state), your state or locality will specify its process and timeline for deciding an appeal, if any. Additional information can be found on your state or district's website. For contact information, refer to the **Resources** chart at the beginning of this chapter.

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.

If your short-term disability benefits end and you do not return to work for any reason, you must request an extension of your leave (refer to the **Resources** chart at the beginning of the chapter for contact information). Failure to do so may result in your employment being terminated.

Benefits provided under a state or locally mandated program may have different end dates from Walmart's short-term disability plan.

Returning to work following a leave

Sedgwick will contact you before your expected return-to-work date and advise you of steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

To ensure a smooth transition back to work and avoid a potential impact to your pay, you will need to contact Sedgwick **up to seven days prior to your actual return-to-work date.** If your return-to-work date changes, you should notify Sedgwick immediately. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options, which include requesting an extension of your leave or voluntarily terminating your employment. Failure to request an extension may result in your employment being terminated.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less and you are classified as a full-time 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 are on a leave of absence or experience a temporary layoff

If you are not on active status due to a leave of absence or temporary layoff, your eligibility for short-term disability benefits will continue for 90 days from the beginning of your leave or temporary layoff. Your eligibility for short-term disability coverage ends on the 91st day after the beginning of your leave of absence or temporary layoff, but is reinstated if you return to work within one year. See **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits while on leave.

When your truck driver short-term disability coverage ends

Your short-term disability coverage ends on the earliest of:

- The date your employment terminates
- The last day of the pay period in which your job status changes from an eligible job status
- The date of your death
- The 91st day of a leave of absence or layoff (unless you return to work), or
- The date the benefit is no longer offered by Walmart.

If you leave Walmart and are rehired

If you leave Walmart and return to work for Walmart 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, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by The Lincoln National Life Insurance Company (Lincoln) regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Full-time hourly and salaried long-term disability

If you become disabled and can't work, Walmart's long-term disability plan can help. When you enroll, the plan works with other benefits you get during a disability to replace part of your paycheck.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get more details or file a claim	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 plan** replaces 50% of your average monthly wage.
- **The long-term disability enhanced plan** replaces 60% of your average monthly wage.

The long-term disability plans

If you become disabled, as defined in the **When you qualify for long-term disability benefits** section, the long-term disability plan provides a benefit of 50% of your average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive, after your benefit waiting period.

If you become disabled, as defined in the **When you qualify for long-term disability benefits** section, the long-term disability enhanced plan provides a benefit of 60% of your average monthly wage up to a maximum monthly benefit of $18,000, minus the amount of certain other benefits or income you are eligible to receive, after your benefit waiting period.

Both plans are insured by Lincoln. For information about your benefit waiting period, see **When long-term disability benefits begin** later in this chapter. For information about your average monthly wage or other income or benefits that may reduce your benefit, see **Calculating your benefit** and **Other benefits or income that reduce long-term disability benefits** later in this chapter.

THE COST OF LONG-TERM DISABILITY COVERAGE

Your cost for long-term disability coverage is based on your eligible earnings, your age, and whether you select the long-term disability plan or the long-term disability enhanced plan. Premiums are deducted from all wages, including bonuses. If you have no eligible earnings in a pay period, no premiums are due for that pay period. If while receiving long-term disability benefits you receive any other eligible earnings, including bonuses, through Walmart's payroll systems, your premiums for all benefits, including long-term disability, will be withheld from those payments. To review how to maintain coverage for other benefits while receiving long-term disability benefits, see **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

When you qualify for long-term disability benefits

Under the terms of the long-term disability plan and long-term disability enhanced plan, "disability" or "disabled" generally means that, due to a covered injury or sickness during the benefit waiting period and for the next 24 months of disability, you are unable to perform the material and substantial duties of your own occupation, and after 24 months of benefit payments, you are unable to perform, with reasonable continuity, the material and substantial duties of any occupation for which you are reasonably fitted by training, education, experience, age, and physical or mental capacity. However, if you are employed as a pilot, copilot, or crewmember of an aircraft, "disability" or "disabled" means that, as a result of an injury or sickness, you are unable to perform the material and substantial duties of your own occupation under the applicable Federal Aviation Administration fitness standards.

In determining whether you are disabled, for persons other than pilots or copilots, Lincoln does not consider employment factors, including interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing, or loss of professional or occupational license or certification.

To qualify for long-term disability benefits:

- You must be unable to return to work after the initial benefit waiting period of disability.
- You must continue to be under the appropriate care of a qualified doctor (qualified doctors include legally licensed physicians and practitioners who are not related to you and are performing services within the scope of their licenses).
- Lincoln must receive and approve certification with accompanying medical documentation of a disability from your qualified doctor before benefits are considered for payment.
- You must be actively at work at the time of your disability. You will be considered actively at work if you are performing services at Walmart's usual place of business or a location designated by Walmart or if you were actually at work on the day immediately preceding:
  - A weekend or holiday (except where one or both of these days are scheduled work days)
  - Paid time off (PTO)
  - Any non-scheduled work day, or
  - An approved leave of absence.

PRE-EXISTING CONDITION EXCLUSION

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

Filing a long-term disability claim

If you are on an approved short-term disability claim and are enrolled in long-term disability benefits, your claim will be automatically transitioned from Sedgwick to Lincoln. You may also call Lincoln at **877-353-6404** as soon as you know you will need to use your long-term disability benefit. Lincoln will provide you with additional information on how to complete your claim.

Associates receiving workers' compensation benefits and enrolled in the long-term disability plan or long-term disability enhanced plan may be eligible for disability benefits after their benefit waiting period has expired. Call Lincoln at **877-353-6404** to report your long-term disability claim.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

When benefits are not paid

Benefits are not paid for any long-term disability claim due to:

- War, declared or undeclared, or any act of war
- Active participation in a riot
- The committing of or attempting to commit a felony or misdemeanor, 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 long-term disability benefits begin

If you are approved by Lincoln for long-term disability benefits, they will begin after your benefit waiting period: 26 weeks or the end of your short-term disability benefits, whichever is longer.

IF YOU RETURN TO WORK DURING YOUR WAITING PERIOD AND BECOME DISABLED AGAIN

If you cease to be disabled and return to work full-time for a total of the specified number of calendar days (as defined below) or less during a benefit waiting period, the waiting period will be suspended and you must meet the balance of the waiting period if you become disabled again. If you return to work for a total of more than the specified number of calendar days while satisfying your benefit waiting period, you must satisfy an entirely new benefit waiting period if you again become disabled before you are eligible to receive long-term disability benefits. The "specified number of calendar days" means (i) 60 days for hourly associates and hourly pharmacists (other than hourly pharmacists working in California), and (ii) 180 days for salaried associates, salaried pharmacists, hourly pharmacists working in California, management, and pilots. The specified number of calendar days need not be consecutive.

Calculating your benefit

The amount of your long-term disability benefit is based on:

- Your average monthly wage, as defined below, and
- If you are enrolled in the long-term disability plan or the long-term disability enhanced plan.

AVERAGE MONTHLY WAGE	
Length of employment	**How average monthly wage is determined**
Employed 12 months or more	Your eligible earnings for the 26 pay periods* immediately prior to your last day worked ÷ 12 For example, the average monthly wage for an associate with pre-disability eligible earnings of $36,000 for the prior 26 pay periods is $3,000 ($36,000 ÷ 12). *If your eligible earnings were paid on a weekly basis during the 12-month period, the number of pay periods used to calculate your average monthly wage will be adjusted accordingly.
Employed less than 12 months	Your eligible earnings since date of hire ÷ number of months worked For example, the average monthly wage for an associate with eligible earnings of $21,000 for seven months of work is $3,000 ($21,000 ÷ 7).

Eligible earnings used to determine average monthly wage include:

- Regular earnings for the 26 pay periods prior to your last day worked (if your regular earnings were paid on a weekly basis, the number of pay periods used will be adjusted accordingly)
- Overtime
- Regularly scheduled target incentive bonuses that you and associates in similarly situated job types or job levels are eligible to earn
- Paid time off and similar pay that replaces regular earnings (e.g., bereavement, jury duty, and sick time)

Any pay periods in which you have no eligible earnings are excluded, decreasing the number of pay periods used for the calculation.

Eligible earnings used to determine average monthly wage exclude any previously paid disability benefits, commissions, or any other extra compensation or fringe benefits not listed above.

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

Your long-term disability benefit is shown below:

YOUR LONG-TERM DISABILITY BENEFIT	
If you are enrolled	**Your coverage is**
In the long-term disability plan	50% of your average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive (for example, Social Security disability benefits)*
In the long-term disability enhanced plan	60% of your average monthly wage up to a maximum monthly benefit of $18,000, minus the amount of certain other benefits or income you are eligible to receive (for example, Social Security disability benefits)*
*See **Other benefits or income that reduce long-term disability benefits** for more information.	

Your benefit will be no less than $50 for any month that you are eligible to receive long-term disability benefits.

Long-term disability benefits are paid as long as you continue to be disabled as defined by the long-term disability plans.

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

PTO AND YOUR LONG-TERM DISABILITY BENEFIT

Paid time off (PTO) may not be used while receiving long-term disability benefits. If you are receiving long-term disability 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 long-term disability benefits.

OTHER BENEFITS OR INCOME THAT REDUCE LONG-TERM DISABILITY BENEFITS

Your long-term disability benefit amount is reduced, or offset, by other benefits or income you receive or are eligible to receive. "Other income" includes any earnings from any form of employment, including under any formal or informal sick leave or salary continuation plans. Except with respect to retirement benefits, "other benefits" only includes amounts you (or, under certain circumstances, your family) are entitled to as the result of the same disability for which your long-term disability benefit is paid. Examples of other benefits include amounts from the following:

- Social Security disability insurance (including amounts your family receives or is eligible to receive due to your disability)
- Social Security retirement benefits granted after the date of disability (including benefits your family receives or is eligible to receive due to your eligibility for retirement benefits)
- Workers' compensation
- Company-related group insurance plans providing disability benefits
- Company-paid or partially paid individual policies providing disability benefits to the extent such benefits, plus your long-term disability benefit, exceed your average monthly wage
- No-fault automobile insurance
- Any ongoing short-term disability benefits payable under Walmart short-term disability coverage (i.e., relapse-related benefits)
- State disability payments
- Unemployment benefits, or benefits under any other governmental benefit act or law
- Settlement or judgment, less associated costs of a lawsuit that represents or compensates for your loss of earnings or bodily function.

If any of the other benefits that reduce your long-term disability benefits are subsequently adjusted by cost-of-living increases, your long-term disability benefit will not be further reduced. Refer to the policy for a complete list of offsets. You may obtain a copy of the long-term disability policy by calling Lincoln at **877-353-6404**.

REDUCTION OF LONG-TERM DISABILITY BENEFIT EXAMPLE		
Annual salary: $36,000	**Long-term disability plan (50%)**	**Long-term disability enhanced plan (60%)**
Average monthly wage	$3,000	$3,000
Benefit amount (percentage of average monthly wage, subject to the monthly maximum)	$1,500	$1,800
Less estimated Social Security disability benefit	- $750	- $750
Less dependent's estimated Social Security benefit	- $375	- $375
Long-term disability payment (monthly)	$375	$675

APPLYING FOR SOCIAL SECURITY DISABILITY BENEFITS

You may be eligible to receive Social Security disability benefits after you have been disabled for five months. If your disability has lasted 12 consecutive months, or is expected to, the long-term disability policy terms may require you to apply for Social Security disability benefits. If the Social Security Administration denies your application for benefits, you will be required to follow the Social Security Administration's appeal process.

If you are required to pursue Social Security disability benefits and you do not apply, or you do not provide proof of application or appeal, your long-term disability benefits will be reduced by the amount you and any eligible dependents are estimated to receive from Social Security disability.

If you qualify for Social Security disability or retirement benefits while you are receiving benefits under the long-term disability plan and your Social Security disability claim is approved retroactively, you must reimburse Lincoln for any long-term disability benefits overpaid during the period covered by the retroactive Social Security approval.

Lincoln may assist you in filing for Social Security disability benefits. To be eligible for assistance, you must be receiving a benefit from Lincoln.

If you are disabled and working

You may be eligible to receive disability benefits if you are partially disabled. Under the Plan, "partial disability" and "partially disabled" mean that, as a result of sickness or injury, you are able to:

- Perform one or more, but not all, of the material and substantial duties of your own or any occupation on a full-time or part-time basis, or
- Perform all of the material and substantial duties of your own occupation or any occupation on a part-time basis, and
- Earn between 20% and 80% of your indexed average monthly wage.

If you accept a new position and perform all of the material and substantial duties on a full-time basis, you are not partially disabled.

Lincoln offers a work incentive benefit for the first six pay periods (12 pay periods if paid weekly) that you are partially disabled and working. You will continue to receive the full amount of your monthly benefit for the first six or 12 pay periods, as applicable, if you are partially disabled, unless your benefit and current monthly earnings from work while partially disabled exceed your average monthly wage. If this occurs, your monthly benefit will be reduced by the excess amount so that the monthly benefit plus your eligible earnings do not exceed 100% of your average monthly wage.

After the first six or 12 pay periods, as applicable, that you are partially disabled and working, the following calculation is used to determine your monthly benefit for a partial disability.

DISABLED AND WORKING BENEFIT CALCULATION	
[(A - B) ÷ A] x C = D	
A	Your indexed average monthly wage*
B	Your current partial monthly eligible earnings
C	The monthly long-term disability benefit payable if you were totally disabled, less other benefits or income that reduces long-term disability benefits
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 LONG-TERM DISABILITY BENEFITS

Coverage under the long-term disability plan ends upon your death. However, if you pass away while receiving long-term disability benefits, a lump-sum payment of $5,000 or three times your last monthly long-term disability benefit, whichever is greater, will be paid to your surviving spouse/partner. If you are not survived by a spouse/partner, the payment will be made to your surviving children, including stepchildren and legally adopted children, in equal shares. However, if any of these children are minors or incapacitated, payment will be made on their behalf to the court-appointed guardian of the children's property. If you are not survived by a spouse/partner or children, the payment will be made to your estate.

When long-term disability benefit payments end

Long-term disability benefit payments end on the earliest of:

- The date you fail to furnish proof of continued disability or partial disability and regular attendance of a doctor
- The date you fail to cooperate in the administration of your claim. For example: providing information or documents needed to determine whether benefits are payable and/or determining the benefit amount
- The date you refuse to be examined or evaluated at reasonable intervals
- The date you refuse to receive appropriate available treatment
- The date you refuse a job with Walmart, paying comparable wages, where workplace modifications or accommodations are made to allow you to perform the material and substantial duties of your job
- The date you are able to work in your own occupation on a part-time basis but choose not to
- The date your partial disability monthly earnings exceed 80% of your indexed average monthly wage
- The date you no longer meet the plan's definition of disabled
- The last day of the maximum period for which benefits are payable (see charts below), or
- The date of your death.

NOTE: Your employment is not a condition of the continuation of long-term disability benefits.

MAXIMUM DURATION OF LONG-TERM DISABILITY BENEFITS

Age when you become disabled	Benefits duration
Prior to age 62	Until Social Security normal retirement age (as listed below)
62	48 months
63	42 months
64	36 months
65	30 months
66	27 months
67	24 months
68	21 months
69 or older	18 months

SOCIAL SECURITY NORMAL RETIREMENT AGE

Year of birth	Normal retirement age
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 through 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

IF THE DISABILITY IS DUE TO MENTAL ILLNESS, ALCOHOLISM, OR DRUG ADDICTION

To receive long-term disability benefits for more than 24 months for the following disabilities, you must be confined in a hospital or other facility licensed to provide medical care:

- Mental illness (excluding demonstrable, structural brain damage)
- Any condition that results from mental illness
- Alcoholism, 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 long-term disability benefits will pick up where they left off before you came back to work. There will be no additional waiting period. The combined benefit duration for both periods of disability will not exceed the maximum duration listed in the chart 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 long-term disability coverage is effective, if you are not actively at work due to a leave of absence or temporary layoff, your long-term disability coverage continues for 90 days from the beginning of your leave or temporary layoff. Your long-term disability coverage ends on the 91st day after your leave of absence or temporary layoff begins, but is reinstated if you return to active work status within one year. See **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits coverage while on leave.

NOTE: If your long-term disability coverage ends because your leave of absence or temporary layoff exceeds 90 days, you remain eligible for long-term disability benefits for any illness or injury that occurred before the date your coverage ends.

When your long-term disability coverage ends

Your long-term disability coverage ends:

- The day you voluntarily drop coverage (as described below)
- At termination of your employment, unless you have been absent due to disability during the 26-week benefit waiting period and any period during which premium payments are waived
- On the last day of the pay period immediately preceding the pay period in which your job status changes from an eligible job status
- The last day of coverage for which premiums were paid, if you fail to pay your premiums within 30 days of the date your premium is due
- On the date you lose eligibility
- If you do not return to work after the last day of a leave of absence
- When the benefit is no longer offered by Walmart, or
- On the date of your death.

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

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

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

If you leave Walmart and are rehired

If you are a full-time hourly or management associate (excluding full-time truck drivers), see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

Truck driver long-term disability

The 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 a recent transfer to a full-time truck driver job classification, eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by The Lincoln National Life Insurance Company (Lincoln) regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Truck driver long-term disability

If a disability keeps you off the road and unable to work, Walmart's long-term disability plans work with other benefits you get to replace part of your paycheck. There are two long-term disability plans for truck drivers that pay different levels of benefits.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get more details or file a claim	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 a long-term disability plan and also a long-term disability enhanced plan. Each plan offers a choice of five-year coverage or full-duration coverage.
- The truck driver long-term disability plans work with certain other benefits you receive while disabled to replace 50% of your average monthly wage if you select the truck driver long-term disability plan or 60% of your average monthly wage if you select the truck driver long-term disability enhanced plan.
- If you enroll in either plan after your initial enrollment period, your coverage is subject to Lincoln's approval. You will have to submit Proof of Good Health, and you may be required to undergo a medical exam at your own expense before you can be approved for coverage.

The truck driver long-term disability plans

You are eligible to enroll in truck driver long-term disability coverage if you are a full-time truck driver. You can choose between two coverage plans, each of which is available in two options:

- **Long-term disability plan**
  - Five-year coverage
  - Full-duration coverage
- **Long-term disability enhanced plan**
  - Five-year coverage
  - Full-duration coverage

The options under the truck driver long-term disability plan and long-term disability enhanced plan pay benefits as described in the following chart.

TRUCK DRIVER LONG-TERM DISABILITY		
	Long-term disability plan	**Long-term disability enhanced plan**
Five-year coverage	Pays 50% of average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive*	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 long-term disability benefits** chart (later in this chapter) will result in a benefits duration of less than 60 months, in which case the monthly benefit will be payable for the lesser period.	
	Long-term disability plan	**Long-term disability enhanced plan**
Full-duration coverage	Pays 50% of average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive*	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 long-term disability benefits** chart (later in this chapter).	
*See **Calculating your benefit** and **Other benefits or income that reduces truck driver long-term disability benefits** (later in this chapter) for more information.		

Both plans are insured by Lincoln. For information about your benefit waiting period, see **When truck driver long-term disability benefits begin** later in this chapter. For information about your average monthly wage or other income or benefits that may reduce your benefit, see **Calculating your benefit** and **Other benefits or income that reduces truck driver long-term disability benefits** later in this chapter.

If you enroll during your initial enrollment period, your coverage will be effective on your date of hire.

If you enroll at any time after your initial enrollment period, you will be considered a late enrollee and required to submit Proof of Good Health. You may be required to undergo a medical exam at your own expense before you can be approved for coverage.

If you enroll in the five-year coverage option and subsequently decide to enroll in the full-duration coverage option, or if you enroll in the truck driver long-term disability plan and subsequently decide to enroll in the truck driver long-term disability enhanced plan, you will be considered a late enrollee and required to provide Proof of Good Health before you can be approved for coverage.

See the **Eligibility, enrollment, and effective dates** chapter for more details about when coverage is effective.

THE COST OF TRUCK DRIVER LONG-TERM DISABILITY COVERAGE

Your cost for truck driver long-term disability coverage is based on your eligible earnings, your age, and your choice of coverage under either the long-term disability plan or the long-term disability enhanced plan. Premiums are deducted from all wages, including bonuses. If you have no earnings in a pay period, no premiums are due for that pay period. If while receiving long-term disability benefits you receive any other earnings, including bonuses, through Walmart's payroll systems, your premiums for all benefits, including long-term disability, will be withheld from those payments. To review how to maintain coverage for other benefits while receiving long-term disability benefits, see **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter.

When you qualify for truck driver long-term disability benefits

Under the terms of the truck driver long-term disability plans, "disability" or "disabled" generally means that, due to a covered injury or sickness, during the benefit waiting period and for the next 24 months of disability, you are unable to perform the material and substantial duties of your own occupation, or you lose medical certification in accordance with the Federal Motor Carrier Safety

Administration regulations. After 24 months of benefit payments, "disability" or "disabled" generally means that you are unable to perform, with reasonable continuity, the material and substantial duties of any occupation for which you are reasonably fitted by training, education, experience, age, and physical or mental capacity.

In determining whether you are disabled, Lincoln does not consider employment factors, including interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing, or loss of professional or occupational license or certification for reasons other than a covered injury or sickness.

To qualify for truck driver long-term disability benefits:

- You must be unable to return to work after the initial benefit waiting period of disability.
- You must continue to be under the appropriate care of a qualified doctor (qualified doctors include legally licensed physicians and practitioners who are not related to you and are performing services within the scope of their licenses).
- Lincoln must receive and approve certification with accompanying medical documentation of a disability from your qualified doctor before benefits are considered for payment.
- You must be actively at work at the time of your disability. You will be considered actively at work if you are performing services at Walmart's usual place of business or a location designated by Walmart or if you were actually at work on the day immediately preceding:
  - A weekend or holiday (except where one or both of these days are scheduled work days)
  - Paid time off (PTO)
  - Any non-scheduled work day, or
  - An approved leave of absence.

If your long-term disability coverage was subject to Proof of Good Health and approved by Lincoln, Lincoln has the right to reexamine your Proof of Good Health questionnaire within the first two years from the date long-term disability coverage became effective. If material facts about you are found to have been stated inaccurately, the true circumstances will be used to determine if your coverage should be in effect and for what amount, and your premium may be adjusted.

PRE-EXISTING CONDITION EXCLUSION

You will not receive truck driver long-term disability benefits for any disability or partial disability which begins in your first 12 months after your coverage effective date if such disability or partial disability is caused, partially or entirely, or results from a 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 long-term disability plans, or if you change from the truck driver long-term disability plan to the truck driver long-term disability enhanced plan, the 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 long-term disability plan and then suffer a disability before you satisfy the pre-existing condition exclusion of the full-duration coverage option or truck driver long-term disability enhanced plan, you will only receive benefits under the five-year duration coverage plan or truck driver long-term disability plan, as applicable.

Filing a truck driver long-term disability claim

If you are on an approved short-term disability claim and are enrolled in long-term disability benefits, your claim will be automatically transitioned from Sedgwick to Lincoln. You may also call Lincoln at **877-353-6404** as soon as you know you will need to use your truck driver long-term disability benefit. Lincoln will provide you with additional information on how to complete your claim.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

When benefits are not paid

Benefits are not paid for any truck driver long-term disability claim due to:

- War, declared or undeclared, or any act of war
- Active participation in a riot
- The committing of or attempting to commit a felony or misdemeanor, 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 long-term disability benefits begin

If you are approved by Lincoln for truck driver long-term disability benefits, they will begin after your benefit waiting period: 26 weeks or the end of your short-term disability benefits, whichever is longer.

IF YOU RETURN TO WORK DURING YOUR WAITING PERIOD AND BECOME DISABLED AGAIN

If you cease to be disabled and return to work for a total of 60 calendar days or less during a waiting period, the waiting period will be suspended and you must meet the balance of the waiting period if you become disabled again. If you return to work for a total of more than 60 calendar days while satisfying your benefit waiting period, you must satisfy an entirely new benefit waiting period if you again become disabled before you are eligible to receive long-term disability benefits. The specified number of calendar days need not be consecutive.

Calculating your benefit

The amount of your truck driver long-term disability is based on:

- Your average monthly wage, and
- Which truck driver long-term disability plan you're enrolled in.

AVERAGE MONTHLY WAGE	
Length of employment	**How average monthly wage is determined**
Employed 12 months or more	Your activity pay, mileage rate, and bonuses paid in the 26 pay periods prior to your last day worked ÷ 12
Employed less than 12 months	Your activity pay, mileage rate, and bonuses since date of hire ÷ the number of months worked

Note that any pay periods in which you have no eligible earnings are excluded, decreasing the number of pay periods used for the calculation.

Your truck driver long-term disability benefit is shown below:

YOUR TRUCK DRIVER LONG-TERM DISABILITY BENEFIT	
If you are enrolled	**Your coverage is**
In the truck driver five-year coverage long-term disability plan or the truck driver full-duration coverage long-term disability plan	50% of your average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive (for example, Social Security disability benefits)*
In the truck driver five-year coverage long-term disability enhanced plan or the truck driver full-duration coverage long-term disability enhanced plan	60% of your average monthly wage up to a maximum monthly benefit of $18,000, minus the amount of certain other benefits or income you are eligible to receive (for example, Social Security disability benefits)*
*See **Other benefits or income that reduces truck driver long-term disability benefits** for more information.	

Your benefit will be no less than $50 for any month that you are eligible to receive long-term disability benefits.

Truck driver long-term disability benefits are paid as long as you continue to be disabled as defined by the truck driver long-term disability plans.

Lincoln has the right to recover, and you must repay, any amount that is overpaid to you for truck driver long-term disability benefits under the truck driver long-term disability plan or the truck driver long-term disability enhanced plan.

PTO AND YOUR LONG-TERM DISABILITY BENEFIT

Paid time off (PTO) may not be used while receiving long-term disability benefits. If you are receiving long-term disability 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 long-term disability benefits.

OTHER BENEFITS OR INCOME THAT REDUCES TRUCK DRIVER LONG-TERM DISABILITY BENEFITS

Your truck driver long-term disability benefit amount is reduced, or offset, by other benefits or income you receive or are eligible to receive. "Other income" includes any earnings from any form of employment, including under any formal or informal sick leave or salary continuation plans. Except with respect to retirement benefits, "other benefits" only includes amounts you (or, under certain circumstances, your family) are entitled to as the result of the same

disability for which your truck driver long-term disability benefit is paid. Examples of other benefits include amounts from the following:

- Social Security disability insurance (including amounts your family receives or is eligible to receive due to your disability)
- Social Security retirement benefits that are granted after the date of disability (including benefits your family receives or is eligible to receive due to your eligibility for retirement benefits)
- Workers' compensation
- Company-related group insurance plans providing disability benefits
- Company-paid or partially paid individual policies providing disability benefits to the extent such benefits, plus your truck driver long-term disability benefit, exceed your average monthly wage
- No-fault automobile insurance
- Any ongoing short-term disability benefits payable under Walmart short-term disability coverage (i.e., relapse-related benefits)
- State disability payments
- Unemployment benefits, or benefits under any other governmental benefit act or law
- Settlement or judgment, less associated costs of a lawsuit, that represents or compensates for your loss of earnings or bodily function.

If any of the other benefits that reduce your long-term disability benefits are subsequently adjusted by cost-of-living increases, your long-term disability benefit will not be further reduced. Refer to the policy for a complete list of offsets. You may obtain a copy of the truck driver long-term disability policy by calling Lincoln at **877-353-6404**.

EXAMPLE: REDUCTION OF TRUCK DRIVER LONG-TERM DISABILITY BENEFIT

	Long-term disability Plan (50%)	Long-term disability Enhanced Plan (60%)
Average monthly wage	$3,000	$3,000
Benefit amount (percentage of average monthly wage, subject to the monthly maximum)	$1,500	$1,800
Less estimated Social Security disability benefit	- $750	- $750
Less dependent's estimated Social Security benefits	- $375	- $375
Long-term disability payment (monthly)	$375	$675

APPLYING FOR SOCIAL SECURITY DISABILITY BENEFITS

You may be eligible to receive Social Security disability benefits after you have been disabled for five months. If your disability has lasted 12 consecutive months, or is expected to, the truck driver long-term disability policy terms may require you to apply for Social Security disability benefits. If the Social Security Administration denies you benefits, you will be required to follow the Social Security Administration's appeal process.

If you are required to pursue Social Security disability benefits and you do not apply, or you do not provide proof of application or appeal, your long-term disability benefits will be reduced by the amount you are estimated to receive from Social Security disability.

If you qualify for Social Security disability or retirement benefits while you are receiving benefits under any of the truck driver long-term disability plan options and your Social Security disability claim is approved retroactively, you must reimburse Lincoln for any long-term disability benefits overpaid during the period covered by the retroactive Social Security approval.

Lincoln may assist you in filing for Social Security disability benefits. To be eligible for assistance, you must be receiving a benefit from Lincoln.

If you are disabled and working

You may be eligible to receive disability benefits if you are partially disabled. Under the truck driver long-term disability plans, "partial disability" and "partially disabled" mean that, as a result of sickness or injury, you are able to:

- Perform one or more, but not all, of the material and substantial duties of your own or any occupation on a full-time or part-time basis, or
- Perform all of the material and substantial duties of your own occupation or any occupation on a part-time basis, and
- Earn between 20% and 80% of your indexed average monthly wage.

If you accept a new position and perform all of the material and substantial duties on a full-time basis, you are not partially disabled.

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

After the first six pay periods that you are partially disabled and working, the following calculation is used to determine your monthly benefit for a partial disability.

DISABLED AND WORKING BENEFIT CALCULATION	
[(A - B) ÷ A] x C = D	
A	Your indexed average monthly wage*
B	Your current partial monthly earnings
C	The monthly benefit payable if you were totally disabled, less other benefits or income that reduces truck driver long-term disability benefits
D	The disabled and working benefit payable

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

IF YOU PASS AWAY WHILE RECEIVING TRUCK DRIVER LONG-TERM DISABILITY BENEFITS

Coverage under the truck driver long-term disability plans ends upon your death. However, if you pass away while receiving truck driver long-term disability benefits, a lump sum payment of $5,000 or three times your gross last monthly long-term disability benefit, whichever is greater, will be paid to your surviving spouse/partner. If you are not survived by a spouse/partner, the payment will be made to your surviving children, including stepchildren and legally adopted children, in equal shares. However, if any of these children are minors or incapacitated, payment will be made on their behalf to the court-appointed guardian of the children's property. If you are not survived by a spouse/partner or children, the payment will be made to your estate.

When truck driver long-term disability benefit payments end

Truck driver long-term disability benefit payments end on the earliest of:

- The date you fail to furnish proof of continued disability and regular attendance of a doctor
- The date you fail to cooperate in the administration of your claim. For example: providing information or documents needed to determine whether benefits are payable and/or determining the benefit amount
- The date you refuse to be examined or evaluated at reasonable intervals
- The date you refuse to receive appropriate available treatment
- The date you refuse a similar job with Walmart, paying comparable wages, where workplace modifications or accommodations are made to allow you to perform the material and substantial duties of your job
- The date you are able to work in your own occupation on a part-time basis but choose not to
- The date your partial disability monthly earnings exceed 80% of your indexed average monthly wage
- The date you no longer meet the plan's definition of disabled
- The last day of the maximum period for which benefits are payable (see charts below), or
- The date of your death.

NOTE: Your employment is not a condition of the continuation of long-term disability benefits.

FIVE-YEAR COVERAGE

Five-year coverage pays benefits for 60 months unless the amount of time shown in the **Maximum duration of truck driver long-term disability benefits** chart below will result in a benefits duration of less than 60 months, in which case the monthly benefit will be payable for the lesser period.

FULL-DURATION COVERAGE

Full-duration coverage pays benefits for the amount of time shown in the **Maximum duration of truck driver long-term disability benefits** chart below.

MAXIMUM DURATION OF TRUCK DRIVER LONG-TERM DISABILITY BENEFITS	
Age when you become disabled	**Benefits duration**
Prior to age 62	Until Social Security normal retirement age (as listed below)
62	48 months
63	42 months
64	36 months
65	30 months
66	27 months
67	24 months
68	21 months
69 or older	18 months

SOCIAL SECURITY NORMAL RETIREMENT AGE	
Year of birth	**Normal retirement age**
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 through 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

IF THE DISABILITY IS DUE TO MENTAL ILLNESS, ALCOHOLISM, OR DRUG ADDICTION

To receive truck driver long-term disability benefits for more than 24 months for the following disabilities, you must be confined in a hospital or other place licensed to provide medical care:

- Mental illness (excluding demonstrable, structural brain damage)
- Any condition that results from mental illness
- Alcoholism, 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 long-term disability benefits will pick up where they left off before you came back to work. No additional waiting period will be required. The combined benefit duration for both periods of disability will not exceed the maximum duration listed in the chart on the previous page.

If you return to work as an active full-time associate for six consecutive months or more, any recurrence of a disability will be treated as a new disability. A new benefit waiting period must be completed.

If you go on a leave of absence or experience a temporary layoff

Once your truck driver long-term disability coverage is effective, if you are not actively at work due to a leave of absence or temporary layoff, your truck driver long-term disability coverage continues for 90 days from the beginning of your leave or temporary layoff. Your truck driver long-term disability coverage ends on the 91st day after your leave of absence or temporary layoff begins, but is reinstated if you return to active work status within one year. See **Keeping your premiums current** in the **Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits coverage while on leave.

NOTE: If your long-term disability coverage ends because your leave of absence or temporary layoff exceeds 90 days, you remain eligible for long-term disability benefits for any illness or injury that occurred before the date your coverage ends.

When your long-term disability coverage ends

Your truck driver long-term disability coverage ends:

- The day you voluntarily drop coverage (as described below)
- On the last day of the pay period immediately preceding the pay period in which your job status changes from an eligible job status
- The last day of coverage for which premiums were paid, if you fail to pay your premiums within 30 days of the date your premium is due
- On the date you lose eligibility
- If you do not return to work after the last day of a leave of absence
- When the benefit is no longer offered by Walmart, or
- On the date of your death.

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

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

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

If you leave Walmart and are rehired

If you are a full-time truck driver, see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

Company-paid life insurance

The information in this chapter describes company-paid life insurance benefits that may be available to you if:

- You are a full-time hourly or salaried (management) associate, and
- You have met all requirements for coverage to be effective, including actively-at-work requirements.

For questions about eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Company-paid life insurance

Life insurance is automatically provided by Walmart at no cost to you. So you can rest easy knowing your loved ones will have financial help if the unthinkable happens.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Change your beneficiary designation	Go to **One.Walmart.com/Beneficiary**	Beneficiary changes cannot be made over the phone
• Get more coverage details • Request an accelerated benefit • Get details about continuing your insurance		Call Prudential at **877-740-2116**
File a claim		Call Prudential at **877-740-2116**

What you need to know about company-paid life insurance

- If you are an eligible associate, Walmart provides life insurance coverage at no cost to you. No enrollment is necessary, and Proof of Good Health is not required.
- Your coverage amount is equal to your annualized rate of pay, including overtime and bonuses, during the one-year period prior to your 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, based on the previous 26 pay periods of active status (if paid biweekly) or 52 weeks (if paid weekly) prior to your last day worked, rounded to the nearest $1,000, to a maximum of $50,000. Commissions and all other benefits are not included in your annualized rate of pay.

If your death occurs outside a 100-mile radius of your home, there is a benefit for expenses incurred to return your body to either a preferred location within the United States or to your residence at the time of death. The benefit includes expenses for embalming, cremation, coffin, and transportation of your remains. The benefit is the lesser of the cost to return your remains or $20,000.

Naming a beneficiary

To ensure your company-paid life insurance benefit is paid according to your wishes, you must name a beneficiary(ies). You may do this by going to **One.Walmart.com/Beneficiary**. Your beneficiary designation must be completed and submitted to the Plan before your death. If you are unable to access the Beneficiary Online tool you should contact People Services at **800-421-1362** for assistance.

You can name anyone you wish. If the beneficiary(ies) listed in your beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails. 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** on this page.

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/Beneficiary**. Any change in beneficiary must be completed and submitted to the Plan before your death and can be submitted only by you, the covered associate. If you are unable to access the Beneficiary Online tool you should contact People Services at **800-421-1362** for assistance.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to surviving family members in the following order:

- Spouse or partner of the deceased; if not surviving, then
- Children in equal shares; if not surviving, then
- Parents in equal shares; if not surviving, then
- Siblings in equal shares; if not surviving, then
- Your estate.

Be sure to keep your beneficiary information up to date. Proceeds will go to whoever is listed in your beneficiary designation on file with the Plan, regardless of your current relationship with that person, unless applicable law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com/Beneficiary**.

Early payout due to terminal illness

If you are terminally ill, you may elect to receive an "accelerated benefit" while you are still living of up to 50% of the coverage amount your beneficiary(ies) would have received upon your death (measured on the date you provide proof of your terminal illness). Payment is made to you in a lump sum. Upon your death, your beneficiary(ies) receives the amount of life insurance coverage in effect on the date of your death, reduced by the amount of early payouts you received before your death.

If you terminate from Walmart after you have received (or begun to receive) the accelerated benefit, you will need to convert the policy for your beneficiary(ies) to receive the remaining balance upon your death. If you do not convert the policy upon termination of your employment, no benefit will be payable to your beneficiary(ies). See the **Continuing your company-paid life insurance after you leave Walmart or lose coverage** section in this chapter for details on conversion.

Under the policy, you are considered terminally ill if death is expected within 12 months and a doctor can certify the illness or injury as terminal.

There may be circumstances in which the accelerated benefit is not paid. Contact Prudential at **877-740-2116** for details.

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

Filing a company-paid life insurance claim

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

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

An original or certified copy of the death certificate may be required as proof of death. The death certificate should be mailed to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

If a death certificate is required, the claim will not be finalized until Prudential receives the death certificate. Acceptance of the death certificate is not a guarantee of payment.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. Your beneficiary(ies) has the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For details, contact Prudential at **877-740-2116**.

When benefits are not paid

No benefits are paid if you die before your coverage effective date.

When your company-paid life insurance coverage ends

Your company-paid life insurance coverage ends:

- At termination of your employment
- On the last day of the pay period in which your job status changes to part-time
- On the date of your death
- On the date that you lose eligibility
- On the last day of an approved leave of absence (unless you return to work), or
- When the benefit is no longer offered by Walmart.

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

EstateGuidance®

EstateGuidance offers you the convenience of online will preparation from your personal computer at no cost to you. Wills ensure that your assets will be distributed in accordance with your wishes and allow you to name a guardian of your minor children. To complete the online will questionnaire, log on to **willguidance.com**, 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 in your beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails.

Walmart makes EstateGuidance available to you as a convenience and does not specifically recommend or endorse EstateGuidance for preparation of your will. You should choose a will preparation service or service provider that best suits your personal needs and objectives. EstateGuidance does not provide tax or legal advice.

Continuing your company-paid life insurance after you leave Walmart or lose coverage

In most circumstances, you have two options to continue your company-paid life insurance if your group life coverage ends. The first option, called **portability**, allows you to continue all or a portion of your coverage through a group term policy with Prudential. The second option, called **conversion**, allows you to convert all or a portion of your coverage to a Prudential individual policy.

You must apply for portability or conversion within 31 days of the date your company-paid coverage ends. If you die within 31 days of a qualifying loss of coverage and before electing portability or conversion of your life insurance coverage, Prudential will pay a death benefit to your beneficiary. The benefit will be paid based on the amount of coverage in effect prior to the qualifying loss of coverage, even if you did not apply for portability or conversion of your coverage.

> **!** You will not be able to continue your coverage unless you contact Prudential within 31 days of the date your coverage ends.

Portability enables you to maintain similar term life insurance with Prudential after your employment ends if certain conditions are met. Proof of Good Health is required to "port" your coverage. If you do not pass or do not submit Proof of Good Health, you will be eligible to convert your company-paid life insurance to an individual policy, as described below.

You can apply for term life coverage under the portability feature if you meet all of these conditions:

- Your company-paid life coverage ends for any reason other than:
  - you leave Walmart due to a disability, or
  - Walmart changes group life insurance carriers and you are, or become, eligible within the next 31 days.
- You are actively at work on the day your company-paid insurance ends.
- You are less than age 80.
- Your amount of insurance is at least $20,000 on the day your company-paid insurance ends.

If you meet these conditions, you will have 31 days from your termination date to contact Prudential and enroll.

Conversion is a required Plan provision that allows you to convert your life insurance coverage to an individual policy if coverage would end due to your termination of employment or transfer from an eligible class. Proof of Good Health is not required. Rates are based on your age and amount converted. You have 31 days from the termination date of coverage to request to convert your coverage to an individual policy. If a conversion notification was mailed to you and your death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted. If a conversion notification was not mailed to you and your death occurs during the 91-day period immediately following the termination date of your coverage, the death benefit will be payable up to the amount that could have been converted.

If you are a resident of Minnesota, you have a continuation right instead of a conversion right when you lose coverage due to a reduction in your hours or termination of employment (other than for gross misconduct). You may elect to continue coverage at your expense until you obtain coverage under another group life insurance policy; however, the maximum period that coverage may be continued is 18 months. If you continue coverage, at the expiration of the continuation period you may convert your life insurance coverage to an individual policy, as described above.

To request information on portability or conversion, call Prudential at **877-740-2116**.

If you leave Walmart and are rehired

If you are a full-time hourly or management associate (including full-time truck drivers but not part-time truck drivers), see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

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, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Optional associate life insurance

Optional associate life insurance takes care of your family by giving them extra financial protection during a difficult time.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Change your beneficiary designation	Go to **One.Walmart.com/Beneficiary**	Beneficiary changes cannot be made over the phone
• Get more details • Request an accelerated benefit • Get details about continuing your insurance		Call Prudential at **877-740-2116**
File a claim		Call Prudential at **877-740-2116**

What you need to know about optional associate life insurance

- Depending on the amount of coverage you choose and when you enroll, you may be required to provide Proof of Good Health.
- An early payout due to terminal illness is available.
- Coverage is provided through The Prudential Insurance Company of America (Prudential).
- This policy is term life insurance. It has no cash value.
- The Certificate of Insurance available online at **One.Walmart.com** or at **Prudential.com/Walmart**. The certificate provides detailed information about company-paid life insurance, in addition to the highlights available in this chapter.

Optional associate life insurance

Optional associate life insurance protects your family if you die while coverage is in effect. If you become terminally ill, a benefit may be payable to you while you are still living.

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

HOURLY ASSOCIATES AND PART-TIME 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/Beneficiary**. Your beneficiary designation must be completed and submitted to the Plan before your death. If you are unable to access the Beneficiary Online tool you should contact People Services at **800-421-1362** for assistance.

You can name anyone you wish. If the beneficiary(ies) listed in your beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails. 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/Beneficiary**. Any change in beneficiary must be completed and submitted to the Plan before your death and can only be submitted by you, the associate. If you are unable to access the Beneficiary Online tool you should contact People Services at **800-421-1362** for assistance.

Be sure to keep your beneficiary information up to date. Proceeds will go to whoever is listed in your beneficiary designation on file with the Plan, regardless of your current relationship with that person, unless applicable law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com/Beneficiary**.

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 Walmart after you have received (or begun to receive) the accelerated benefit, you will need to convert the policy for your beneficiary(ies) to receive the remaining balance upon your death. If you do not convert the policy upon termination of your employment, no benefit will be payable to your beneficiary(ies). See the **Continuing your optional associate life insurance after you leave Walmart or lose coverage** section later in this chapter for details on conversion.

Under the policy, you are considered terminally ill if death is expected within 12 months and a doctor can certify the illness or injury as terminal.

There may be circumstances in which the accelerated benefit is not paid. Contact Prudential at **877-740-2116** for details.

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

Filing an optional associate life insurance claim

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

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

An original or certified copy of the death certificate may be required as proof of death. The death certificate should be mailed to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

If a death certificate is required, the claim will not be finalized until Prudential receives the death certificate. Acceptance of the death certificate is not a guarantee of payment.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. Your beneficiary has the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For more details, contact Prudential at **877-740-2116**.

When benefits are not paid

No benefits are paid to your beneficiary(ies) if you die as a result of suicide while sane or insane during the first two years of coverage. If you increase your coverage and you die as a result of suicide within two years of the date you increase your coverage, your beneficiary(ies) will receive the prior coverage amount.

If your beneficiary(ies) files a claim within the first two years of your approval date, Prudential has the right to reexamine your Proof of Good Health questionnaire. If material facts about you are found to have been stated inaccurately, the true circumstances will be used to determine what amount of coverage should have been in effect, if any, and:

- The claim may be denied, and
- 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 within 30 days of the due date will result in cancellation of coverage.

For details on how to make premium payments to continue your coverage, **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 your optional associate life insurance coverage ends

Your optional associate life insurance coverage ends:

- On the date you voluntarily drop coverage (as described below)
- At termination of your employment
- On the last day of coverage for which 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 Walmart.

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

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

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

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

Continuing your optional associate life insurance after you leave Walmart or lose coverage

In most circumstances, you have two options to continue your optional associate life insurance if your group life coverage ends. The first option, called **portability**, allows you to continue all or a portion of your current coverage through a group term policy with Prudential. The second option, called **conversion**, allows you to convert all or a portion of your coverage to a Prudential individual policy.

You must apply for portability or conversion within 31 days of the date your coverage ends. If you die within 31 days of a qualifying loss of coverage and before electing portability or conversion of your life insurance coverage, Prudential will pay a death benefit to your beneficiary. The benefit will be paid based on the amount of coverage in effect prior to the qualifying loss of coverage, even if you did not apply for portability or conversion of your coverage.

> You will not be able to continue your coverage unless you contact Prudential within 31 days of the date your coverage ends.

Portability enables you to maintain similar term life insurance with Prudential after your employment ends if certain conditions are met. Proof of Good Health is not required to "port" your coverage. You can, however, receive preferred rates similar to the rates you paid while an active associate if you submit and pass Proof of Good Health. If you do not pass or do not submit Proof of Good Health, your rates will be based on Prudential's standard portability rates.

You can apply for term life coverage under the portability feature if you meet all of these conditions:

- Your optional associate life coverage ends for any reason other than:
  - your failure to pay premiums while an active associate
  - you leave Walmart due to a disability, or
  - Walmart changes group life insurance carriers and you are, or become, eligible within the next 31 days.
- You meet the active work requirement on the day your insurance ends.
- You are less than age 80.
- Your amount of insurance is at least $20,000 on the day your insurance ends.

If you meet these conditions, you will have 31 days from your termination date to contact Prudential and enroll. Prudential will notify you of the amount of portability coverage offered. The amount of insurance coverage offered will be no more than the lesser of the amount of coverage you elected under the plan or not more than five times your annual earnings; provided, however, the amount will not be less than $20,000.

Conversion is a required Plan provision that allows you to convert your life insurance coverage to an individual policy if coverage would end due to your termination of employment or transfer from an eligible class. Proof of Good Health is not required. Rates are based on your age and amount converted. You must apply for the individual contract and pay the first premium by the later of:

- the 31st day after you cease to be insured, or
- the 15th day after you have been given written notice of the conversion privilege.

If a conversion notice was mailed to you and your death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted. If a conversion notice was not mailed to you and your death occurs during the 91-day period immediately following the termination date of your coverage, the death benefit will be payable up to the amount that could have been converted.

If you are a resident of Minnesota, you have a continuation right instead of a conversion right when you lose coverage due to a reduction in your hours or termination of employment (other than for gross misconduct). You may elect to continue coverage at your expense until you obtain coverage under another group life plan; however, the maximum period that coverage may be continued is 18 months. If you continue coverage, at the expiration of the continuation period you may convert your life insurance coverage to an individual policy, up to the amount of coverage in effect at that time. You have 31 days from the date continuation coverage would end to request to convert your coverage to an individual policy.

To request information on portability or conversion, call Prudential at **877-740-2116**.

If you leave Walmart and are rehired

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

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

Optional dependent life insurance

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, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Optional dependent life insurance

Optional dependent life insurance can help ease your financial situation if you lose someone close to you, like a spouse, partner, or child.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get more details	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/partner.
- Proof of Good Health for your spouse/partner is required if you enroll for a coverage amount above $5,000 during your initial enrollment period, or for any coverage amount if you enroll 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 covered dependent dies, you may receive a lump sum payment for the coverage amount you select. The coverage choices for optional dependent life insurance are as follows:

SPOUSE/PARTNER COVERAGE*		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), the coverage effective date is delayed until the spouse/partner or child has a medical release (does not apply to a newborn child).

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

PROOF OF GOOD HEALTH

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

- 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 an optional dependent life insurance claim

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

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

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

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

If a death certificate is required, the claim will not be finalized until Prudential receives the death certificate. Acceptance of the death certificate is not a guarantee of payment.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For more details, contact Prudential at **877-740-2116**.

When benefits are not paid

No benefits are paid to you if your spouse/partner dies as a result of suicide while sane or insane during the first two years of coverage. If you increase your spouse/partner's coverage and your spouse/partner dies as a result of suicide within two years of the increase in coverage, you will receive the prior coverage amount.

If you file a claim for your spouse/partner within the first two years of your approval date, Prudential has the right to reexamine your spouse/partner's Proof of Good Health questionnaire. If material facts about your spouse/partner are found to have been stated inaccurately, the true circumstances will be used to determine what amount of coverage should have been in effect, if any, and:

- The claim may be denied, and
- 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 within 30 days of the due date will result in cancellation of coverage.

For details on how to make premium 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 optional dependent life insurance 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 your optional dependent life insurance coverage ends

Your optional dependent life insurance coverage ends:

- On the date you voluntarily drop coverage (as described below)
- At termination of your employment
- On the last day of coverage for which 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 in which 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 Walmart.

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

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

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

Continuing spouse/partner coverage after you leave Walmart or lose coverage

If you are a full-time or management associate and carry optional dependent life insurance for your spouse/partner, you have two options to continue your spouse/partner coverage after your group life coverage ends. The first option, called **portability**, allows you and your spouse/partner to continue all or a portion of your current coverage through a group term policy with Prudential. The second option, called **conversion**, allows you to convert all or a portion of your spouse/partner coverage to a Prudential individual policy. These options are not available to part-time hourly associates, temporary associates, or part-time truck drivers.

You must apply for portability or conversion within 31 days of the date your spouse/partner coverage ends. If your spouse/partner dies within 31 days of a qualifying loss of coverage and before electing portability or conversion of the life insurance coverage, Prudential will pay a death benefit. The benefit will be the amount of coverage your spouse/partner could have converted, even if your dependent did not apply for portability or conversion of coverage.

> You will not be able to continue your spouse/partner coverage unless you contact Prudential within 31 days of the date coverage ends.

Portability enables you to maintain similar term life insurance for your spouse/partner with Prudential after your associate coverage ends or your spouse/partner loses eligibility due to divorce or separation, if certain conditions are met.

Proof of Good Health is not required to "port" your spouse/partner coverage. You can, however, receive preferred rates for spouse/partner coverage similar to the rates you paid while an active associate if your spouse/partner submits and passes Proof of Good Health. If you do not pass or submit Proof of Good Health for your spouse/partner, your rates will be based on Prudential's standard portability rates.

You can apply for term life coverage under the portability feature if you meet all of these conditions:

- The optional dependent life coverage ends because your optional associate life coverage ends for any reason other than:
  - your failure to pay 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/partner, that person is less than age 80.
- The dependent is covered for optional dependent life coverage on the day your optional associate life coverage ends.
- The dependent is not confined for medical care or treatment, at home or elsewhere, on the day your optional associate life coverage ends.

Your spouse/partner may also apply for term life coverage under the portability feature if they meet all of these conditions:

- Your spouse/partner's coverage ends due to divorce or termination of partnership.
- Your spouse/partner is less than age 80.
- Your spouse/partner is not confined for medical care or treatment, at home or elsewhere, on the day your optional dependent life coverage ends.

If you meet these conditions, you will have 31 days from your termination date to contact Prudential and enroll. Prudential will notify you of the amount of portability coverage offered. The amount of insurance coverage offered will not be more than the amount of spouse/partner coverage you elected under the plan. However, if your spouse/partner provides Proof of Good Health, and Prudential accepts such proof, you may increase the amount of your spouse/partner's coverage by $20,000 (or, if less, by your annual earnings amount).

Conversion is a required Plan provision that allows you to convert your dependent life insurance coverage to an individual policy if coverage would end for any reason other than failure to pay 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 dependent coverage to an individual policy. If your dependent's death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted.

If you are a resident of Minnesota, you have a continuation right instead of a conversion right when you lose dependent coverage due to a reduction in your hours or termination of employment (other than for gross misconduct). You may elect to continue dependent coverage at your expense until you obtain coverage for your dependent under another group life insurance policy; however, the maximum period that coverage may be continued is 18 months. If you continue coverage for your dependent, at the expiration of the continuation period, you may convert your dependent life insurance coverage to an individual policy, up to the amount of coverage in effect at that time. You have 31 days from the date continuation coverage would end to request to convert your dependent coverage to an individual policy. In addition, if you lose coverage for any reason other than a reduction in your hours or termination of employment (other than for gross misconduct), you may convert up to the amount of coverage that was in force under the plan.

To request information on portability or conversion, call Prudential at **877-740-2116**.

If you leave Walmart and are rehired

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

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

Business travel accident insurance

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**	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/Beneficiary**. Your beneficiary designation must be completed and submitted to the Plan before your death. If you are unable to access the Beneficiary Online tool you should contact People Services at **800-421-1362** for assistance. 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) listed in your beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails. 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** on this page.

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/Beneficiary**. Any change in beneficiary must be completed and submitted to the Plan before your death and can only be submitted by you, the covered associate. If you are unable to access the Beneficiary Online tool you should contact People Services at **800-421-1362** for assistance.

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 in your beneficiary designation on file with the Plan, regardless of your current relationship with that person, unless applicable law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com/Beneficiary**.

Filing a business travel accident insurance claim

Within 12 months of the covered associate's injury or death or within 90 days after any periodic payment is due (such as periodic payments for coma), the following information must be provided regarding the associate:

- Name
- Social Security number
- Occurrence, character, and extent of the injury

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

An original or certified copy of the death certificate may be required as proof of death. The death certificate should be mailed to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

If a death certificate is required, the claim will not be finalized until Prudential receives the death certificate, where applicable. Acceptance of the death certificate is not a guarantee of payment.

Benefits can be paid in a lump sum or, upon written request, in monthly installments. Only one benefit, the highest, will be paid if you suffer more than one loss resulting from a single accident.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. Your beneficiary(ies) has the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For details, contact Prudential at **877-740-2116**.

When benefits are paid

Benefits are paid if you sustain an accidental injury while traveling on authorized company business or due to a felonious assault while you are working; your injuries are the direct and sole cause of a covered loss; and you properly provide proof of the accidental loss and covered loss to Prudential.

Traveling for business includes travel using a common carrier or any means of transportation owned and operated by Walmart. An accidental injury includes exposure to the elements. “Direct and sole cause” means the covered loss occurs within 12 months of the date of the accidental injury and is a direct result of the accidental injury, independent of other causes.

BENEFIT AMOUNT

COVERED INJURY OCCURS…	BENEFIT AMOUNT
While traveling on authorized company business	Three times your base annual earnings to a maximum of $1,000,000 Minimum benefit: $200,000
Due to a felonious assault while you are working	Up to $10,000

COVERED LOSSES PAID AT FULL BENEFIT

- Quadriplegia: Total paralysis of both upper and lower limbs.
- Paraplegia: Total paralysis of both lower limbs.
- Hemiplegia: Total paralysis of upper and lower limbs on one side of the body.
- Loss of both hands, both feet, or sight in both eyes: Severance through or above both wrists or both ankle joints, or total and irrecoverable loss of sight.
- Loss of one hand and one foot: Severance through or above the wrist or ankle joint.
- Loss of speech and hearing in both ears: Total loss of speech and hearing that lasts for at least six consecutive months following the accident.
- Loss of hand or foot and sight in one eye: Severance through or above the wrist or ankle joint, with total and irrecoverable loss of sight in one eye.

50% OF FULL BENEFIT

- Loss of hand or foot: Permanent severance through or above the wrist but below the elbow, or permanent severance at or above the ankle but below the knee.
- Brain damage: Brain damage means permanent and irreversible physical damage to the brain, causing the complete inability to perform all of the substantial and material functions and activities of everyday life. Such damage must manifest itself within 30 days of the accidental injury, require hospitalization of at least five days, and persist for 12 consecutive months.
- Loss of sight in one eye: Total and permanent loss of sight in one eye.
- Loss of speech or hearing in both ears: Total loss of speech or hearing that lasts for at least six consecutive months following the accident.

25% OF FULL BENEFIT

- Loss of thumb and index finger of the same hand: Severance of each through or above the joint closest to the wrist.
- Uniplegia: Total paralysis of one limb.

“Paralysis” means loss of use, without severance, of a limb. A doctor must determine that the loss is complete and not reversible. (“Severance” means complete separation and dismemberment of the limb from the body.)

COMA BENEFIT

If you are comatose or become comatose within 365 days as the result of a covered accident, a monthly coma benefit equal to the greater of 2% of your full benefit amount or $100 is paid for up to 50 months. The benefit is payable after 31 consecutive days of being comatose.

"Coma" means a profound state of unconsciousness from which the comatose person cannot be aroused, even by powerful stimulation, as determined by the person's doctor. Such state must begin within 365 days of the accidental injury and continue for 31 consecutive days and is total, continuous, and permanent at the end of the 31-day period.

The maximum amount the business travel accident insurance will pay you for all covered losses resulting from a covered accident is the full benefit amount. If more than one associate suffers a loss as a result of the same accident, the maximum the business travel accident insurance policy will pay for all losses is $10 million per accident and, if necessary, benefits will be prorated among the affected associates suffering a loss in the accident. The maximum total payment is increased to $20 million if the covered accident occurs while you are traveling to or from, or while you are attending, Walmart's Annual Shareholders Meeting, annual holiday meeting, or annual year beginning meeting.

Additional benefits

Business travel accident insurance provides these additional benefits:

- Seat belt benefit: If you suffer a loss of life as a result of a covered accident that occurs while wearing a seat belt, an additional benefit of up to $10,000 may be payable.
- Airbag benefit: If you suffer a loss of life as a result of a covered accident that occurs while you are wearing a seat belt and a properly functioning airbag deploys in the seat you were occupying, an additional benefit of up to $10,000 may be payable.
- Funeral expenses benefit: If you suffer a loss of life within 365 days of and as a result of a covered accident, an additional benefit of up to $5,000 may be payable.
- Medical evacuation benefit: If, as a result of a covered accident, you require medical evacuation and are at least 100 miles from your home, an additional benefit of up to $15,000 may be payable.
- Family relocation and accompaniment: If your spouse or partner or dependent child suffers a covered loss while traveling with you on business (or while on their way to meet you), an additional benefit of up to $100,000 may be payable for losses sustained by your spouse or partner, and $10,000 for losses sustained by each dependent child.

All of these additional benefits are subject to additional eligibility criteria established by Prudential. Please contact Prudential if any of these benefits might apply for additional information.

When benefits are not paid

Business travel accident insurance benefits will not be paid for any loss that results from any of the following:

- Suicide or attempted suicide, while sane or insane
- Intentionally self-inflicted injuries, or any attempt to inflict such injuries
- Sickness, whether the loss results directly or indirectly from the sickness
- Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment
- Any bacterial or viral infection, except a pyogenic infection resulting from an accidental cut or wound or a bacterial infection resulting from accidental ingestion of a contaminated substance
- War or act of war (declared or undeclared), including resistance to armed aggression or an accident while on full-time active duty with the armed services for more than 30 days (this does not include Reserve or National Guard active duty for training)
- Riding in an unlicensed aircraft
- Flying as a crew member of an airplane, except one owned and operated by Walmart
- Commission or attempted commission of an assault or felony
- Operating a land, water, or air vehicle while being legally intoxicated, 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 your business travel accident insurance coverage ends

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

If you leave Walmart and are rehired

Any coverage that was in effect (or the most similar coverage offered under the Plan) on your termination date will be reinstated when you return to work.

International business travel medical insurance

International business travel medical insurance is available through a policy with 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, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by 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. The coverage is provided under forms GACWM4 or state variations thereof. The coverage has exclusions and limitations. 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 received.
- 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 Benefits will return the pro-rata portion of the premium paid for any period of such service.

Accident insurance benefits

Accident insurance pays a benefit if you or a covered dependent sustains an injury caused by an off-the-job accident, which results in any of the losses listed in the chart on the following page.

Injuries must be diagnosed by a physician. An accident generally is a covered accident if it occurs while you or your covered dependent is not working at any job for pay or benefits and is the result of a sudden, unforeseen, and unexpected event that occurs without the covered individual's intent and results in injury to you or your covered dependent. Certain accidents are not covered. See **When benefits are not paid** later in this chapter for more information.

Benefits are payable subject to terms of the Certificate of Insurance available at **One.Walmart.com** or **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 coverage effective date. If you should die before your effective date, no accident insurance benefit will be paid to your beneficiary(ies).

Accident insurance pays benefits described in the following chart for injuries resulting from a covered accident and related services, subject to the terms of the Certificate of Insurance.

SERVICE/INJURY	BENEFIT AMOUNT	LIMITATIONS
Ambulance	$400 for ground ambulance or $4,000 for air ambulance if covered individual requires ambulance transportation to a hospital or emergency center as a result of a covered accident	The ambulance transportation must occur within 72 hours of covered accident. Service must be provided by a licensed professional ambulance company.
Appliance to aid personal locomotion or mobility	$200 if covered individual, as a result of a covered accident and on the advice of a physician, requires use of a medical appliance	Covered medical appliances are: crutches, wheelchair, leg brace, back brace, walker, and CAM boot walker. Payable once per covered individual, per covered accident.
Blood, plasma, and/or platelets	$100 if a covered individual, as a result of a covered accident, requires blood, plasma, and/or platelets	Not payable for immunoglobulins. Payable once per covered individual, per covered accident.
Burns	$100–$10,000 depending on degree of burn and size of affected area, when a covered individual sustains a burn as a result of a covered accident	If proof of loss does not specify size of burn, the lowest benefit amount will be paid. Treatment by a physician must occur within 72 hours of the covered accident. Injuries due to sunburn are not covered.
Coma	$10,000 if a covered individual is in a coma as a result of a covered accident	Coma means a continuous state of profound unconsciousness which lasts seven or more consecutive days as a result of a covered accident. A coma is characterized by an absence of spontaneous eye movements, response to painful stimuli, and vocalization. The condition must require intubation for respiratory assistance. Medically induced comas are excluded.
Concussions (brain)	$50 if a covered individual sustains a concussion as a result of a covered accident	
Dislocation	$188–$3,750, depending on joint dislocated, when a covered individual sustains a dislocation as a result of a covered accident	Payable for only the first dislocation of a joint. Pays 25% of the benefit amount if a covered dislocation is reduced by a physician. Payable for up to two covered dislocations per covered individual, per accident. If more than two dislocations occur during a covered accident, the benefit pays for the two dislocations with the largest dollar amounts.
Emergency dental services	$50 for broken teeth resulting in extractions and $150 for broken teeth repaired with crowns	Pays the benefit amount shown when a covered individual receives dental services as a result of a covered accident. Payable once per covered individual, per covered accident.
Eye injury	$250 for surgical repair; $50 for removal of foreign body	For services performed by a physician as a result of a covered accident.
Family lodging for confinement at a non-local hospital	$100 per night for one hotel/motel room for an immediate family member of covered individual	Payable for up to 30 days per covered accident, and only during the days the covered individual is confined to the non-local hospital.
Follow-up treatment (not covered under physical therapy)	$50 per follow-up visit for required follow-up treatment after receiving emergency treatment for which a benefit is paid under immediate care benefit	Follow-up treatment must be administered by a physician in a physician's office or in a hospital on an outpatient basis and must begin within 30 days of the initial covered treatment. Payable for one follow-up treatment per day for a maximum of six treatments per covered individual, per covered accident. Not payable for treatments for which the physical therapy benefit is paid.
Fractures	$375–$3,750, depending on location of fracture when fracture is corrected by open or closed repair as a result of a covered accident; 25% for chip fractures or other fractures not corrected by open or closed repair	Payable for no more than two fractures per covered individual, per covered accident. If more than two fractures occur during a covered accident, the benefit pays for the two fractures with the largest dollar amounts.
Hospital confinement	Daily benefit of $300 for a continuous hospital confinement of at least 18 hours, up to 365 days per covered accident	Hospitalization must begin within 30 days of covered accident. Not payable on same day rehabilitation benefit is paid. Paid in addition to the initial hospitalization benefit.
Immediate care (physician fees, X-rays, and emergency department)	$170 for a covered person's required medical treatment as a result of a covered accident	Payable for physician fees, X-rays, and emergency room services. Treatment must be received within 30 days of covered accident. Payable only once for any and all treatment occurring within 24-hour period, per covered individual, per covered accident.

(Continued on the next page)

SERVICE/INJURY	BENEFIT AMOUNT	LIMITATIONS
Initial hospitalization	$1,500 payable the first time a covered individual is hospitalized for at least 24 hours for treatment as a result of a covered injury; $2,250 if admitted directly to a hospital intensive care unit	Hospitalization must begin within 30 days of the covered accident. Payable only once per continuous hospitalization per calendar year, per covered individual.
Intensive care unit (ICU) confinement	$900 per day, up to 15 days for any one accident	Confinement must begin within 30 days of covered accident. Paid in addition to initial hospitalization benefit.
Lacerations	$25–$400, depending on the size of the laceration	Treatment must occur within 72 hours of the covered accident. If proof of loss does not specify size of laceration, the lowest benefit amount will be paid.
Major diagnostic exams	$400 for one of the following, if a covered individual requires the exam as a result of a covered accident: CT scan, MRI, or EEG	Must be performed in a hospital, physician's office, or ambulatory surgical center. One payment per covered individual, per calendar year.
Physical therapy (not covered by follow-up treatment)	$50 per day for physical therapy received as a result of a covered accident	Therapy must be prescribed by a physician and begin within 30 days of covered accident or discharge from hospital and be received within six months of covered accident or discharge from hospital. Payable for one treatment per day, up to 10 treatments per covered accident, per covered individual. Not payable for treatments for which the follow-up treatment benefit is paid.
Post-traumatic stress disorder	$100 per day for PTSD counseling	Payable only once per day, per covered individual, up to six days per calendar year. The covered individual must have been diagnosed with PTSD by a physician or a licensed mental health professional and be receiving counseling by group and/or individual therapy. PTSD means a mental health condition that is triggered by a covered accident. Symptoms must include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the covered accident.
Prosthesis	$1,000 for a prosthetic device required as a result of a covered accident	Not payable for hearing aids, wigs, or dental aids (including false teeth). Payable once per covered individual, per covered accident.
Rehabilitation unit confinement (after hospitalization)	$100 per day if covered individual is confined to rehabilitation unit as a result of a covered accident	Must have been confined to a hospital immediately prior to being transferred to the rehabilitation unit. Payable for each day a room charge is incurred, up to 30 days per covered individual, per continuous period of confinement; maximum of 60 days. Not payable for days in which hospital confinement benefit is paid.
Skin grafts	50% of benefit amount under the burns benefit if a covered individual receives one or more skin grafts for a covered burn.	Paid in addition to the burns benefit.
Step-down ICU confinement	$200 per day for confinement of at least 18 hours	Payable per covered individual, per covered accident, in addition to any hospital confinement benefit. Payable for up to 15 days per covered individual, per covered accident.
Surgical procedures	$350–$1,400, depending on surgical procedure	Two or more surgical procedures performed through the same incision or entry point are considered one operation. The benefit will pay only for the procedure with the largest dollar amount. Must be performed within one year of covered accident. Miscellaneous surgery is surgery that requires general anesthesia and must not be covered by any other specific surgery benefit listed. The miscellaneous surgery benefit is payable once per 24 hours even though more than one surgery or procedure may be performed.
Transportation for treatment at a non-local hospital	$400 per round trip for treatment at a non-local hospital as a result of a covered accident; additional $400 per round trip for one parent or legal guardian if dependent child is receiving treatment	Physician must prescribe the treatment. Payable for up to three round trips per calendar year per covered individual. Not payable for ambulance transportation.

Naming a beneficiary

If you die while covered under accident insurance, your beneficiary(ies) will receive any benefits due at the time of your death. You must name a beneficiary(ies) to receive your accident insurance benefit if you die. You may do this by going to **One.Walmart.com/Beneficiary**. Your beneficiary designation must be completed and submitted to the Plan before your death. If you are unable to access the Beneficiary Online tool you should contact People Services at **800-421-1362** for assistance.

You can name anyone you wish. If the beneficiary(ies) listed in your beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails. If you have not designated a beneficiary(ies) under the associate accident insurance benefit, payment will be made to your surviving family members as described under **If you do not name a beneficiary** on this page.

The following information is 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/Beneficiary**. Any change in beneficiary must be completed and submitted to the Plan before your death. If you are unable to access the Beneficiary Online tool you should contact People Services at **800-421-1362** for assistance.

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 in your beneficiary designation on file with the Plan, regardless of your current relationship with that person, unless applicable law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com/Beneficiary**.

Filing an accident insurance claim

Within 60 days of the occurrence or commencement of any covered accident, or as soon as reasonably possible, send a notice of claim to:

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 individual:

- 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 Benefits. 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 Benefits 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 within 30 days of the due date will result in an interruption in the payment of any benefit claims and/or cancellation of coverage.

For details on how to make premium 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 your accident insurance coverage ends

Your accident insurance coverage ends on the earliest of the following:

- On the date you voluntarily drop coverage (as described below)
- On the date you terminate employment
- On the last day 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 Walmart.

Accident insurance coverage for your spouse/partner ends:

- On the date your accident insurance coverage ends
- On the last day of the pay period in which your job status changes to part-time, temporary, or part-time 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 your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

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

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

CONTINUATION OF COVERAGE AT TERMINATION

If your coverage under 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 accident insurance terminates.

> You will not be able to continue your coverage unless you contact Allstate Benefits and send in the first premium within 60 days of the date your coverage ends.

Portability coverage will be effective on the day after coverage under the Plan terminates and will end on the earliest of the following:

- The date you again are eligible for accident insurance under the Plan.
- The last day 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 Walmart and are rehired

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

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

Accidental death and dismemberment (AD&D) insurance

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, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Accidental death and dismemberment (AD&D) insurance

AD&D benefits can help pay the cost of medical care, childcare, and education expenses if you're seriously injured or die in an accident.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Change your beneficiary designation	Go to **One.Walmart.com/Beneficiary**	Beneficiary changes cannot be made over the phone
Get more details		Call Prudential at **877-740-2116**
File a claim		Call Prudential at **877-740-2116**

What you need to know about AD&D insurance

- Proof of Good Health is not required for AD&D insurance, regardless of the coverage amount you choose.
- If you have a covered loss, AD&D insurance pays a lump sum benefit based on the nature of the loss and the coverage amount you select. Additional benefits may be payable depending on the circumstances of the covered loss.
- Coverage is provided through The Prudential Insurance Company of America (Prudential).
- The Certificate of Insurance is available at **One.Walmart.com** or at **Prudential.com/Walmart**. The certificate provides detailed information about company-paid life insurance, in addition to the highlights available in this chapter.

AD&D insurance

AD&D insurance pays a lump sum benefit to you or your beneficiary(ies) if you or a covered dependent experiences a covered loss. The amount of your benefit depends on the type of loss you experience, as described later in this chapter.

You have two AD&D coverage decisions. You choose whom you want to cover and your coverage amount.

You can choose to cover:

- Associate only
- Associate + dependents

If you are a part-time hourly associate, temporary associate, or part-time 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/Beneficiary**. Your beneficiary designation must be completed and submitted to the Plan before your death. If you are unable to access the Beneficiary Online tool you should contact People Services at **800-421-1362** for assistance.

You (the associate) will receive any benefits payable for your covered dependents.

You can name anyone you wish. If the beneficiary(ies) listed in your beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails. If you have not designated a beneficiary(ies) under the associate AD&D benefit, payment will be made to your surviving family members as described under **If you do not name a beneficiary** in the next column.

The following information is 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/Beneficiary**. Any change in beneficiary must be competed and submitted to the Plan before your death and can only be submitted by you, the covered associate. If you are unable to access the Beneficiary Online tool you should contact People Services at **800-421-1362** for assistance.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to surviving family members in the following order:

1. Spouse/partner of the deceased; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares, if not surviving, then
5. Your estate.

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

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 an AD&D insurance claim

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

- Name
- Social Security number
- Date of death or injury, 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 70182
Philadelphia, Pennsylvania 19176

Benefits are paid in a lump sum. If you or a covered dependent sustains more than one covered loss due to an accidental injury, the amount paid on behalf of any such injured person will not exceed the full amount of the benefit.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You or your beneficiary has the right to appeal a claim denial.

When benefits are not paid

AD&D benefits are not paid for any loss that occurs prior to your enrollment in the Plan, nor any loss caused or contributed to by the following:

- Suicide or attempted suicide, while sane or insane
- Intentionally self-inflicted injuries, or any attempt to inflict such injuries
- Sickness, whether the loss results directly or indirectly from the sickness
- Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment
- Bacterial or viral infection, but not including:
  - Pyogenic infection resulting from an accidental cut or wound, or
  - Bacterial infection resulting from accidental ingestion of a contaminated substance.
- Taking part in any insurrection
- War, declared or undeclared, or any act of war
- An accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces (not including Reserve or National Guard active duty for training)
- Travel or flight in any vehicle used for aerial navigation if you are riding as a passenger in any aircraft not intended or licensed for the transportation of passengers (including getting in, out, on, or off such vehicle)
- Commission or attempted commission of an assault or felony
- Operating a land, water, or air vehicle while being legally intoxicated, 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 within 30 days of the due date will result in an interruption in the payment of any benefit claims and/or cancellation of coverage.

For details on how to make premium 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 your AD&D insurance coverage ends

Your AD&D coverage ends:

- On the date you voluntarily drop coverage (as described on the following page)
- At termination of your employment
- On the last day of coverage for which 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 Walmart. AD&D coverage cannot be converted to individual coverage after coverage ends.

In addition, if you have chosen associate + dependent(s) coverage and your job status changes to part-time hourly associate, temporary associate, or part-time truck driver, your coverage for your spouse/partner will end on the last day of the pay period in which your job status changes.

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

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

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

If you leave Walmart and are rehired

If you are a part-time hourly associate or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **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 Walmart and then returning to work.

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

Critical illness insurance

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, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by 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. The coverage is provided under forms GCICWM4, or state variations thereof. The coverage has exclusions and limitations. 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 coverage effective date. If you die before your coverage effective date, no critical illness insurance benefit will be paid to your beneficiary(ies).

Benefits of 100% of the coverage amount you elect will be paid upon the occurrence of the following critical illnesses, subject to complete details in the Certificate of Insurance:

- Invasive cancer
- Alzheimer's disease (requires loss of three activities of daily living)
- Coronary artery bypass surgery (excludes balloon angioplasty, laser embolectomy, atherectomy, stent placement, and other non-surgical procedures)
- End-stage renal failure
- Heart attack
- Stroke
- Parkinson's disease (requires loss of two activities of daily living)
- Total and irreversible loss of hearing in both ears continuing for six consecutive months following the illness that caused it and that cannot be corrected by the use of any hearing aid or device
- Permanent and uncorrectable loss of sight in one or both eyes due to sickness
- Quadriplegia
- Paraplegia
- Loss of at least one foot, hand, arm, or leg
- Benign brain tumor, other than tumors of the skull, pituitary adenomas, or germinomas, resulting in persistent neurological deficits
- Coma (not medically induced) lasting at least seven consecutive days due to underlying illness or traumatic brain injury that begins within 31 days of illness
- Sickle cell anemia
- Systemic lupus
- Tuberculosis, 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 and undergoes surgery): 25% of coverage amount
- Specified diseases: 50% of coverage amount

- Addison's disease
- Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- Cerebrospinal meningitis (bacterial)
- Cerebral palsy
- Cystic fibrosis
- Diphtheria
- Encephalitis
- Huntington's chorea
- Legionnaires' disease (confirmation by culture or sputum)
- Malaria
- Multiple sclerosis
- Muscular dystrophy
- Myasthenia gravis
- Necrotizing fasciitis
- Osteomyelitis
- Poliomyelitis
- Rabies
- Systemic sclerosis (scleroderma), 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.)
- Diagnosis of an unrelated cancer is not excluded.

Other benefits payable include:

- Ambulance: $400 for ground ambulance or $4,000 for air ambulance if a covered individual requires ambulance transportation to a hospital or emergency center due to a covered illness.
- Post-traumatic stress disorder (PTSD): $100 for each day a covered individual receives counseling for PTSD; payable once per day per covered individual and limited to six days per calendar year.
- Skin cancer benefit: $500 upon positive diagnosis of skin cancer (basal cell carcinoma and squamous cell carcinoma) by a licensed Doctor of Medicine certified by the American Board of Pathology to practice pathological anatomy, or an osteopathic pathologist, based on microscopic examination of skin biopsy samples). This benefit is not paid for malignant melanoma (which is covered under the invasive cancer benefit). It also does not include any conditions which may be considered precancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; nonmalignant melanoma; moles; or similar diseases or lesions. Payable only once per covered individual each calendar year.
- National Cancer Institute (NCI) evaluation or Walmart Centers of Excellence evaluation: when evaluated for determining the appropriate treatment of a previously diagnosed covered illness, $500 for evaluation; $250 for transportation and lodging if the NCI center or Walmart Centers of Excellence facility is more than 100 miles from your home. Payable once for each initial occurrence or recurrence of a covered illness.
- Lodging benefit: $60 per day when a covered individual receives treatment for a covered illness on an outpatient basis at a treatment facility more than 100 miles from the covered individual's home. This benefit is limited to 60 days per calendar year and is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment.
- Transportation benefit: $0.50 per mile for personal vehicle, up to $1,500, or up to $1,500 round-trip transportation for coach fare on a common carrier. Transportation must be required for treatment of a covered critical illness at a hospital (inpatient or outpatient), radiation therapy center, chemotherapy or oncology clinic, or any other specialized freestanding treatment facility. If the treatment is for a covered child and common carrier travel is necessary, the benefit will be paid for up to two adults to accompany the child. This benefit will not be paid if the covered individual lives within 100 miles of the treatment facility. The Plan does not pay for transportation for someone to accompany or visit the covered individual receiving treatment; visits to a physician's office or clinic; or for other services.

Naming a beneficiary

If you die while covered under critical illness insurance, your beneficiary(ies) will receive any benefits due at the time of your death.

To ensure that your critical illness insurance benefit is paid according to your wishes, you must name a beneficiary(ies) to receive your critical illness insurance benefit if you die. You may do this by going to **One.Walmart.com/Beneficiary**. Your beneficiary designation must be completed and submitted to the Plan before your death. If you are unable to access the Beneficiary Online tool you should contact People Services at **800-421-1362** for assistance.

You can name anyone you wish. If the beneficiary(ies) listed in your beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails. If you have not designated a beneficiary(ies) under the critical illness insurance, payment will be made to your surviving family members as described under **If you do not name a beneficiary** on this page.

The following information is needed for each beneficiary you name:

- Name
- 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 critical illness coverage. If you and your dependent die at the same time, benefits will be paid as if you had not named a beneficiary. See **If you do not name a beneficiary** on this page.

CHANGING YOUR BENEFICIARY

You can change your beneficiary(ies) at any time on **One.Walmart.com/Beneficiary**. Any changes in beneficiary must be completed and submitted to the Plan before your death and can only be submitted by you, the covered associate. If you are unable to access the Beneficiary Online tool you should contact People Services at **800-421-1362** for assistance.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment of any benefits due at your death will be paid in the following order:

- 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 in your beneficiary designation on file with the Plan, regardless of your current relationship with that person, unless applicable law says otherwise. You can change your beneficiary(ies) at any time **One.Walmart.com/Beneficiary**.

Filing a critical illness insurance claim

Within 60 days of the occurrence or commencement of any covered critical illness, or as soon as reasonably possible, send a notice of claim to:

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 individual:

- 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 within 30 days of the due date will result in an interruption in the payment of any benefit claims and/or cancellation of coverage.

For details on how to make premium 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 your critical illness insurance coverage ends

Your critical illness insurance coverage ends on the earliest of the following:

- On the date you voluntarily drop coverage (as described on this page)
- On the date you terminate your employment
- On the last day 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 Walmart.

Critical illness insurance coverage for your spouse/partner ends on the earliest of the following:

- On the date your insurance coverage ends
- On the last day of the pay period in which your job status changes to part-time, temporary, or part-time 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 your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

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

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

CONTINUATION OF COVERAGE AT TERMINATION

If your coverage under critical illness insurance terminates as described above (except due to 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.

> You will not be able to continue your coverage unless you contact Allstate Benefits and send in the first premium payment within 60 days of the date your coverage ends.

Portability coverage will be effective on the day after coverage under the Plan terminates and will end on the earliest of the following:

- The date you again are eligible for critical illness insurance under the Plan.
- The last day 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 Walmart and are rehired

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

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

Claims and appeals

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	Claims must be submitted within the deadlines provided in this chapter. For medical, pharmacy, dental, and vision claims, see your plan ID card for the claims address or call your health care advisor 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 claim decision letter will also specify where and when to file an appeal
Appeal a decision on eligibility for coverage or enrollment status	Write to: **Mail Stop 3610–Benefits Total Rewards Team** **Attn: Internal Appeals** **508 SW 8th Street** **Bentonville, Arkansas 72716-3610** Or email **ghappeal@wal-mart.com** NOTE: **You must send your request to the specific address above, including the mail stop. If your request is not sent to this address, receipt by the Plan will be delayed.** Or for COBRA appeals, write to: **WageWorks (COBRA Appeals)** **P.O. Box 14390** **Lexington, Kentucky 40512-4390**
Designate an authorized representative to submit appeals on your behalf	Call the number on your plan ID card or call People Services at **800-421-1362** to request the Plan's authorized representative form.

What you need to know about claims and appeals

- You have the right to appeal an adverse enrollment or eligibility decision affecting your coverage.
- You have the right to appeal an adverse decision regarding your requested benefits, including requests for preauthorization.
- You have the right to appeal a benefit claim that has been partially or fully denied.
- You can appoint another party to file an 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.
- **You must send your appeal request to the specific address above, including the mail stop. If your request is not sent to this address, receipt by the Plan will be delayed.**

Deadlines to file a claim or bring legal action

You must submit your claim to the Plan within 12 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 12 months from the date of service or other date on which the right to make a claim first arises. Since procedures for filing a claim or an appeal are different for different benefit plans and third-party administrators, be sure to review the relevant section of this chapter for detailed information.

NOTE: The deadline for claims that arose prior to January 1, 2025 is 18 months.

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.

If you disagree with the Plan Administrator's determination regarding your enrollment or eligibility status, you have 180 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.

NOTE: The deadline for enrollment events occurring prior to January 1, 2025 is 365 days.

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. A cancellation of coverage due to failure to pay required contributions or premiums in a timely manner is not a rescission and is not subject to the claims process.

If you voluntarily choose to prenotify the third-party administrator ("TPA") of a scheduled medical service before you receive treatment, and the medical service is not required to be preauthorized, the TPA's response is nonbinding on the Plan and not subject to appeal. However, if the Plan terms or policies, as applied by the TPA, require you or your provider to preauthorize services and your request for 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 on this page. 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—UMR • 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, TX, 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	Your third-party administrator
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 preauthorization.	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
- Be submitted within 180 days of the date of the initial denial (note that for medical and dental claims arising prior to January 1, 2025, the deadline is 365 days), 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, or as otherwise instructed in the denial letter.

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**
BlueAdvantage	**866-823-3790**
UMR (Premier, Contribution, and Saver Plans)	**855-870-9177**
UMR (Mercy Arkansas Local Plan)	**800-804-1272**
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 • 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 Arkansas Local Plan • Cancer records review • Kidney/ESRD records review	**HealthSCOPE Benefits** **P.O. Box 2359** **Little Rock, Arkansas 72203**
Your third-party administrator • Family-building treatment and services • Heart surgery	See your plan ID card
PHARMACY	
OptumRx	**OptumRx** **Attn: Appeals Coordinator** **P.O. Box 2975** **Mission, Kansas 66201**
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, and hip and knee replacement under the Centers of Excellence 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 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 by 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 loss of life, 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 mail: **Mail Stop 3610–Benefits Total Rewards Team**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

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 loss of life, you should file as soon as possible. If you are filing a pre-service exception request because Mayo Clinic has determined that 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.

Post-service exception request to have transplant at a facility other than Mayo Clinic

If you have already received a transplant because your circumstances called for an immediate transplant, without which you would likely have suffered loss of life, you may request that the AMP pay benefits for a transplant received from a facility other than Mayo Clinic under otherwise applicable terms, by filing a post-service claim.

Send your written request for a post-service exception request for a transplant at a facility other than Mayo Clinic to:

By email: ghappeal@wal-mart.com
By mail: Mail Stop 3610–Benefits Total Rewards Team
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

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, Mayo Clinic, or a TPA of the Plan. The Independent Review Organization will review any relevant medical files that were reviewed or generated by Mayo Clinic, as well as any additional materials you submit, and will consider various factors, including your condition, alternative courses of treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit the surgical procedure would have.

You must file your exception request within 120 calendar days of the date of service.

If you file a post-service exception request, the 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 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 mail: **Mail Stop 3610–Benefits Total Rewards Team**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

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 loss of life, 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 loss of life, 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 mail: **Mail Stop 3610–Benefits Total Rewards Team**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

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 mail: **Mail Stop 3610–Benefits Total Rewards Team**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

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:

By email: **ghappeal@wal-mart.com**
By mail: **Mail Stop 3610—Benefits Total Rewards Team**
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

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

REQUESTING A VOLUNTARY REVIEW OF AN APPEAL DENIED FOR ADMINISTRATIVE REASONS: MEDICAL, DENTAL, AND VISION APPEALS

You may request a voluntary review of the decision on your appeal of a denied medical, dental, or vision benefit claim if your appeal was denied for an administrative reason, such as if you exceeded the number of allowed visits, rather than for a medical judgment reason. You must file your request within 180 days 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:

By email: **ghappeal@wal-mart.com**
By mail: **Mail Stop 3610—Benefits Total Rewards Team**
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

External appeal process for medical, pharmacy, or Centers of Excellence benefits

If your internal appeal for medical, pharmacy, or Centers of Excellence benefits under the Plan is denied based on medical judgment or based on a determination that the claim is not subject to surprise billing protections, you may have the right to further appeal your claim in an independent external review process. The denial notice will contain information on the external appeal process.

Your external appeal will be conducted by an Independent Review Organization 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:

By email: **ghappeal@wal-mart.com**
By mail: **Mail Stop 3610—Benefits Total Rewards Team**
Attn: External Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

Send a written request for an external pharmacy appeal to:

OptumRx
Attn: Appeals Coordinator
P.O. Box 2975
Mission, Kansas 66201

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.

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 Walmart may deduct such amounts from your wages, salary, or other compensation or benefits, and pay the same to the Plan until recovery is complete. If you enroll for coverage under the Plan, you are deemed to have consented to the applicable payroll deductions for such coverage. In addition, if you fail to affirmatively enroll or reenroll during Annual Enrollment, you are deemed to have consented to the automatic reenrollment described in the **Eligibility, enrollment, and effective dates** chapter, including the applicable payroll deductions.

The Plan's subrogation and reimbursement rights

NOTE: This section applies to Plan benefits that are funded through company assets. These benefits are generally referred to throughout the *Associate Benefits Book* as self-funded benefits, or self-insured benefits, to indicate they are not insured through an insurance contract issued by an insurer. Insurers of insured benefits may have separate subrogation and reimbursement rights applicable to the benefits they insure. Please see the respective policy and certificate of coverage applicable to any insured benefit you may be enrolled in.

If you or a covered dependent (a covered person) is injured or otherwise harmed due to the conduct of another party and the Plan pays company-funded benefits as a result of such injury or harm, the Plan Administrator has the right to recover payments it makes on the covered person's behalf from the covered person or any party responsible for compensating the covered person for their illnesses or injuries. The legal term for this right of recovery is "subrogation." The Plan shall have a first-priority lien against any amounts the covered person recovers from another responsible party or insurer for the full amount of the benefits that are paid to or for the benefit of the covered person as a result of the third-party injury or harm, and the Plan shall have a right to offset such benefit amounts against future benefits due under the Plan.

The Plan has the right to do any of the following to enforce its lien and right of reimbursement and recovery:

- Reduce or deny benefits otherwise payable by the Plan, and
- Recover or subrogate 100% of the benefits paid or to be paid by the Plan for covered persons, to the extent of any and all of the following payments:
  - Any judgment, settlement, or payment made or to be made because of an accident or malpractice (except for malpractice that results in paraplegia/quadriplegia, severe burns that result in a whole-body impairment rating of at least 50%, as determined by an Independent Review Organization in accordance with American Medical Association guidelines for the evaluation of permanent impairment, total and permanent physical or mental disability, or death), regardless of how such judgment, settlement, or payment is characterized, including payments by any other insurance, whether providing third-party coverage or first-party coverage
  - Any auto or recreational vehicle insurance coverage or benefits, including uninsured/underinsured motorist coverage
  - Business medical and/or liability insurance coverage or payments, 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 first-priority right to reduction, reimbursement, and subrogation shall not be reduced due to the covered person's own negligence.

The Plan will not pursue reduction, reimbursement, or subrogation where the injury or illness that is the basis of the covered person's recovery from any party results in:

- Paraplegia or quadriplegia
- Severe burns that result in a whole-body impairment rating of at least 50%, as determined by an Independent Review Organization in accordance with American Medical Association guidelines for the evaluation of permanent impairment
- Total and permanent physical or mental disability, 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, or has met the requirements to qualify for Social Security disability income. The Plan Administrator will consider claims for physical and mental disability, even if the covered person does not qualify for Social Security disability income benefits, under criteria developed by the Plan Administrator.

Even in circumstances where the Plan is not prohibited from seeking reduction, reimbursement, or subrogation based on the exceptions described previously, the Plan's right to reduction, reimbursement, or subrogation will be limited to no more than 50% of the total amount recovered by or on behalf of the covered person from any party (which shall not be reduced for the covered person's attorney's fees or costs). The Plan requires all covered individuals and their representatives to notify the Plan if they are involved in an incident that gives rise to such right of reduction, reimbursement, or subrogation. Covered individuals are required to cooperate with the Plan and execute any documents that the administrator, acting on the Plan's behalf, deems necessary to protect the Plan's rights of reduction, reimbursement, or subrogation. Covered individuals shall not do anything to hinder, delay, impede, or jeopardize the Plan's priority right of reduction, reimbursement, or subrogation. Failure to comply will entitle the Plan to withhold benefits due to you under the Plan. This is in addition to any and all other rights that the Plan has pursuant to its rights of reduction, reimbursement, and subrogation.

The Plan's rights to reduction, reimbursement, and subrogation apply regardless of any allocation or designation of the applicable settlement or award (e.g., pain and suffering or medical benefits) and regardless of the specific claims or causes of action being settled or adjudicated. The Plan's rights apply regardless of whether the covered person has been made whole or fully compensated for the covered person's injuries and without regard to any state law or equitable doctrine, such as the make whole doctrine, that would limit the Plan's right of recovery based whether the covered person has been made whole, it being intended that the Plan's right of recovery is a right to first dollar recovery.

Additionally, the Plan has the right to file suit on the covered person's behalf for the condition related to the medical expenses to recover benefits paid or to be paid by the Plan. The Plan may also enforce its rights of reduction, reimbursement, and subrogation against any fund, tortfeasor, responsible party, or available insurance coverages, including underinsured, no-fault, or uninsured motorist coverages to the fullest extent allowed by law.

To aid the Plan in its enforcement of its right of reduction, recovery, reimbursement, and subrogation, a covered person or their designated representative must, at the Plan's request and at its discretion:

- Take actions necessary to enable the Plan to exercise its rights of recovery
- Give information, 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:

By email: **ghappeal@wal-mart.com**
By mail: **Mail Stop 3610—Benefits Total Rewards Team**
Attn: Subrogation Review
508 SW 8th Street
Bentonville, Arkansas 72716-3610

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:

By email: **ghappeal@wal-mart.com**
By mail: **Mail Stop 3610—Benefits Total Rewards Team**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

The appeal will be conducted without regard to the initial determination by someone other than the party who decided the initial claim for benefits. The claimant has the right to request copies, free of charge, of all documents, records, or other information relevant to the claimant's claim for benefits. The claimant also has the right to submit written comments, documents, records, and other information, which the Plan will take into account in making its decision on appeal. In deciding any claim for benefits that is based in whole or in part on a medical judgment, the Plan's claims fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be an individual who is neither an individual who was consulted in connection with the Plan's decision on the initial claim for benefits, nor the subordinate of the health care professional. If the advice of a health care professional is obtained in deciding an appeal, the name of the health care professional will be provided to the claimant upon request, regardless of whether the Plan relied on the advice. The Plan must provide the claimant written notice of the Plan's decision on review within 60 days following the Plan's receipt of 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 90-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 70182
Philadelphia, Pennsylvania 19176

Claims for benefits under life insurance coverage must be filed within 90 days after the date of loss.

Claims for benefits under business travel accident insurance coverage must be filed within 365 days after the date of loss.

Claims for benefits under accidental death and dismemberment insurance coverage must be filed within 90 days after the date of loss.

LIFE, BUSINESS TRAVEL ACCIDENT, OR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

When you submit a life insurance claim to Prudential, a claim determination will be made within 45 days. 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 70182
Philadelphia, Pennsylvania 19176

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of 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 short-term disability coverage claims

NOTE: This section describes the claims and appeals process for the full-time hourly short-term disability plan (basic and enhanced). 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 FOR SHORT-TERM DISABILITY BENEFITS UNDER THE FULL-TIME HOURLY SHORT-TERM DISABILITY PLAN

If you become disabled, you should file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption in your wages, or the denial of your claim. The timing and the process you need to follow when filing a claim for short-term disability benefits depend on whether the short-term disability plan is available at your location (i.e., whether you are in a state or locality that provides legally mandated benefits.) See the **Claim filing instructions** on the following page for information about filing your claim.

STEP 1: Contact Sedgwick to apply for a leave of absence. Regardless of the process you follow to file a short-term disability claim with the Plan, you will need to contact Sedgwick by going to **One.Walmart.com/LOA > mySedgwick** or by calling **800-492-5678** to apply for a leave of absence as soon as you know you will be absent from work due to an illness, injury, or pregnancy. Sedgwick will send you an initial packet providing the information you will need and describing any actions you will need to take.

The leave of absence policy is not a benefit offered under, or administered as part of, the Plan and is not discussed here in detail. For specific details about the leave of absence policy, refer to **One.Walmart.com**. The approval of a leave of absence under Walmart's leave of absence policy does not automatically mean your short-term disability claim is approved. See **When benefits begin** in the **Full-time hourly short-term disability** chapter for details.

STEP 2: File a claim for short-term disability or legally mandated benefits. Your claim for short-term disability benefits cannot be fully processed until you have stopped working. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated.

NOTE: Your claim filing date is the date on which you submit your disability claim to Sedgwick. In order for Sedgwick to begin their review of your claim, you must have fully stopped working. If you file your claim prior to your first date of absence, Sedgwick will begin processing your claim as of your first date of absence. If you file your claim on or after your first date of absence, Sedgwick will begin their review as of your reported date.

To file a claim with Sedgwick, you may call **800-492-5678** or file by mail to:

Sedgwick Claims Management Services, Inc.
P.O. Box 14748
Lexington, Kentucky 40512-4748

If you are in a state or locality that offers a mandated benefit, you should file your claim with the appropriate state or locality. See the chart on the following page for details on where and when to file your claim.

CLAIM FILING INSTRUCTIONS

Your state or locality may have unique filing periods, which could potentially exclude benefits for periods prior to the date of your benefits application. It is strongly advised that you promptly apply to your state or locality for any benefits that are mandated by law.

State or locality	Eligibility	Claim administrator	Filing instructions
CA, RI	Not eligible for Walmart short-term disability basic or enhanced Eligible for maternity, as a supplement to legally mandated benefits	State for legally mandated benefit Sedgwick for maternity	**CA:** Go to **edd.ca.gov** or call **800-480-3287** for instructions **RI:** Go to **www.dlt.ri.gov/tdi** or call **401-462-8420** for instructions For maternity benefit, file a claim with Sedgwick within 90 days of the date your disability begins; you will need to provide the determination letter from the state with benefit details. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
HI, NJ	Not eligible for Walmart short-term disability basic or enhanced Eligible for maternity, as a supplement to legally mandated benefits	Lincoln Sedgwick for maternity	**HI:** File a claim with Sedgwick within 90 days of the date your disability begins, and Sedgwick will forward to Lincoln. **NJ:** File a claim with Sedgwick within 30 days of the date your disability begins, and Sedgwick will forward to Lincoln. For maternity benefit, file a claim with Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
CO, CT, MA, OR, WA **Washington, D.C.**	Eligible for Walmart short-term disability plan as a supplement to legally mandated benefits	State or district for legally mandated benefit Sedgwick for supplemental benefits and maternity	**CO:** Go to **famli.colorado.gov** or call **866-263-2654** for instructions **CT:** Go to **ctpaidleave.org** or call **877-499-8606** for instructions **MA:** Go to **paidleave.mass.gov** or call **833-344-7365** for instructions **OR:** Go to **paidleave.oregon.gov** or call **833-854-0166** for instructions **WA:** Go to **paidleave.wa.gov** or call **833-717-2273** for instructions **D.C.:** Go to **dcpaidfamilyleave.dc.gov** or call **202-899-3700** for instructions **Sedgwick:** File a claim with Sedgwick within 90 days of the date your disability begins; you will need to provide the determination letter from the state or district with state or district benefit details. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
NY	Eligible for Walmart short-term disability plan as a supplement to legally mandated benefits	Lincoln Sedgwick for supplemental benefits and maternity	File a claim with Sedgwick within 30 days of the date your disability begins and Sedgwick will forward to Lincoln. For maternity benefit, file a claim with Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
All others	Eligible for Walmart short-term disability plan	Sedgwick	File a claim with Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

STEP 3: Let your doctor's office know it will be contacted for information. Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide 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 4: Follow up with your doctor to ensure that the requested information was forwarded to Sedgwick. Any delay in sending information to Sedgwick could result in a delay, or denial, in the processing of your claim and the payment of benefits.

Claims are determined under the time frames and requirements set out in this chapter. You have the right to appeal a claim denial. See **Appealing a short-term disability claim that has been fully or partially denied** that has been fully or partially denied later in this chapter.

You may be required to provide written proof of your disability or additional medical information before your claim is approved.

INITIAL CLAIM DETERMINATION

See the chart on the previous page for filing deadlines. Once a claim has been filed, a decision will be made in no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for up to two additional 30-day periods, provided that, prior to any extension period, you are notified in writing that an extension is necessary due to matters beyond 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 (including a description of any contractual limitation period that applies and the date on which the contractual limitation period expires).

APPEALING A SHORT-TERM DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

NOTE: If your claim for short-term disability benefits is denied because Sedgwick did not receive objective medical documentation supporting your claim, or the documentation provided did not support your claim, you will have a grace period of 30 calendar days from the date of your denial letter to submit objective medical information to Sedgwick for review without the need to file an appeal. Once your grace period has ended, if your claim remains denied and you would like to appeal, you must submit a formal written or oral appeal to Sedgwick or Lincoln (as applicable) within 180 days of the denial.

For associates in states or localities with legally mandated programs in California, Colorado, Connecticut, Massachusetts, Oregon, Rhode Island, Washington, D.C., and Washington state, you should submit your appeal of a determination relating to a claim for mandated benefits directly to the state or local government. For information, including filing timelines, call the appropriate phone number listed in the **Resources** chart at the beginning of the **Full-time hourly short-term disability** chapter.

If your appeal relates to a claim that was denied by Sedgwick or Lincoln and you would like to appeal, you must submit a written or oral appeal to Sedgwick or a written appeal to Lincoln (as applicable) within 180 days of the denial at the following address, as applicable:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

Appeals for associates in Hawaii, New Jersey, and New York: Based on your particular circumstances, send your appeal to the appropriate entity listed below:

BENEFIT	ADDRESS YOUR APPEAL TO
Enhanced short-term disability appeals and New York paid family leave	**Group Benefits Claims Appeal Unit** **Lincoln Financial Group** **Group — Charlotte WM** **Attn: Appeal Review Unit** **P.O. Box 2578** **Omaha, Nebraska 68172-9688**
New York Disability Benefits Law appeals	**Workers' Compensation Board** **Disability Benefits Bureau** **P.O. Box 9029** **Endicott, NY 13761-9029**
New Jersey Temporary Disability Insurance appeals	**New Jersey Department of Labor and Workforce Development** **Division of Temporary Disability Insurance** **Private Plan Compliance** **P.O. Box 957** **Trenton, NJ 08625-0957**

Your appeal will be conducted without regard to your initial determination by someone other than the party who decided your initial claim or a subordinate of the individual who decided your initial claim. No deference will be afforded to the initial determination. You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You have the right to request copies, free of charge, of all documents, records, or other information relevant to your claim. The third-party administrator, on behalf of the Plan, will provide you with any new or additional evidence or rationale considered in connection with your claim sufficiently in advance of the appeals determination date to give you a reasonable opportunity to respond.

If your claim involves a medical judgment question, the third-party administrator, on behalf of the Plan, will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the third-party administrator, on behalf of the Plan, will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

Sedgwick or Lincoln (as applicable) will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if it is determined that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification of the denial that will include:

- The specific reasons for the adverse determination
- Reference to the specific Plan provisions on which the determination was based
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the benefit determination, 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.

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.

AUTHORITY OF SHORT-TERM DISABILITY CLAIMS ADMINISTRATOR

Sedgwick or Lincoln (as applicable) shall, subject to the requirements of ERISA, have the sole and exclusive discretionary authority to interpret the Plan's short-term disability provisions with respect to all claims for short-term disability benefits properly brought by a Plan participant or beneficiary. Sedgwick's or Lincoln's (as applicable) determination on review of an appeal shall be made in a fair and consistent manner to ensure the independence and impartiality of persons involved in the decision-making process, in accordance with the Plan terms, and their decision shall be final, subject only to a determination by a court of competent jurisdiction that their decision was arbitrary or capricious.

VOLUNTARY SECOND APPEAL OF A CLAIM FOR 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.

Claims and appeals process for long-term disability coverage claims

Claims under the long-term disability plan should be submitted to:

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

If you are on an approved short-term disability claim, Sedgwick will automatically transition the claim to Lincoln for consideration. You may also call Lincoln at **877-353-6404** to request a claim form as soon as you know you will need to use your long-term disability benefit, but no later than 30 days after the long-term disability benefit would otherwise start. If that is not possible, you should call Lincoln as soon as reasonably possible to do so. Lincoln will provide you with additional information regarding how to complete your claim.

If you elected truck driver long-term disability and were required to submit Proof of Good Health but your proof was not approved, you may submit an appeal in writing to Lincoln Financial Group. Contact Lincoln Financial Group for specific procedures regarding the appeal of a Proof of Good Health decision, including timing requirements. Submit your appeal via email at **EOIQuestions@lfg.co**. or by U.S. mail to:

Lincoln Financial Group
ATTN: Medical Underwriting
P.O. Box 2870
Omaha, NE 68103-2870

Once a claim has been filed, Lincoln will notify you of its decision on your claim within a reasonable period of time, but no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for up to two additional 30-day periods, provided that, prior to any extension period, you are notified in writing that an extension is necessary due to matters beyond Lincoln's control, those matters are identified, and you are given the date by which a decision will be rendered. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date your response is received. If your claim is approved, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and will include:

- Specific reasons for the decision
- Specific reference to the Plan provisions on which the decision is based
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by you to the Plan of health care professionals treating you and vocational professionals 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 (including a description of any contractual limitation period that applies and the date on which the contractual limitation period expires).

APPEALING A LONG-TERM DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for long-term disability benefits is denied and you would like to appeal, you must submit a written appeal to Lincoln within 180 days of the denial.

Your appeal will be conducted without regard to your initial determination by someone other than the party who decided your initial claim or a subordinate of the individual who decided your initial claim. No deference will be afforded to the initial determination. You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You have the right to request copies, free of charge, of all documents, records, or other information relevant to your claim. Lincoln will provide you with any new or additional evidence or rationale considered in connection with your claim sufficiently in advance of the appeals determination date to give you a reasonable opportunity to respond.

If your claim involves a medical judgment question, Lincoln will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, Lincoln will provide you with the identification of any medical expert whose advice was obtained in connection with your appeal. Lincoln will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if it is determined that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification of the denial that will include:

- The specific reasons for the adverse determination
- Reference to the specific Plan provisions on which the determination was based
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by you to Lincoln of health care professionals treating you and vocational professionals who evaluated you
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the benefit determination, 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.

My Mental Health Resources

You do not have to file a claim for My Mental Health Resources benefits. As long as you remain eligible, you may access the Lyra website or contact Lyra by phone at any time. However, if you have a question about your benefits, or disagree with the benefits provided, you may contact People Services at **800-421-1362** or file a claim by writing to the following address:

Mail Stop 3610–Benefits Total Rewards Team
Attn: Custodian of Records
508 SW 8th Street
Mail Stop #3610
Bentonville, Arkansas 72716-3610

Claims and appeals are determined under the time frames and requirements set out in the procedures for filing a claim for medical benefits, as described earlier in this chapter.

International business travel medical insurance

Claim forms are generally not required for 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 2025 *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 (2025 *Associate Benefits Book)* includes the following chapters:

- **Eligibility, enrollment, and effective dates**
- **Eligibility, enrollment, and effective dates for associates in Hawaii**
- **The medical plan**
- **The pharmacy benefit**
- **The dental plan**
- **The vision plan**
- **Associate assistance resources (excluding Help Now)**
- **COBRA**
- **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: **Mail Stop 3610–Plan Administrator** **Administrative Committee** **Associates' Health and Welfare Plan** **508 SW 8th Street** **Mail Stop #3610** **Bentonville, Arkansas 72716-3610** **NOTE:** You must send your request to the specific address above, including the mail stop. If your request is not sent to this address, receipt by the Plan Administrator will be delayed. Call **479-621-2058**
Answers to questions about the HIPAA Privacy Notice	Email your question to **AHWPrivacy@walmart.com**	Call People Services at **800-421-1362**
Answers to questions about Medicare prescription drug plans	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-insured medical benefits, including pharmacy*
- Medical insurance (including HMOs)**
- Self-insured dental benefits
- Vision insurance
- Self-insured employee assistance program (associate assistance resources, excluding Help Now)
- Self-insured short-term disability for full-time hourly associates
- 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-insured 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 discretion to delegate some or all of its fiduciary responsibility to a third party. The Plan Administrator has delegated fiduciary responsibility for determinations of claims for benefits and appeals under the self-funded benefit components to third-party administrators. For insured benefit components, insurers have fiduciary responsibility for determinations of claims for benefits and appeals. The **Claims and appeals** chapter in this SPD identifies the specific third party, including insurers that administer claims and appeals for the respective benefits.

The Plan Administrator (or its delegates, including third-party administrators and insurers deciding claims and appeals) has complete discretion to interpret and construe the provisions of the Plan, 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:
Mail Stop 3610–Plan Administrator
Administrative Committee
Associates' Health and Welfare Plan
508 SW 8th Street
Mail Stop #3610
Bentonville, Arkansas 72716-3610

Named Fiduciary (for self-funded medical, pharmacy, dental, and short-term disability benefits): For each of the self-funded component benefit programs, the applicable third-party administrator is a named fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the Plan.

Named Fiduciary (for insured medical, vision, company-paid life, optional associate life, optional dependent life, business travel accident, long-term disability, accident, AD&D, and critical illness insurance): For each of the insured component benefit programs, the applicable insurance company is a named fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the insurance contract.

Plan Trustee:
J. P. Morgan
4 New York Plaza, 15th Floor
New York, New York 10004-2413

Agent for Service of Legal Process:
Corporation Trust Company
1209 Orange Street Corporation Trust Center
Wilmington, Delaware 19801

Legal process may also be served on the Plan Administrator or Trustee.

Plan Year: January 1 through December 31

Plan funding

Walmart Inc. may fund Plan benefits out of its general assets or through contributions made to the Walmart Inc. Associates' Health and Welfare Trust. Contributions also may be required by associates, in an amount determined by Walmart Inc. in its sole discretion. All assets of the Plan, including associate contributions and any dividends or earnings of the Plan, shall be available to pay any benefits provided under the Plan or expenses of the Plan, including insurance premiums.

Plan amendment or termination

Walmart reserves the right within its sole discretion to amend or terminate any benefit or provision under the Plan, at any time and for any reason, as it relates to any current, past, or future participant or beneficiary under the Plan. The Plan may be amended only in accordance with the terms of the Wrap Document.

Neither the Plan nor the benefits described in this 2025 *Associate Benefits Book* can be orally amended. All oral statements and representations shall be without force or effect, even if such statements and representations are made by the Plan Administrator, a management associate of Walmart, a representative in the benefits call center, or a third-party administrator. In addition, any written representations from anyone, including any AI-generated material on any Walmart system, do not amend or modify the Plan. Only written statements relating to interpretation of current Plan terms by the Plan Administrator and amendments adopted in accordance with the terms of the Wrap Document shall bind the Plan.

Your rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified facilities, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You have the right to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this 2025 *Associate Benefits Book* and the documents governing the Plan on the rules governing your COBRA continuation coverage rights. (See the **COBRA** chapter for more information.)

You should be provided a certificate of creditable coverage, free of charge, from the Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage.

The Plan's medical benefit component does not have a 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**.

Use of associate and participant data

Information such as your address, email, phone number, dependent information, and other details you provide during an enrollment session will be used to enroll you in the Plan. Solely for purposes of effectively operating the Plan, including providing you with important information about your benefits, Walmart Inc. may share the information you provide during enrollment with the Plan or with the service providers to the Plan, as reasonably necessary and as permitted by law. See the **Walmart Associate Information Privacy Notice** for additional details.

The Plan may share data relating to your benefits among service providers to the Plan solely for the purposes of providing Plan benefits, as permitted by law. Walmart Inc., the Plan, or service providers to the Plan may contact you regarding your benefits at the email address or the personal phone number you provide.

HIPAA notice of privacy practices

This notice was updated May 15, 2023

THIS NOTICE APPLIES TO THE ASSOCIATES' MEDICAL PLAN (AMP), DENTAL PLAN, AND MY MENTAL HEALTH RESOURCES, 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 My Mental Health Resources 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 My Mental Health Resources.

HOW THE AMP, DENTAL PLAN, AND MY MENTAL HEALTH RESOURCES 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 My Mental Health Resources' 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 My Mental Health Resources, 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 My Mental Health Resources, 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:

Mail Stop 3610–Benefits Total Rewards Team
Attn: HIPAA Compliance Team
508 SW 8th Street
Mail Stop #3610
Bentonville, Arkansas 72716-3610

Email your questions to: **AHWPrivacy@walmart.com**
Telephone: **800-421-1362**

Medicare and your prescription drug coverage

Please read this notice about Medicare and your prescription drug coverage carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage under the Associates' Medical Plan (the AMP) and your prescription drug coverage option under Medicare. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium. For purposes of the *Associate Benefits Book*, any of the Medicare drug plans covered under this notice are considered Part D plans.
- The AMP has determined that the prescription drug coverage offered under all self-funded options of the AMP, is on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered creditable coverage. If you enroll in one of these options, you may keep your current coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

You should also know that if you are enrolled in an AMP option and drop or lose your AMP coverage and do not join a Medicare drug plan within 63 continuous days after your current AMP coverage ends, you may pay a higher premium (a penalty) to join the Medicare drug plan later.

Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may always be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following Medicare annual enrollment period beginning in October to join.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current coverage under the AMP will be affected. Plan guidelines restrict you from enrolling in the AMP if you are enrolled in a Medicare drug plan. If your dependent is enrolled in a Medicare drug plan and you are not, you are able to enroll in the AMP, but your dependent would not be eligible for coverage.

If you decide to join a Medicare drug plan and drop your coverage under the AMP, be aware that you and your dependents will be able to reenroll, but only during Annual Enrollment or due to an election change event, provided you are not still enrolled in a Medicare drug plan.

If you enroll in a Medicare drug plan and decide within 60 days to switch back to a plan option under the AMP, you will need to call People Services at **800-421-1362** to reenroll. See the **Eligibility, enrollment, and effective dates** chapter for further details.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR PRESCRIPTION DRUG COVERAGE

Contact People Services at **800-421-1362** for further information. Note:

- You will get this notice each year before the next period during which you can join a Medicare drug plan.
- If we make a plan change that affects your creditable coverage under the AMP, you will receive another notice.
- If you need a copy of this notice, you can request one at any time from People Services at **800-421-1362**.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is available through the *Medicare & You* handbook from Medicare. You may also be contacted directly by Medicare drug plans. You will get a copy of the handbook in the mail every year from Medicare.

For more information about Medicare prescription drug coverage:

- Visit **medicare.gov**.
- Call your State Health Insurance Program for personalized help. (See your copy of the *Medicare & You* handbook for its telephone number.)
- Call **800-MEDICARE** (**800-633-4227**). TTY users should call **877-486-2048**.

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

REMEMBER

Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage, and therefore, whether or not you are required to pay a higher premium (a penalty).

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from Walmart Inc., your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed on the following page, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial **877-KIDS NOW** or visit **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for the Plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Walmart Inc. Plan, the Plan must allow you and your dependents to enroll in the Plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **866-444-EBSA** (**3272**).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your state for more information on eligibility.

ALABAMA – Medicaid
Website: **http://myalhipp.com**
Phone: **855-692-5447**

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: **http://myakhipp.com**
Phone: **866-251-4861**
Email: **CustomerService@MyAKHIPP.com**
Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**

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

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

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

GEORGIA – Medicaid
GA HIPP website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: **678-564-1162**, press **1**
GA-CHIPRA website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: **678-564-1162**, press **2**

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: **https://www.in.gov/medicaid**
http://www.in.gov/fssa/dfr
Phone: **800-403-0864**
Member services phone: **800-457-4584**

IOWA MEDICAID AND CHIP (Hawki)
Medicaid website: **https://hhs.iowa.gov/programs/welcome-iowa-medicaid**
Medicaid phone: **800-338-8366**
Hawki website: **https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki**
Hawki phone: **800-257-8563**
HIPP website: **https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp**
HIPP phone: **888-346-9562**

KANSAS – Medicaid
Website: **http://www.kancare.ks.gov**
HIPP phone: **800-967-4660**

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: **855-459-6328**
Email: **KIHIPP.program@ky.gov**
KCHIP website: **https://kynect.ky.gov**
Phone: **877-524-4718**
Medicaid website: **https://chfs.ky.gov/agencies/dms**

LOUISIANA – Medicaid
Website: **www.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.mymaineconnection.gov/benefits/s/?language=en_US**
Phone: **800-442-6003** TTY: Maine relay **711**
Private health insurance premium webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: **800-977-6740** TTY: Maine relay **711**

MASSACHUSETTS – Medicaid and CHIP
Website: **http://www.mass.gov/masshealth/pa**
Phone: **800-862-4840** TTY: **711**
Email: **masspremassistance@accenture.com**

MINNESOTA – Medicaid
Website: **https://mn.gov/dhs/health-care-coverage**
Phone: **800-657-3739**

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**
Email: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**

NEW JERSEY – Medicaid and CHIP
Medicaid website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid
Phone: **800-356-1561**
CHIP premium assistance phone: **609-631-2392**
CHIP website: **http://www.njfamilycare.org/index.html**
CHIP phone: **800-701-0710** (TTY: **711**)

NEW YORK – Medicaid
Website: **https://www.health.ny.gov/health_care/medicaid**
Phone: **800-541-2831**

NORTH CAROLINA – Medicaid
Website: **https://medicaid.ncdhhs.gov**
Phone: **919-855-4100**

NORTH DAKOTA – Medicaid
Website: **https://www.hhs.nd.gov/healthcare**
Phone: **844-854-4825**

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

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

PENNSYLVANIA – Medicaid and CHIP
Website: **https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html**
Phone: **800-692-7462**
CHIP website: **https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx**
CHIP phone: **800-986-KIDS (5437)**

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: **https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**
Phone: **800-440-0493**

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: **https://medicaid.utah.gov/upp**
Email: **upp@utah.gov**
Phone: **877-543-7669**
Adult expansion website: **https://medicaid.utah.gov/expansion**
Utah Medicaid Buyout Program website:
https://medicaid.utah.gov/buyout-program
CHIP website: **https://chip.utah.gov**

VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program / Department of Vermont Health Access website:
https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: **800-250-8427**

VIRGINIA – Medicaid and CHIP
Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select**
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP phone: **800-432-5924**

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

WEST VIRGINIA – Medicaid and CHIP
Website: **https://dhhr.wv.gov/bms**
http://mywvhipp.com
Medicaid phone: **344-558-1700**
CHIP toll-free phone: **855-MyWVHIPP** (**855-699-8447**)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: **800-362-3002**

WYOMING – Medicaid
Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility**
Phone: **800-251-1269**

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/ebsa
866-444-EBSA (**3272**)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option **4**, Ext. **61565**

Valued Plan Participant

THE ASSOCIATES' HEALTH AND WELFARE PLAN (AHWP) RESPECTS THE DIGNITY OF EACH INDIVIDUAL WHO PARTICIPATES IN THE PLAN.

The Associates' Health and Welfare Plan (AHWP) does not discriminate on the basis of race, color, national origin, sex, age, or disability and strictly prohibits retaliation against any person making a complaint of discrimination. Additionally, we gladly provide our participants with language assistance, auxiliary aids and services at no cost. We value you as our participant and your satisfaction is important to us.

If you need such assistance or have concerns with your Plan services, please call the number on the back of your plan ID card. If you have any questions or concerns, please use one of the methods below so that we can better serve you.

For assistance, call the number on the back of your plan ID card.

To learn about or use our grievance process, contact People Services at 1-**800-421-1362**

To file a complaint of discrimination, contact the U.S. Department of Health and Human Services, Office of Civil Rights:

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

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

عربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-421-1362. رقم هاتف الصم والبكم.

ကြမာန်မာ (Burmese)
သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-800-421-1362. သုိ ေခၚဆိုပါ။

漢語廣東話 (Cantonese)
請指出您的語言。翻譯服務免費提供1-800-421-1362.

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید 1-800-421-1362.

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. 1-800-421-1362.

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-421-1362.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-421-1362. まで、お電話にてご連絡ください。

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-421-1362. 번으로 전화해 주십시오.

汉语普通话 (Mandarin)
请指出您的语言 翻译服务免费提供 1-800-421-1362.

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-421-1362.

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-421-1362.

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-421-1362. 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian)
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la -1-800-421-1362.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-421-1362.

Soomaali (Somali)
Tilmaan luuqadaada. Adeegyada turjubaanka, lacag la'aan ayaa laguugu siinayaa. 1-800-421-1362.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-421-1362.

Kiswahili (Swahili)
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-421-1362.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 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 • 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 distribution or loan from the Plan	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.
- Starting February 1, 2025, you can request withdrawals of up to $1,000 to assist you with emergency personal or family expenses (referred to as a limited emergency withdrawal), or up to $22,000 if you are impacted by a federally declared major disaster (referred to as a qualified disaster recovery withdrawal).

This is a summary of benefits offered under the Plan as of October 1, 2024 (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, 2023 and you are credited with 1,095 hours by December 15, 2024 (your first anniversary), then you will begin receiving matching contributions on January 1, 2025, with respect to any contributions you make to the Plan on or after that date.

If you are not credited with 1,000 hours of service during your first year, your eligibility for matching contributions will be determined based on hours credited during the Plan year, which runs from February 1 to January 31. You will be eligible to receive matching contributions on any contributions you make to the Plan on or after the February 1 that follows the Plan year in which you are credited with at least 1,000 hours of service. For example, if your date of hire is December 15, 2023, and you are credited with only 895 hours by December 15, 2024 (your first anniversary), but you work 1,095 hours during the February 1, 2024–January 31, 2025 Plan year, you will begin receiving matching contributions on February 1, 2025 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, 2023, and you leave Walmart on February 25, 2024, 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, 2024 (prior to your first anniversary date) and are not credited with 1,000 hours of service by your first anniversary date of December 15, 2024, 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. Only participants who contribute their own funds to the Plan will have those contributions matched by Walmart, subject to eligibility requirements outlined in the **Walmart's contributions to your Company Match Account** section.

It is your responsibility to review your paychecks to confirm that your election is implemented correctly. If you believe your election has not been implemented correctly, notify the Customer Service Center at **888-968-4015** in a timely manner so that corrective steps can be taken. Your notification will not be considered timely if it is made more than three months after the date you make your election.

Your Walmart 401(k) Plan accounts

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

- **Pretax Account:** This account holds your pretax contributions to the Plan (including your catch-up contributions, if any), as adjusted for earnings or losses on those contributions.
- **Roth Account:** This account holds your Roth contributions to the Plan (including your Roth catch-up contributions, if any), as adjusted for earnings or losses on those contributions. The Roth Account will also hold any amounts you elected to convert in an In-Plan Roth Conversion, to the extent those amounts were not otherwise distributable under the Plan at the time of conversion, as adjusted for earnings or losses.
- **Company Match Account:** This account holds Walmart's matching contributions, as adjusted for earnings or losses on those contributions.
- **Pretax Rollover Account:** This account holds any contributions (other than contributions from a designated Roth salary deferral account) that you rolled over to this Plan from another eligible retirement plan, as adjusted for earnings or losses on those contributions.
- **Roth Rollover Account:** This account holds any amounts you rolled over to this Plan from your designated Roth salary deferral account in another eligible retirement plan, as well as any amounts that you elected to convert in an In-Plan Roth Conversion, to the extent those amounts were otherwise distributable under the Plan at the time of conversion, as adjusted for earnings or losses.
- **Company Funded 401(k) Account:** This account holds the discretionary Walmart contributions to the Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.
- **Company Funded Profit Sharing Account:** This account holds the discretionary Walmart contributions to the Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.

Differences between these accounts are discussed in more detail throughout this summary.

Note that if you become an associate of Walmart or any subsidiary as the result of the acquisition of your prior employer, and you participated in your prior employer's 401(k) plan, you may have other accounts in this Plan that hold amounts you contributed to your prior employer's

plan. If you think this applies to you, you can obtain more information on your other accounts by calling the Customer Service Center at **888-968-4015**.

Making a rollover from a previous employer's plan or IRA

When you come to work for Walmart, you may have funds owed to you from a previous employer's retirement plan (including a 401(k) plan, a profit-sharing plan, a 403(b) plan of a tax-exempt employer or a 457(b) plan of a governmental employer). If so, you may be able to roll over that money to this Plan. You may also roll over pretax funds you have in an individual retirement account (IRA). You may generally roll over only pretax funds, but you may directly roll into the Plan amounts from a designated Roth salary deferral account in another qualified retirement plan. If you roll over funds to this Plan, keep these points in mind:

- Once you roll funds into the Walmart 401(k) Plan, those funds are subject to the rules of this Plan, including payout rules, and not the rules of your former employer's plan or your IRA
- Your rollover contribution will be placed in your Rollover Account or your Roth Rollover Account, as applicable, and will be 100% vested, and
- You may withdraw all or any portion of your rollover contributions at any time.

If you're interested in making a rollover contribution to the Plan, contact the Customer Service Center at **888-968-4015** or visit **benefits.ml.com** to obtain 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 as long as you do so within three years of the date you received the distribution (or by December 31, 2025 in the case of a qualified birth or adoption distribution received on or before December 29, 2022), and they will be considered part of your Rollover Account, subject to the rules above:

- A qualified birth or adoption distribution.
- A limited emergency withdrawal.
- A qualified disaster recovery withdrawal.

In addition, if you receive a hardship withdrawal for the purpose of purchasing or constructing your principal residence but are not able to use it for that purpose due to a federally declared major disaster, you generally may repay the withdrawal to the Plan within 180 days from the first day of the incident period (that is, the period specified by the Federal Emergency Management Administration (FEMA) as the period in which the disaster occurred).

For more information on these distributions, see the **Receiving a payout while working for Walmart** section below. If you're interested in recontributing all or part of your prior distribution to the Plan, contact the Customer Service Center at **888-968-4015** or visit **benefits.ml.com**.

Making contributions to your account

After you become a participant in the Plan, you may generally choose to contribute from 1% up to 50% of each paycheck to your Pretax Account and/or your Roth Account. Your contributions (including both pretax contributions and Roth contributions) in any calendar year, however, may not exceed a limit set by the IRS. For 2025, the limit is $23,500. 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, 2026, this limit is $350,000.

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 $79,000 or less (for 2025) or a single taxpayer with $39,500 or less (for 2025) 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 (except as noted below) and any pretax dollars you use for your pretax contributions or to purchase benefits available under the Walmart Inc. Associates' Health and Welfare Plan
- Overtime, paid time off (used and paid out), bereavement, jury duty, and premium pay
- Holiday bonuses
- Special recognition awards, such as the Outstanding Performance Award
- Differential wage payments you receive from Walmart while you are on a qualified military leave. This means that the contribution you have in effect when you go on the leave will continue to be applied to your differential wage payments while you are on the leave unless you change your election, and
- Transition pay designated as relating to a WARN Act event.

The percentage of pay you elect to contribute to the Plan will not be applied to the following types of pay:

- The 15% Walmart match on the Associate Stock Purchase Plan
- Reimbursement for expenses like relocation
- Welfare benefits
- Fringe benefits
- Allowances
- Approved disability pay
- A signing bonus paid to you for coming to work for Walmart
- Severance pay
- Deferred compensation and stock income, including income from stock options or restricted stock rights, or
- Upon your termination of employment, a final paycheck paid prior to the end of a normal pay cycle (unless it is administratively practicable to withhold your contribution from that paycheck).

CHANGING YOUR 401(K) CONTRIBUTION AMOUNT

You can increase, decrease, stop, or begin your contributions at any time by logging on to **One.Walmart.com** or **benefits.ml.com**. You may also call the Customer Service Center at **888-968-4015**. Your change will be effective as soon as administratively feasible, normally within two pay periods. If you change your contribution amount, a confirmation notice will be sent to your home address or, if you have chosen electronic delivery of Plan documents, you will receive an email notification when the confirmation is available. It is your responsibility to review your paychecks to confirm that your election is implemented correctly. If you believe your election has not been implemented correctly, notify the Customer Service Center at **888-968-4015** in a timely manner, so that corrective steps can be taken. Your notification will not be considered timely if it is more than three months after the date you make your election. If you do not notify the Customer Service Center in a timely manner, the amount that is being withheld from your paycheck will be treated as your deferral election.

IF YOU ARE AGE 50 OR OLDER (CATCH-UP CONTRIBUTIONS)

If you are age 50 or older (or will be age 50 by the end of the applicable calendar year) and you are contributing up to the Plan or legal limits, you are allowed to make additional contributions. 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 2025, your catch-up contributions may be any amount up to the lesser of $7,500 or 75% of your eligible annual pay. Your catch-up contributions (including both pretax catch-up contributions and Roth catch-up contributions) in any calendar year, however, may not exceed a limit set by the IRS. Beginning in 2025, if you turn age 60, 61, 62, or 63 by the end of the calendar year, you are able to make catch-up contributions of up to $11,250. These dollar amounts 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 are age 55 and you elect to contribute the maximum amount in the 2025 calendar year, which is the lesser of $23,500 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 2025 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 $23,500

for the 2025 calendar year, or $31,000 if you are eligible for catch-up contributions. (Beginning in 2025, the catch-up limit is higher for years in which you turn age 60, 61, 62, or 63, as described in the section above.) These amounts may be increased from time to time by the IRS. If you contribute to more than one plan during the year, it is your responsibility to determine if you have exceeded the legal limit.

If your total contributions go over the legal limit for a calendar year, you should request that the excess amount be refunded to you. The excess amount (except as noted below with respect to Roth contributions) must be included in your income for the year deferred and will be taxed. Earnings on the excess amount are taxable in the year refunded to you. In addition, if the excess amount is not refunded to you by April 15 following the year the amount was deferred, you will be taxed a second time when the excess amount is distributed to you. To request that excess contributions be returned to you from this Plan, contact the Customer Service Center at **888-968-4015** no later than April 1 following the calendar year in which the excess contributions were made. The Administrator will establish procedures for determining whether your pretax contributions or Roth contributions will be returned to you, if you contributed both types of contributions during the calendar year. To the extent excess amounts are distributed from your Roth contributions, the Roth contributions will not be taxable to you, but related earnings that are distributed will be taxable to you. Any matching contributions related to refunded contributions will be forfeited.

IF YOU HAVE QUALIFIED MILITARY SERVICE

If you miss work because of qualified military service, you may be entitled under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) to make up contributions you miss during your military service (that is, to make contributions equal to the amount you would have been eligible to make if you were working for Walmart). For more information, contact the Customer Service Center at **888-968-4015**.

Making an In-Plan Roth Conversion

You can choose to convert all or any part of the vested contributions in your account (other than Roth contributions and related earnings, and funds that are part of an outstanding loan balance) to Roth contributions through an "In-Plan Roth Conversion." The contributions you choose to convert, along with any earnings on those contributions through the date of the conversion, will be subject to applicable federal, state, and local taxes in the year of conversion. No taxes will be withheld at the time of conversion, however, so it will be up to you to ensure that you can pay the related taxes when due. Accordingly you may want to increase your payroll withholdings or make estimated tax payments. The amount converted is not subject to a 10% penalty. Once converted, the funds may not be converted back to pretax funds.

The rules applicable to your funds after conversion differ depending on whether the funds were eligible for distribution from the Plan at the time of the conversion.

- If the funds you convert were otherwise eligible for distribution (for instance, you are age 59½) and eligible for rollover, then the funds will be treated as though they were distributed from the Plan and then rolled back into the Plan. This means they will be credited to your Roth Rollover Account and may be withdrawn at any time.
- If the funds you convert were not eligible for distribution, they will be credited to your Roth Account and will remain subject to the same distribution rules after the conversion as they were before the conversion. For instance, if you elect to convert your pretax salary deferral contributions, those funds generally will not be eligible for distribution until you reach age 59½, incur a financial hardship, or terminate employment.

Walmart's contributions to your Company Match Account

Once you are eligible to receive matching contributions, Walmart will make matching contributions to your Company Match Account equal to 100% of your subsequent contributions (including pretax, Roth, and catch-up contributions) for the Plan year, up to 6% of your eligible annual pay for the Plan year. Matching contributions are not made with respect to contributions you make before you become eligible for matching contributions. After you become eligible for matching contributions, the company matching contribution will be made to your Company Match Account each pay period until you reach the full amount of the company matching contribution for which you are eligible for that Plan year. Your eligible annual pay for this purpose is the same as outlined above for determining your 401(k) contributions to the Plan, but does not include amounts paid to you before you become eligible to receive matching contributions.

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 ($23,500 for 2025) 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 $23,500 in 401(k) contributions in January of 2025, 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, 2025.

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 (see **Your Walmart 401(k) Plan accounts** earlier in this summary).

Investing your account

YOUR INVESTMENT OPTIONS

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

- **The *myRetirement* Funds.** The *myRetirement* Funds are a series of customized investment options created solely for Plan participants by the Benefits Investment Committee, and are commonly known as "target retirement date" funds. The *myRetirement* Funds are diversified investment options that automatically change their asset allocation over time to become more conservative as you get closer to retirement. This is done by shifting the amount of money invested in more aggressive investments, such as stocks, and allocating those amounts to more conservative investments, such as bonds, as you near retirement.
- **From among a menu of investment options made available under the Plan.** Note that Walmart stock is an investment option only for your Company Funded Profit Sharing Account. Walmart stock is not available for investment through any of your other Plan accounts (although to the extent these other accounts hold Walmart stock, you may always sell such shares, but no future purchases of Walmart stock are allowed).

You may choose one of the investment options or you may spread your money among the various investment options. The investment gains or losses on your accounts depend on the performance of the investments you choose.

If you do not make an investment choice for current contributions to your account, they will be invested in one of the *myRetirement* Funds based on your age. For more information, refer to the Qualified Default Investment Alternative (QDIA) notice and the Investment Guide. These documents can be obtained by going to **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

Because the Company Funded Profit Sharing Account is an Employee Stock Ownership Plan, all or a significant portion of Walmart's profit-sharing contribution was invested in Walmart stock for Plan years ending prior to January 31, 2006. If you were a participant in the Plan prior to that date, you may have Walmart stock in your

Company Funded Profit Sharing Account. For Plan years ending January 31, 2007 or later, Walmart's profit-sharing contribution was not invested in Walmart stock.

A description of all investment options, including the *myRetirement* Funds, is included in the enrollment packet you receive when you are eligible to enroll. You also may obtain additional information for each investment option by reviewing the Annual Participant Fee Disclosure Notice and Investment Guide. You may obtain these documents free of charge 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.
- To assist with limited emergency expenses.
- If you are impacted by a federally declared major disaster.
- After you reach age 59½.
- In connection with the birth or adoption of your child.
- Rollovers can be withdrawn at any time.
- You may request a loan from your Plan account.

You can request any of these withdrawals online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

It's important to understand how any type of payout or loan from the Walmart 401(k) Plan affects your tax situation. For more information, see **The income tax consequences of a payout** later in this summary.

Note that if you become an associate of Walmart or any subsidiary as the result of the acquisition of your prior employer, and you participated in your prior employer's 401(k) plan and that plan was merged into this Plan, you may have other withdrawal options with respect to amounts from your prior employer's plan. For more information regarding withdrawal options available for your other accounts, call the Customer Service Center at **888-968-4015**.

FINANCIAL HARDSHIP WITHDRAWALS

You may withdraw some or all of your vested Plan accounts as necessary to meet a "financial hardship." You will be required to certify that you have insufficient cash or other liquid assets to satisfy the need.

Under IRS guidelines, a financial hardship may exist if the request is for:

- Payment of medical care expenses not covered by insurance for you, your spouse, your dependents, or your affirmatively designated primary beneficiary
- Costs directly related to the purchase of your primary residence
- Payment of tuition, fees, and room and board expenses for up to the next 12 months of post-high school education for you, your spouse, your dependents, or your affirmatively designated primary beneficiary
- Payments necessary to prevent eviction from, or foreclosure on, your primary residence
- Payment for burial or funeral expenses for your deceased parent, spouse, children, dependent, or your affirmatively designated primary beneficiary, or
- Expenses for the repair of damage to your principal residence that would qualify for a casualty deduction under federal income tax rules (determined without regard to whether the casualty was a federally declared disaster and whether the loss exceeds 10% of your adjusted gross income).
- Expenses and losses (including loss of income) incurred by you on account of a federally declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, provided your principal residence or principal place of employment at the time of the disaster was in an area designated for individual assistance with respect to disaster.

Federal tax law requires that you must have already obtained all in-service payouts available (including in-service withdrawals of rollover contributions and withdrawals after age 59½) before you can request a financial hardship payout. Pursuant to the terms of the Plan, you must have also obtained any available limited emergency withdrawal before you can request a financial hardship payout. Also, please note that if you request a financial hardship payout within five business days of the record date of a dividend and you are entitled to elect a cash payout of that dividend, the dividend will automatically be distributed to you in cash.

Note that if you take a hardship withdrawal to purchase or construct your principal residence in a federally declared disaster area, but you are not able to do so because of the disaster, you may be able to repay the withdrawal to the Plan and avoid taxation. For this to apply, you must have taken the withdrawal during the period from 180 days before the "incident period" through 30 days after the end of the incident period, and you generally must repay the withdrawal to the Plan within 180 days from the first day of the incident period. The incident period is the period specified by the Federal Emergency Management Administration (FEMA) as the period in which the disaster occurred. If you think this may apply to you, you should contact the Customer Service Center at **888-968-4015** for more information.

LIMITED EMERGENCY WITHDRAWALS

Beginning February 1, 2025, you may request a withdrawal from your vested account of up to $1,000 (or, if less, the vested amount in your account in excess of $1,000) for any

unforeseeable emergency or immediate financial need relating to necessary personal or family emergency expenses. You are required to make a representation to the Plan that your request is for this purpose. You can request one withdrawal per calendar year and cannot request another in the following three calendar years, unless you timely repay the full withdrawal amount to the Plan or, since your withdrawal, you have made 401(k) contributions at least equal to the withdrawal amount. If you want to repay your withdrawal, you must do so within three years of the date you receive it.

QUALIFIED DISASTER RECOVERY WITHDRAWALS

Beginning February 1, 2025, you may request a withdrawal from your vested account of up to $22,000 if your principal residence is in a federally declared disaster area and you sustain an economic loss due to the disaster, such as damage to your home or expenses you incur because you cannot live in your home. (Note that this $22,000 limit applies, in the aggregate, to all withdrawals you receive from all plans and IRAs that you own.) Your distribution generally must be taken within 180 days after the first day of the "incident period" (the period specified by FEMA as the period in which the disaster occurred). You will be required to make a representation to the Plan that you are eligible for this withdrawal. If you want to repay your withdrawal, you must do so within three years of the date you receive it.

WITHDRAWALS AFTER YOU REACH AGE 59½

Any time after you reach age 59½, you may elect to withdraw all or any portion of your Plan accounts, to the extent vested, even though you are still working for Walmart.

WITHDRAWALS RELATED TO THE BIRTH OR ADOPTION OF YOUR CHILD

You may request a withdrawal of up to $5,000 from the vested portion of your Plan account within one year of the birth or adoption of your child. In the case of adoption, the adoptee must be under the age of 18 or physically or mentally incapable of self-support, and must not be the child of your spouse. You are required to make a representation to the Plan that the withdrawal is related to the birth or adoption of your child. If you want to repay your withdrawal, you must do so within three years of the date you receive it, or by December 31, 2025 in the case of a qualified birth or adoption distribution received on or before December 29, 2022.

NOTE: Your distribution will not be considered a qualified birth or adoption distribution unless you include the name, age, and taxpayer identification number of the child or adoptee on your federal income tax return for the year in which the distribution is made.

WITHDRAWALS OF ROLLOVER CONTRIBUTIONS

You may withdraw all or any portion of your Pretax Rollover Account, Roth Rollover Account, and your Profit Sharing Rollover Account at any time even if you are still working for Walmart or its subsidiaries.

PLAN LOANS

You may apply for a loan from the vested portion of your Plan account while you are still working for Walmart. The Administrator has established a written loan program explaining the Plan's loan requirements in detail. You can request a copy of the loan program or make a request for a loan online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

Generally, the rules for loans include the following:

- The maximum loan amount is limited by IRS rules, which generally limit your total loan balances to the lesser of (1) 50% of the total of your vested Plan account, or (2) $50,000 (reduced by the excess, if any, of your highest outstanding loan balance during the one-year period prior to the date of the loan over your current outstanding balance of loans). The minimum loan amount is $1,000.
- All loans must be secured by a pledge of up to one-half of your vested Plan account.
- A fee will be charged to process your loan application. Additional fees may be 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.

Note that beginning February 1, 2025, if your principal residence is in a federally declared disaster area and you sustain an economic loss due to the disaster, you may be eligible for the following loan relief:

- If you take a loan within 180 days after the first date of the "incident period" (the period specified by FEMA as the period in which the disaster occurred), the maximum loan amount increases to the lesser of 1) 100% of the total of your vested Plan account, or 2) $100,000 (reduced by the excess, if any, of your highest outstanding loan balance during the one-year period prior to the date of the loan over your current outstanding balance of loans).
- You may delay repayment of any loan payments due during the period beginning on the first day of the incident period through 180 days after the end of the incident period for up to one year. Your payments after the delay will be adjusted to reflect the deferred payments and any interest accruing during the delay.

NOTE: As the Plan only allows one general purpose loan and one residential loan outstanding at any time, if you already have a loan outstanding, you may not take another loan of that type, even if you are impacted by a federally declared disaster.

When you are on an authorized unpaid leave of absence, you may be excused from making scheduled loan repayments for a period of up to one year. If you have an outstanding loan when you are called to qualified military service, special rules under USERRA may apply. Call the Customer Service Center at **888-968-4015** for more details.

If you die: your designated beneficiary

In the event of your death, your entire Plan balance will be paid out to your beneficiary. It is very important for you to keep your beneficiary information up to date to ensure that your beneficiary under the Plan reflects your current intent. 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, or are on a leave of absence, 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.

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, 2024, you may elect your payout on or after August 18, 2024.

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, 2024, your payout will automatically be made to you as soon as possible after October 31, 2024, or
- **If you are over age 72½, regardless of the amount of your total vested Plan balance.** This automatic payout will be made as soon as possible after the last business day of the second calendar month following the calendar month in which you turn age 72½, unless you consent to an earlier payout as described above. For instance, if you turn age 72½ in July 2024 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, 2024, according to Plan provisions.

If your total vested Plan balance is more than $1,000 and you are under age 72½, you must consent to payout of all or any portion of your account. Payout will be made as soon as possible after the Customer Service Center receives your consent, but no earlier than 30 calendar days after your termination is entered into the payroll system.

If your total vested Plan balance is more than $1,000, you can choose to delay some or all of your payout until any date up to age 72½, but your Plan balance will be subject to an annual maintenance fee and possibly other expenses. For information regarding these charges, refer to the Annual Participant Fee Disclosure Notice. If you choose to delay your payout, you will be able to continue to make changes in your investment choices just as you did while you were an active participant in the Plan.

If you return to work with Walmart before your payout is completed, the payout will be canceled and no payout will be made from your account.

THE AMOUNT OF YOUR PAYOUT

The entire value of your Pretax Account, your Roth Account, your Company Funded 401(k) Account, your Rollover Accounts, and the Company Match Account will be available to be paid out to you. In addition, if you have a Company Funded Profit Sharing Account (see **Your Walmart 401(k) Plan accounts** earlier in this summary), the vested portion of your Company Funded Profit Sharing Account will also be available for payout to you. You will forfeit (give up) the nonvested portion of your Company Funded Profit Sharing Account, as explained in the **Vesting in your company funded profit sharing account** section earlier in this summary.

The amount you will receive will be based on the value of your accounts as of the date the payout is processed. If a cash payout is made directly to you rather than rolled over to an IRA or other employer plan, applicable taxes will be withheld from your check.

A check processing fee will be applied to your Plan balance when it is paid out to you.

HOW YOU RECEIVE YOUR PAYOUT

You have several options for receiving your payout.

Your accounts will normally be paid to you in cash. However, you may elect to have your Company Funded Profit Sharing Account and Profit Sharing Rollover Account (even if those amounts have been converted to your Roth Account or Roth Rollover Account) distributed to you in the form of Walmart stock (even if it is not invested in Walmart stock at the time your payout is processed) or partly in cash and partly in Walmart stock. (Only whole shares of Walmart stock will be distributed; partial shares will be distributed in cash.) You may also elect to have your Pretax Account, your Company Funded 401(k) Account, and your Rollover Accounts (even if those amounts have been converted to your Roth Account or Roth Rollover Account) paid to you in Walmart stock to the extent those accounts are invested in Walmart stock at the time your payout is processed. Any part of those accounts not invested in Walmart stock at the time of your payout will be distributed in cash.

If the total of your vested accounts is $1,000 or less, or if you are over age 72½ (regardless of the amount of your vested accounts), your payout will be made directly to you in a single cash payout. If you wish to take any of your payout in the form of Walmart stock or if you wish to roll over your payout to an IRA or other employer plan, you must contact the Customer Service Center at **888-968-4015** with your payout instructions within the time period shown in your payout notice. If you fail to contact the Customer Service Center in a timely manner, your payout will be made in a single cash payment to you.

If the total of your vested accounts in the Plan is more than $1,000, your payout will not be made until you make an election regarding the form of payout and consent to the distribution, or until you reach age 72½. You can choose to take all or any portion of your vested account. (Note, however, that if you take a partial payout of your account and the amount remaining in your account drops to $1,000 or less, it will be cashed-out as explained above.) To obtain your payout, contact the Customer Service Center at **888-968-4015**.

Your accounts normally will be distributed directly to you, unless you elect to roll them over to an IRA or to another employer's retirement plan.

NOTE: If your vested account cannot be paid to you because you cannot be found, the Administrator will make a diligent attempt to locate you. If you still cannot be found, your vested account will be forfeited. If you are later found, your account will be reinstated but you will not receive any earnings for the period after forfeiture. (This also applies if you die and your beneficiary cannot be located.) Thus, it is important that you make sure you update your contact information if there is a change.

If you leave and are rehired by Walmart

If you leave Walmart and its subsidiaries and are later rehired as an eligible associate, you will be immediately eligible to make your own contributions to the Plan on your date of rehire.

If you leave Walmart and its subsidiaries after you became eligible to receive matching contributions and are later rehired by Walmart, you will automatically be eligible to receive matching contributions on your rehire date. Similarly, if you leave Walmart and its subsidiaries after you have met the 1,000-hour requirement for matching contribution eligibility but before your actual participation date, you will be eligible to receive matching contributions beginning on the later of the date you would have initially become a participant or your rehire date (with respect to contributions you make after that date). 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 normally can postpone paying taxes on your payout if you direct the Plan to issue your payout directly to an IRA or to another employer's qualified retirement plan, a 403(b) plan, or a governmental 457 plan. This is called a direct rollover. (The check will be made payable to the IRA or other plan trustee and will be delivered to you or your IRA or rollover institution. If the check is mailed to you, you will be responsible for delivering it to the IRA or other plan trustee within 60 days.)

If you elect this method for your payout, no taxes will be withheld from the amount you are rolling over. It will not be taxed until you later receive a payout from the IRA or other plan.

If your payout is eligible for rollover and you do not elect to have your payout directly rolled over, federal law requires that Walmart withhold 20% of the payout for federal taxes, in addition to any required state withholding. In some cases, 20% withholding may not be enough, which could mean that you will owe additional taxes when you file your income tax return.

If your payout is eligible for rollover and you do not elect a direct rollover (and instead receive an actual payout from the Plan), you may still roll over those funds to an IRA or an employer's qualified retirement plan, 403(b) plan, or governmental 457 plan, as long as you do so within 60 calendar days after you received the distribution. The amount rolled over will not be subject to federal income tax until you take it out of the IRA or other plan. If you want to roll over 100% of your payout to an IRA or other plan, however, you will have to use other money to replace the 20% that was withheld from your payout. If you roll over only the 80% that you received, you will be taxed on the 20% that was withheld.

Note that not all payouts from the Plan are eligible for rollover to an IRA or other eligible retirement plan. For instance, financial hardship withdrawals, payouts on account of the birth or adoption of your child, limited emergency withdrawals, and qualified disaster recovery withdrawals are not eligible for rollover. More information on the taxation of these payouts is provided below.

NOTE: You may roll over all or any portion of your account that is eligible for rollover to a Roth IRA. Any amount rolled over that would have been taxable if not rolled over will be taxable at the time of the rollover to the Roth IRA. (Note that you may voluntarily choose to have taxes withheld from amounts at the time you roll over to a Roth IRA.)

For more information regarding these rollover rules, review the **Special tax notice addendum** that follows. Retain this addendum for review when you are eligible to take a distribution.

TAXATION OF PAYOUTS OF ROTH CONTRIBUTIONS

Your Roth contributions and earnings on those contributions are not taxed when distributed from the Plan as long as the distribution is a "qualified" distribution. A "qualified" distribution is a distribution that is made: (1) on account of your death, disability, or after you attain age 59½, and (2) after you have completed a five-year participation period. The five-year participation period is the five-year period beginning with the first calendar year in which you first make a Roth contribution to the Plan (or to another 401(k) plan or 403(b) plan, if such amount was rolled over to this Plan) and ending on the last day of the fourth calendar year thereafter. For instance, if you make your first Roth contribution in July 2021, your five-year participation period will end on December 31, 2025. 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 payouts on account of death, disability, retirement after age 55, payouts for certain medical expenses, payouts related to the birth or adoption of your child, limited emergency withdrawals, and qualified disaster recovery withdrawals. Special rules also apply to distributions made to reservists who are called to active military duty.

TAXATION OF PAYOUTS OF WALMART STOCK

There are also special rules for distributions of Walmart common stock. If you receive cash (in excess of $200) in addition to Walmart stock and the cash is not directly rolled over, some withholding may apply, but the withheld amount will not be greater than the amount of cash you receive.

Generally, if you receive Walmart common stock as part of 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 pursuant to a QDRO (e.g., state-ordered child support) may result in federal income taxation to the participant even though the payout is made to or on behalf of the dependent alternate payee.

TAXATION OF FINANCIAL HARDSHIP WITHDRAWALS

A financial hardship payout (other than Roth contributions and, if the payout is a qualified distribution, earnings on your Roth contributions) is immediately taxable to you, including the 10% early withdrawal penalty unless you are eligible for an exemption. You may not roll over the distribution and Walmart is not required to withhold 20%, but the distribution will be subject to 10% withholding, unless you elect a different withholding rate.

TAXATION OF LIMITED EMERGENCY WITHDRAWALS

If you receive a limited emergency withdrawal from the Plan, the distribution is immediately taxable to you (other than Roth contributions and, if the payout is a qualified distribution, earnings on your Roth contributions), but is not subject to the 10% early withdrawal penalty. You may not roll over the distribution and Walmart is not required to withhold 20%, but the distribution will be subject to 10% withholding, unless you elect a different withholding rate.

TAXATION OF QUALIFIED DISASTER RECOVERY WITHDRAWALS

If you receive a distribution related to a federally declared major disaster, the distribution amount is taxable to you over a three-year period, beginning with the year in which the distribution is received, unless you elect to have the entire distribution taxed in the year you receive it. You may not roll over the distribution and Walmart is not required to withhold 20%, but the distribution will be subject to 10% withholding, unless you elect a different withholding rate. The distribution is not subject to the 10% early withdrawal penalty.

TAXATION OF LOANS

Under current tax law, loans made from the Plan, regardless of their purpose, are not considered taxable income to the participant unless a default occurs. If you default on a loan from the Plan (as discussed above), your tax statement will show the amount of income to report for the year of the default. You may also be subject to 10% early withdrawal penalty.

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 the distribution will be subject to 10% withholding unless you elect a different rate.

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.

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 Total Rewards, 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 Total Rewards/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 and Chief People Officer. Neither the Plan nor the benefits described in this summary may be orally amended. All oral statements and representations have no force or effect, even if the statements and representations are made by a management associate of Walmart or a participating subsidiary, by the Administrator, by any member of the Benefits Investment Committee or by Merrill Lynch.

You may obtain a copy of the formal Plan document by writing to:

Walmart Inc.
Attn: Benefits Compliance
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 may be entitled to recover the mistaken payout from the recipient by either reducing his or her Plan account or future payouts due to the recipient, or may demand that the recipient promptly repay the Plan.

STATEMENT OF ERISA RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the ERISA Plan Administrator's office and at other specified facilities, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the ERISA Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The ERISA Plan Administrator may make a reasonable charge for the copies. Your request must be mailed to:

  Walmart Inc. — ERISA Section 104(b) Request
  Attn: Benefits Compliance
  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.

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
- Hardship distributions
- Payments of employee stock ownership plan (ESOP) dividends
- Corrective distributions of contributions that exceed tax law limitations
- Withdrawals related to the birth or adoption of your child
- Limited emergency withdrawals
- Qualified disaster recovery withdrawals
- 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 to alternate payees under a qualified domestic relations order (QDRO)
- Payments made while you are terminally ill
- 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
- Payments of up to $1,000 for purposes of meeting limited emergency expenses
- Payments of up to $10,000 to a domestic abuse victim within one year of the date on which the individual becomes a victim
- Payments of up to $22,000 made in connection with federally declared 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 73.

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 73.

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
- Hardship distributions
- Payments of employee stock ownership plan (ESOP) dividends
- Corrective distributions of contributions that exceed tax law limitations
- Withdrawals related to the birth or adoption of your child
- Limited emergency withdrawals
- Qualified disaster recovery withdrawals
- 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 to alternate payees under a qualified domestic relations order (QDRO)
- Payments made while you are terminally ill
- 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

- Payments of up to $1,000 for purposes of meeting limited emergency expenses
- Payments of up to $10,000 to a domestic abuse victim within one year of the date on which the individual becomes a victim
- Payments of up to $22,000 made in connection with 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 73.

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 $26,000 withheld from your biweekly paycheck to buy stock (for a maximum annual payroll deduction amount of $26,000). Walmart matches $0.15 for every dollar that you contribute through payroll deduction to purchase stock, up to the first $1,800 you contribute to the Plan in each Plan year (April through March).

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Enroll in the Plan or change your deduction amount	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 **One.Walmart.com/StockApp** 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 $26,000 can be withheld from your paycheck to buy stock (up to a maximum annual payroll deduction of $26,000).

Walmart contributes to your stock purchase account by matching $0.15 for every $1 you contribute to the Plan through payroll deductions, up to your first $1,800 you contribute each Plan year. The Plan year runs from April through March. The company match is reflected as income on your check stub and on your Form W-2.

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 placed when the stock market is open are executed immediately after they are placed. The price at which your order will be executed is not guaranteed, and the Walmart stock price prior to the execution of your order is not necessarily the price at which your order will be executed.

Generally, any sales of your stock will be executed over the 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, **One.Walmart.com/StockApp** (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 **One.Walmart.com/StockApp**.

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, **One.Walmart.com/StockApp** (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.

115,694,815 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, 2024

Introduction and overview

The Plan is an amendment and restatement of the Wal-Mart Stores, Inc. 2004 Associate Stock Purchase Plan which had previously amended and restated the Wal-Mart Stores, Inc. Associate Stock Purchase Plan of 1996. The Plan was most recently approved by the shareholders of Walmart at our Annual Shareholders' Meeting held on June 3, 2016. As of August 31, 2024, up to 115,694,815 shares of the Company's common stock, par value $.10 per share (the "Stock"), were available for purchase from the Company or on the open market under the Plan; 60,000,000 shares of Stock were available for purchase from the Company under the Plan; and 90,000,000 shares of Stock were available for purchase on the open market under the Plan. On November 30, 2018, 150,000,000 shares (as adjusted to reflect the Company's 3-for-1 forward stock split effective February 23, 2024) were registered with the United States SEC for offer and sale on Registration Statements on Form S-8. Shares of the Stock are listed for trading on the 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 $26,000 per biweekly payroll period (for a maximum annual payroll deduction amount of $26,000). The amount of any biweekly deduction in excess of the minimum must be in $1 increments. The Company or your Participating Employer will make a matching cash contribution on your behalf to your Plan account when you make contributions to the Plan by payroll deduction. The matching contribution is currently fifteen percent (15%) of the first $1,800 you contribute to the Plan by payroll deduction, or up to $270 per Plan year. The Company's matching contribution will be used to buy Stock for your Plan account.

If you 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, 2024;
- The Company's Quarterly Reports on Form 10-Q for the fiscal quarters ended April 30, 2024, July 31, 2024, and October 31, 2024;
- The Company's Current Reports on Form 8-K filed with the Commission on August 15, 2024;
- The Company's definitive Proxy Statement for the 2024 Annual Shareholders' Meeting, filed with the Commission on April 25, 2024; 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/Pharmacy**	OptumRx: **844-705-7493**
Health savings account (HSA) for associates enrolled in the Saver Plan	**Learn.HealthEquity.com/Walmart/HSA** **One.Walmart.com/Saver**	HealthEquity: **866-296-2860**
Centers of Excellence	**One.Walmart.com/COE** Contigo Health (hip and knee replacement, spine surgery, weight loss surgery) HealthSCOPE (cancer medical record review, fertility travel, heart surgery e-review, transplants)	BlueAdvantage: **866-823-3790** Aetna: **800-525-6257** UMR: **855-870-9177** Mercy Arkansas Local Plan: **800-804-1272** Banner Local Plan: **855-548-2387** Contigo Health: **877-230-7037** HealthSCOPE Benefits: **800-804-1289** **479-621-2830** (transplants)
Digestive health program: All states except Hawaii	**One.Walmart.com/Cylinder**	Cylinder: **833-336-9488** *(Or call the number on your plan ID card)*
Digital physical therapy program: All states except Hawaii	**One.Walmart.com/OmadaHealth**	*(See 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, CO, CT, DC, HI, MA, NJ, NY, OR, RI, WA: For more information about state plans, see the **Full-time hourly short-term disability** chapter	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**
Associate assistance resources	Help Now: **One.Walmart.com/HelpNow** My Mental Health Resources: **One.Walmart.com/HelpNow**	**855-4HLPNOW** (**855-445-7669**) Mon.–Fri. 7 a.m.–7 p.m. CT **800-825-3555**, available 24/7
AiRCare: Personalized support for well-being	**One.Walmart.com/AiRCare**	**866-307-2081**
Family building support	**One.Walmart.com/FamilyBuilding** **One.Walmart.com/LifeWithBaby**	Call your health plan administrator at the number on your plan ID card
Quit Tobacco	**One.Walmart.com/QuitTobacco**	Kick Buts: **855-955-1905** Available Mon.–Fri. 9 a.m.–6 p.m. CT
myAgileLife	**One.Walmart.com/HealthyLiving** **One.Walmart.com/Diabetes**	MyAgileLife: **855-955-1905**, Mon.–Fri. 9 a.m.–6 p.m. CT
Twin Health: Diabetes and metabolic management	**Connect.TwinHealth.com/Walmart** *After Jan. 2025*	**888-99-TWINHEALTH** or **888-998-9464** *After Jan. 2025*
Walmart 401(k) Plan	**Benefits.ML.com** **One.Walmart.com/401k**	Merrill: **888-968-4015**
Associate Stock Purchase Plan	**ComputerShare.com/Walmart** **One.Walmart.com/ASPP**	ComputerShare: **800-438-6278** Associates who are hard of hearing: **800-925-9245**

Find a doctor and get medical plan help

Your contact information for medical plan help depends on two things:

- Where you work, or in some cases which plan you're enrolled in.
- Which plan administrator serves your area. You'll find yours on the back of your plan ID card.

LOCATION OR PLAN	PLAN ADMINISTRATOR	FIND A DOCTOR	CLAIMS, CUSTOMER SERVICE, CARE MANAGEMENT
Premier, Contribution, Saver	BlueAdvantage Aetna UMR	Aetna, BlueAdvantage, and UMR (through Included Health): **800-941-1384** **IncludedHealth.com/Walmart** Virtual primary care doctor: **One.Walmart.com/VirtualPrimaryCare**	BlueAdvantage: **866-823-3790** Aetna: **855-548-2387** UMR: **855-870-9177**
Mercy Arkansas Local Plan	UMR	Included Health: **800-941-1384** **IncludedHealth.com/Walmart** Virtual primary care doctor: **One.Walmart.com/VirtualPrimaryCare**	UMR: **800-804-1272**
Banner Local Plan	Aetna	Included Health: **800-941-1384** **IncludedHealth.com/Walmart** 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	Included Health: **800-941-1384** **IncludedHealth.com/Walmart** 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
Health Net	**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	**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**

2025 Associate Benefits Book | Summary Plan Descriptions

Libro de beneficios para asociados de 2025

Descripción resumida del plan

Contenido

Vigente a partir del **1.º de enero de 2025**

Plan 401(k) de Walmart vigente a partir del **1.º de febrero de 2025**

Plan de compra de acciones para asociados vigente a partir del **1.º de abril de 2025**

Versión 1.0 | Dic. 2024

Le presentamos su Libro de beneficios para asociados de 2025

Aquí encontrará descripciones resumidas del Plan de salud y bienestar de los asociados (el Plan) y el Plan 401(k) de Walmart.

Aquí también se incluye el folleto del Plan de compra de acciones para asociados.

Consulte el índice para obtener una lista completa de lo que podrá encontrar en este libro. Es un excelente recurso para ayudarlo a comprender sus beneficios.

Mucha información. Muy fácil de encontrar.

Cuando descarga el *Libro de beneficios para asociados de 2025* desde **One.Walmart.com**, tendrá respuestas a sus preguntas sobre los beneficios al alcance de su mano.

Simplemente abra el PDF con Adobe Reader y haga clic en “Edit” (Editar) en la barra de herramientas. Luego, haga clic en “Find” (Buscar) e ingrese una palabra o frase que describa lo que está buscando “preventivo” o “copago”. ¡Fácil!

Índice

Plan de salud y bienestar de los asociados

La información que obtenga por medio de las comunicaciones con Walmart Inc. o cualquier proveedor de servicios del Plan no anula ninguna disposición o limitación del Plan. La información proporcionada o las declaraciones realizadas a través de cualquier forma de comunicación no garantizan el pago de beneficios. Además, los precios de los beneficios informados por teléfono se basan en la información que se proporciona al momento de la llamada. Si se descubre información relevante adicional, puede afectar el pago de su reclamación. Todos los beneficios están sujetos a elegibilidad, pago de primas, limitaciones y todas las excepciones descritas en los documentos del plan correspondiente, incluso toda póliza de seguro. Puede solicitar una copia de los documentos que rigen estos planes escribiendo a: Mail Stop 3610–Benefits Total Rewards Team, Custodian of Records, 508 SW 8th Street, Bentonville, Arkansas 72716-3610.

Atención Asociados Hispanos: Este folleto contiene un resumen en inglés de los derechos y beneficios para todos losasociados bajo el plan de beneficios de Walmart. Si Ud. tienedificultades para entender cualquier parte de este folleto puede dirigirse a la siguiente dirección: Mail Stop 3610–Benefits Total Rewards Team, Custodian of Records, 508 SW 8th Street, Bentonville, Arkansas 72716-3610.

O puede llamar si tiene preguntas al 800-421-1362. Contamos con asociados que hablan español y pueden ayudarlo a comprender sus beneficios de Walmart. El Libro de beneficios para asociados está disponible en español. Si desea una copia en español, hable con su representante de Personal.

Elegibilidad, inscripción y fechas de vigencia

Si usted (y/o sus dependientes) tienen Medicare o son elegibles para tener Medicare en los próximos 12 meses, una ley federal le da más opciones sobre la cobertura de medicamentos recetados. Para obtener más información, consulte la página 4 del capítulo **Información legal**.

Elegibilidad, inscripción y fechas de vigencia

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
• Inscripción en los beneficios de Walmart • Notificación a Servicios al Personal dentro de un plazo de 60 días de un evento de cambio de elección	Visite **One.Walmart.com/Enroll**	Llame a Servicios al Personal al **800-421-1362.**
Comuníquese con Servicios al Personal si tiene alguna pregunta sobre las deducciones de la nómina para sus beneficios		Llame a Servicios al Personal al **800-421-1362.**
Pago de las primas para los beneficios mientras está haciendo uso de una licencia de ausencia		Consulte la sección **Mantener las primas al día** en este capítulo para obtener información detallada. Si no paga sus primas para mantener la cobertura actualizada, la cancelación de la cobertura será retroactiva a la última fecha en la que se pagaron las primas. Puede pagar con tarjeta de débito o crédito Visa, MasterCard, American Express o Discover ingresando en **One.Walmart.com/Enroll** y eligiendo "make a payment" (realizar un pago), o llamando al **800-421-1362** y diciendo luego "make a payment" (realizar un pago). También puede enviar un cheque o un giro postal pagaderos al Fondo de Salud y Bienestar para Asociados a: **Walmart People Services** **P.O. Box 1039** **Department 3001** **Lowell, Arkansas 72745** Para garantizar la acreditación oportuna del pago, incluya su número de identificación de Walmart (WIN) y la ubicación de su trabajo en el cheque. Si no puede realizar los pagos de su prima, el Plan aceptará los pagos que otra persona realice en su nombre.

Lo que debe saber sobre la elegibilidad, la inscripción y las fechas de vigencia

- Si es asociado pagado por hora de Hawái:
  - **Discapacidad médica y a corto plazo y pago de primas durante una licencia:** consulte el capítulo titulado **Elegibilidad, inscripción y fechas de vigencia para los asociados en Hawái**.
  - **Beneficios que no sean los médicos y por discapacidad a corto plazo:** consulte este capítulo.
- Su clasificación profesional determina para qué beneficios puede ser elegible y cuándo puede hacerlo por primera vez. Cuando reúna los requisitos para inscribirse por primera vez, tendrá un "periodo de inscripción inicial". En sus comunicaciones de inscripción se le indicará cuándo finaliza su periodo de inscripción inicial. Asegúrese de inscribirse antes de la fecha de vencimiento. Consulte la sección **Inscripción y fechas efectivas por clasificación laboral** de este capítulo para obtener detalles adicionales.
- Si no se inscribe durante el periodo de inscripción inicial:
  - **Seguro médico, dental, de la visión, discapacidad a corto plazo mejorada, discapacidad a largo plazo, enfermedad grave, accidente o muerte accidental y desmembramiento (AD&D):** no tendrá otra oportunidad de inscribirse hasta la Inscripción Anual o después de que surja un evento de cambio de elección.
  - **Discapacidad a largo plazo para conductores de camión:**
    - No tendrá otra oportunidad de inscribirse hasta la Inscripción Anual o después de que surja un evento de cambio de elección
    - Tendrá que presentar un Certificado de buena salud si elige la cobertura más adelante.
  - **Beneficios opcionales del seguro de vida: si se inscribe posteriormente, deberá presentar un Certificado de buena salud para el seguro de vida opcional del asociado o cónyuge.**
- La transferencia de una clasificación de empleo a otra puede afectar su elegibilidad para los beneficios, que incluye los beneficios para los que es elegible y cuándo. Consulte la sección **Si cambia su clasificación laboral** de este capítulo para obtener detalles importantes.

Plan de salud y bienestar para asociados

Walmart Inc. (Walmart) patrocina el Plan de salud y bienestar de los asociados (el Plan), que es un plan integral de beneficios para los empleados que ofrece beneficios médicos, dentales, de la visión, recursos para los asociados, de discapacidad, seguro de vida, seguro de accidentes en viajes de negocios, seguro de accidentes, seguro de muerte accidental y desmembramiento y seguro de enfermedad grave para los asociados y familiares elegibles. La elegibilidad para estos beneficios se describe en este capítulo, y los términos y condiciones de los beneficios específicos que se ofrecen conforme a este Plan se describen en los capítulos correspondientes de este *Libro de beneficios para asociados* de 2025. Queda automáticamente inscrito para recibir ciertos beneficios conforme al Plan a partir de la fecha de su contratación o una fecha posterior. Sin embargo, para recibir otros beneficios, debe inscribirse para tener cobertura. Para obtener detalles sobre su elegibilidad, consulte la sección **Elegibilidad del asociado** de este capítulo; para obtener información sobre la elegibilidad de los dependientes, incluyendo los miembros de la familia que pueden inscribirse para la cobertura, consulte la sección **Elegibilidad de los dependientes** de este capítulo y para obtener detalles sobre los periodos de inscripción inicial y cuando la cobertura es efectiva para todos los beneficios disponibles bajo el Plan, la sección **Inscripción y fechas efectivas por clasificación laboral** de este capítulo.

La elegibilidad para los beneficios y los términos y condiciones de cada beneficio se describen en el documento del Plan, las pólizas de seguro que rigen los beneficios asegurados y en este *Libro de beneficios para asociados* de 2025. En la medida en que cualquier información proporcionada a usted a través de otras fuentes, ya sea verbal o escrita, incluido cualquier material generado por IA o la respuesta de un administrador externo a una solicitud de información, entre en conflicto con el documento del Plan, las pólizas de seguro o este *Libro de beneficios para asociados* de 2025, los términos del documento del Plan, las pólizas de seguro o el *Libro de beneficios para asociados* de 2025 prevalecerán. En caso de conflicto entre una póliza de seguro que rija los beneficios asegurados y el documento del Plan o el presente *Libro de beneficios para asociados* de 2025, prevalecerán los términos de la póliza de seguro. En caso de conflicto entre los términos del documento del Plan y este *Libro de beneficios para asociados* de 2025, prevalecerán los términos del documento del Plan. Consulte el capítulo **Información legal** de este *Libro de beneficios para asociados* si desea revisar el documento del Plan, el cual detalla su derecho a revisar el Documento del Plan.

Si no está de acuerdo con una decisión relativa a su elegibilidad o a su afiliación, o con una decisión sobre una reclamación de beneficios, el Plan dispone de un procedimiento específico que debe seguir para apelar la decisión. Consulte el capítulo **Reclamaciones y apelaciones** para obtener una descripción detallada del proceso de apelación. Si no sigue el proceso de reclamaciones y apelaciones del Plan, su capacidad para impugnar una decisión puede verse afectada negativamente.

Resumen general del capítulo

Este capítulo contiene mucha información útil que será importante para usted no solo cuando sea elegible para los beneficios por primera vez, sino durante todo el tiempo que mantenga su empleo con Walmart. En algunos casos, la información contenida en este capítulo y en otros capítulos del *Libro de beneficios para asociados* será relevante incluso después de que haya dejado de trabajar (por ejemplo, si elige continuar con la cobertura conforme a la ley COBRA). Contiene toda la información que necesita sobre los beneficios para los que es elegible, cuándo es elegible, qué dependientes puede cubrir, cuándo puede inscribirse en esos beneficios o cambiarlos, cuándo entra en vigencia la cobertura, cómo se pagan las primas, la repercusión de ciertos eventos en su elegibilidad para los beneficios y cuándo termina su cobertura.

> **NOTA:** Tenga en cuenta que los hechos de su situación individual determinarán las respuestas a sus preguntas específicas y pueden requerir la aplicación de más de una regla en cualquier sección particular de este capítulo. Es importante revisar todo el capítulo para comprender totalmente sus beneficios en lugar de una sola sección en forma individual.

Es posible que necesite consultar la información de este capítulo en diferentes momentos, dependiendo de su situación en particular. Para ayudarle a centrarse en la información que le resultará más útil en un momento determinado, le presentamos un resumen que le permitirá orientarse en la dirección correcta:

1	**SU CLASIFICACIÓN LABORAL** Su clasificación laboral en el sistema de nóminas de Walmart afecta sus beneficios. Consulte la página 7.
2	**SER ELEGIBLE PARA LOS BENEFICIOS** • ¿A quién puede cubrir? Consulte la página 19. • ¿Para qué beneficios es elegible? Consulte la página 24. • ¿Cuándo debe inscribirse? Consulte la página 24. • ¿Cuándo entra en vigencia su cobertura? Consulte la página 24.
3	**PAGO DE LOS BENEFICIOS** ¿Cómo debe pagar los beneficios? Consulte la página 34. ¿Cuándo tiene que hacer arreglos especiales para pagar sus beneficios? Consulte la página 36.
4	**EVENTOS QUE PUEDEN AFECTAR SU COBERTURA** ¿Qué puede afectar sus beneficios? • Si se toma una licencia de ausencia: consulte la página 37. • Un acontecimiento de la vida, como un cambio en su situación familiar: consulte la página 40. • Circunstancias especiales como una orden judicial o la posibilidad de acogerse a un periodo de inscripción especial: consulte la página 41.

Elegibilidad del asociado

Su clasificación laboral en el sistema de nóminas de Walmart determina los beneficios a los que se puede inscribir. El momento en que puede seleccionar los beneficios depende de una serie de factores, que pueden incluir su fecha de contratación, el promedio de horas semanales y si se ha transferido de una clasificación laboral a otra. Si su clasificación requiere una cantidad determinada de horas semanales promedio a fin de que sea elegible para el beneficio, ese promedio se indicará en la siguiente sección. Las horas trabajadas se determinan sobre una base retrospectiva, tal como se describe en las siguientes secciones. Asimismo, para algunos beneficios, es posible que tenga que satisfacer un periodo de espera de elegibilidad o presentar Certificado de buena salud antes de que entren en vigencia los beneficios en los que se inscribió.

Esta sección aborda los requisitos generales de elegibilidad aplicables a una clasificación específica. En la sección **Inscripción y fechas efectivas por clasificación laboral** de este capítulo encontrará una lista de los beneficios para los que es elegible con base en su clasificación laboral y los requisitos de periodo de espera o Certificado de buena salud que pueden aplicarse.

> **NOTA:** Si pasa de una clasificación laboral a otra, las reglas que se exponen en esta sección podrían verse afectadas por ese cambio, por lo que deberá consultar la sección **Cambio de una clasificación laboral a otra** más adelante en este capítulo.

Walmart espera que proporcione información correcta y precisa cuando solicite o se inscriba en los beneficios. Si no lo hace, puede estar sujeto a la pérdida de beneficios, incluida la cancelación retroactiva de la cobertura según lo permita la ley, y/o al despido. Asimismo, algunas aseguradoras de beneficios asegurados pueden reservarse el derecho, hasta dos años después de que entre en vigencia su cobertura, de reexaminar las declaraciones que haya hecho durante el proceso de solicitud. Si se verifica que se declararon hechos relevantes de forma inexacta, esto puede afectar la elegibilidad para el beneficio.

Consulte el Código de Conducta, que puede encontrar en **One.Walmart.com** para revisar la política de Walmart sobre la deshonestidad intencionada. Para obtener información sobre los documentos que se le pueden solicitar para verificar la elegibilidad de los dependientes, consulte la sección **Documentación legal para la cobertura de los dependientes** más adelante en este capítulo.

ELEGIBILIDAD DEL ASOCIADO PAGADO POR HORA A TIEMPO COMPLETO

Para poder inscribirse en los beneficios para asociados pagados por hora a tiempo completo, debe estar clasificado en el sistema de nóminas de Walmart como asociado pagado por hora a tiempo completo. Esto incluye a los farmacéuticos pagados por hora a tiempo completo (excepto los farmacéuticos pagados por hora a tiempo completo de California), los asociados de la cadena de suministro de campo por hora a tiempo completo y los supervisores de campo por hora a tiempo completo en tiendas y clubes, pero excluye a los gerentes del Centro de visión por hora a tiempo completo.

CLASIFICACIÓN LABORAL PARA DETERMINAR LAS OPCIONES A BENEFICIOS	INCLUYE
Asociado pagado por hora a tiempo completo	• Asociados pagado por hora a tiempo completo, excepto gerentes de Centros de visión por hora a tiempo completo • Farmacéuticos pagados por hora a tiempo completo, excepto farmacéuticos de California • Asociados de la cadena de suministro de campo pagado por hora a tiempo completo • Supervisores de campo pagado por hora a tiempo completo dentro de las tiendas y los clubes • Los asociados pagados por hora a tiempo completo en Hawái, a excepción de los beneficios médicos y de discapacidad a corto plazo
Gerente del Centro de visión pagado por hora a tiempo completo	• Gerentes del Centro de visión por hora a tiempo completo
Asociados pagados por hora temporales o a tiempo parcial	• Asociados pagados por hora a tiempo parcial (excepto los conductores de camión a tiempo parcial) • Asociados temporales
Conductor de camión a tiempo parcial	• Asociados conductores de camión a tiempo parcial
Asociados gerenciales o asalariados	• Asociados asalariados • Gerentes en formación • Farmacéuticos de California pagados por hora a tiempo completo • Asociados conductores de camión a tiempo completo

Los farmacéuticos de California pagados por hora a tiempo completo son elegibles para los beneficios en las mismas condiciones que los asociados gerenciales. Si usted es gerente pagado por hora a tiempo completo de un Centro de visión, vea la siguiente información.

Si es un asociado pagado por hora a tiempo completo en Hawái, consulte el capítulo titulado **Elegibilidad, inscripción y fechas de vigencia para los asociados en Hawái** para conocer las normas especiales de elegibilidad para los beneficios médicos y de discapacidad a corto plazo.

ELEGIBILIDAD DEL GERENTE DEL CENTRO DE VISIÓN PAGADO POR HORA A TIEMPO COMPLETO

Para poder inscribirse en los beneficios como gerente de un Centro de visión pagado por hora a tiempo completo, debe estar clasificado en el sistema de nóminas de Walmart como gerente de Centro de visión pagado por hora a tiempo completo.

ELEGIBILIDAD DEL ASOCIADO A TIEMPO PARCIAL PAGADO POR HORA

Para poder inscribirse en los beneficios para asociados pagados por hora a tiempo parcial, debe estar clasificado en el sistema de nóminas de Walmart como asociado pagado por hora a tiempo parcial. Si es conductor de camión que trabaja a tiempo parcial, vea la siguiente información.

Además de estar clasificado en el sistema de nóminas de Walmart como asociado pagado por hora a tiempo parcial, para poder inscribirse en los beneficios médicos, debe trabajar un promedio de al menos 30 horas semanales, con las siguientes excepciones:

- Los farmacéuticos a tiempo parcial pagados por hora contratados antes del 1 de febrero de 2012 no necesitan trabajar una cantidad mínima de horas a la semana.
- Los farmacéuticos a tiempo parcial pagados por hora contratados a partir del 1 de febrero de 2012 deben trabajar un promedio de al menos 24 horas por semana.
- Los asociados pagados por hora a tiempo parcial en la cadena de suministro de campo deben trabajar un promedio de al menos 24 horas a la semana.
- Los asociados pagados por hora a tiempo parcial en Hawái están sujetos a diferentes normas de elegibilidad para los beneficios médicos y de discapacidad a corto plazo. Para más detalles, consulte el capítulo titulado **Elegibilidad, inscripción y fechas de vigencia para los asociados en Hawái**.

Si es asociado pagado por hora a tiempo parcial, se revisarán las horas que trabaja para determinar su elegibilidad para los beneficios médicos. Si es elegible para los beneficios médicos durante las primeras 52 semanas de trabajo, también será elegible para otros beneficios voluntarios al mismo tiempo. De lo contrario, será elegible para otros beneficios voluntarios después de haber estado empleado durante 52 semanas, independientemente de si es elegible para los beneficios médicos. Consulte la sección **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** de este capítulo para más información.

ELEGIBILIDAD DE LOS ASOCIADOS TEMPORALES

Para poder inscribirse en los beneficios del asociado temporal, debe estar clasificado en el sistema de nóminas de Walmart como asociado temporal. Si está clasificado como asociado temporal, está sujeto a las normas de elegibilidad descritas en esta sección, independientemente de si trabaja a tiempo completo o parcial, o de si desempeña un puesto por hora o gerencial.

Además de estar clasificado en el sistema de nóminas de Walmart como asociado temporal, para poder inscribirse en los beneficios médicos, debe trabajar un promedio de al menos 30 horas semanales, con las siguientes excepciones:

- Los asociados pagados por hora temporales de la cadena de suministro de campo deben trabajar un promedio de al menos 24 horas por semana.
- Los asociados temporales en Hawái están sujetos a reglas diferentes. Para más detalles, consulte el capítulo titulado **Elegibilidad, inscripción y fechas de vigencia para los asociados en Hawái**.

Si usted es asociado temporal, se revisarán las horas que trabaja para determinar su elegibilidad para los beneficios médicos. Si es elegible para los beneficios médicos durante las primeras 52 semanas de trabajo, también será elegible para otros beneficios voluntarios al mismo tiempo. En caso contrario, será elegible para recibir otros beneficios voluntarios después de haber estado empleado durante 52 semanas, independientemente de que sea elegible para los beneficios médicos, según las condiciones del Plan. Para más información, consulte la sección titulada **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos**.

ELEGIBILIDAD DE LOS CONDUCTORES DE CAMIÓN A TIEMPO PARCIAL

Para poder inscribirse en los beneficios para conductores de camión a tiempo parcial, debe estar clasificado en el sistema de nóminas de la compañía como conductor de camión a tiempo parcial. No es necesario que trabaje una cantidad mínima de horas a la semana para poder inscribirse en los beneficios médicos como conductor de camión a tiempo parcial.

ELEGIBILIDAD DE LOS ASOCIADOS GERENCIALES (INCLUIDOS LOS CONDUCTORES DE CAMIÓN A TIEMPO COMPLETO)

Para poder inscribirse en los beneficios como asociado gerencial o asalariado, debe estar clasificado en el sistema de nóminas de Walmart como asociado gerencial, gerente en formación, farmacéutico de California pagado por hora a tiempo completo o conductor de camión a tiempo completo.

PERSONAS QUE NO SON ELEGIBLES

A menos que se indique lo contrario, usted no reúne los requisitos para el Plan si se encuentra en alguna de las siguientes categorías, incluso si resulta reclasificado por un tribunal, el IRS o el Departamento de Trabajo como empleado conforme a las normas del derecho consuetudinario de Walmart o de cualquier filial participante:

- Empleado contratado
- Extranjero no residente (a excepción de que, a los fines del seguro de vida opcional para asociados, el seguro de vida opcional para dependientes, el seguro de muerte y discapacidad accidental y el seguro de accidentes en viajes de negocios, serán elegibles los extranjeros no residentes clasificados “a tiempo completo” en el sistema de nóminas de los EE. UU., y los extranjeros no residentes cubiertos por una póliza de seguro específica para expatriados o nacionales de países terceros que estén empleados por Walmart serán elegibles para los beneficios que se detallan en esas pólizas, sujeto a los términos de las pólizas)
- Contratista independiente
- Asesor
- Un asociado que resida fuera de los Estados Unidos, a excepción de los asociados cubiertos por una póliza de seguro específica para expatriados, tendrán derecho a los beneficios descritos en tales pólizas, sujetos a los términos correspondientes.
- Persona que no está clasificada como asociado de Walmart ni de sus filiales participantes
- Asociado que está inscrito en un plan Medicare de medicamentos recetados (solo aplicable a la elegibilidad para opciones de planes de seguro médico y beneficios de farmacia, incluidas las opciones de planes HMO y PPO), o
- Asociado cubierto por un acuerdo de negociación colectiva, en la medida en que el acuerdo no prevea la participación en un beneficio ofrecido por el Plan.

INFORMACIÓN SOBRE LA ELEGIBILIDAD PARA OTRAS CATEGORÍAS DE ASOCIADOS

Asociados que se inscriben en los beneficios médicos a través de una opción de plan HMO o PPO: Hay opciones médicas del plan HMO y PPO disponibles para algunos lugares de trabajo. Las pólizas y los materiales de inscripción para las opciones de los planes HMO y PPO pueden describir diferentes requisitos de elegibilidad y periodos de espera en comparación con los que se describen en este capítulo. Si llegara a haber alguna diferencia entre los términos de elegibilidad de la opción del Plan para una HMO o PPO y los términos de elegibilidad aplicables a la cobertura médica del Plan tal y como se describe en este capítulo, los términos de elegibilidad de este capítulo prevalecerán.

Asimismo, algunas HMO requieren que los participantes acepten las condiciones de arbitraje, cuando esté permitido por ley, antes de que la cobertura de la HMO entre en vigencia. Si hay una HMO disponible en su zona y usted se inscribe, la HMO debe recibir su acuerdo dentro de un plazo de 60 días a partir de su inscripción inicial o su cobertura HMO no entrará en vigencia. Si la HMO no recibe su acuerdo dentro de un plazo de 60 días, no tendrá cobertura médica bajo el Plan médico para asociados (AMP) y no podrá volver a inscribirse hasta el siguiente periodo de Inscripción anual o hasta que tenga un evento de cambio de elección válido, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.

Asociados de Hawái: Si usted es un asociado a tiempo completo pagado por hora, a tiempo parcial pagado por hora o temporal en Hawái, existen normas especiales que rigen la elegibilidad y la inscripción de los beneficios médicos y de discapacidad a corto plazo. Consulte el capítulo titulado **Elegibilidad, inscripción y fechas de vigencia para los asociados en Hawái**. Si es asociado gerencial en Hawái, las condiciones de elegibilidad e inscripción que se describen en este capítulo **Elegibilidad, inscripción y fechas de vigencia** se aplican a todos los beneficios.

Asociados localizados: si Walmart ha aprobado su condición de localizado, usted y sus dependientes residentes en los Estados Unidos son elegibles para los mismos beneficios del Plan que los asociados que son ciudadanos estadounidenses que residen y trabajan en los Estados Unidos.

No es necesario obtener un número de Seguro Social para inscribirse en los beneficios del Plan. Se anula cualquier periodo de espera. Usted no es elegible para la cobertura del Plan como expatriado. Si usted es asociado localizado y un dependiente que reúne los requisitos reside fuera de los Estados Unidos, las reclamaciones médicas se procesarán como reclamaciones de la red, independientemente del estado de la red del proveedor, y se pagarán a la tasa de copago o coseguro aplicable para los cargos de la red, sujeto a las limitaciones y exclusiones aplicables según el Plan. En ese caso, usted o sus dependientes inscritos deben presentar una reclamación de reembolso según los procedimientos de reclamación del Plan.

Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos

NOTA: Las normas que se exponen a continuación podrían verse afectadas por la transferencia de un puesto de trabajo a otro o por la finalización del empleo y la reincorporación a otro puesto. Debe revisar la sección **Cambio de una clasificación laboral a otra** más adelante en este capítulo para obtener más información si:

- Se transfiere de una clasificación laboral a otra, o
- Ha cesado en su empleo cuando era asociado pagado por hora a tiempo parcial y vuelve a ser contratado menos de 13 semanas después de la fecha de cese del empleo en una clasificación laboral diferente, en cuyo caso se le tratará como si nunca hubiera cesado para los fines de determinar la elegibilidad y las fechas de vigencia.

Si es asociado temporal o a tiempo parcial pagado por hora, su elegibilidad para inscribirse en los beneficios médicos dependerá del promedio de horas que trabaje por semana. Las horas trabajadas se determinan sobre una base retrospectiva, tal como se describe en las siguientes secciones. Esta sección detalla descripciones de tres tipos diferentes de verificaciones de elegibilidad que se llevan a cabo para determinar la elegibilidad inicial y continua de los beneficios médicos y otros beneficios voluntarios para los asociados temporales y a tiempo parcial pagados por hora.

- **Durante las primeras 52 semanas de trabajo:** Para determinar el derecho a la cobertura de los beneficios médicos y otros beneficios voluntarios, las horas se miden cada 60 días durante sus primeras 52 semanas de empleo. Consulte **Sus verificaciones de elegibilidad de 60 días durante sus primeras 52 semanas de empleo** en esta sección.
- **A las 52 semanas de trabajo:** Para determinar el derecho a los beneficios médicos, las horas trabajadas a lo largo de las primeras 52 semanas consecutivas de empleo se miden una sola vez, al final de las 52 semanas. Consulte **Verificación única de elegibilidad a las 52 semanas de trabajo** en esta sección.
- **Después de un año de trabajo: Para determinar el derecho a los beneficios médicos en el siguiente año calendario, las** horas trabajadas durante un periodo de 52 semanas se miden cada año. Consulte **Su verificación anual de elegibilidad** en esta sección.

Use la herramienta de elegibilidad por horas (EBH) en OneWalmart.com/EBH para verificar sus horas para el periodo de medición actual.

NOTA: Las verificaciones de elegibilidad descritas en esta sección no se aplican a los asociados a tiempo parcial pagados por hora ni asociados temporales en Hawái. Para obtener más información, consulte el capítulo titulado **Elegibilidad, inscripción y fechas de vigencia para los asociados en Hawái**.

SUS VERIFICACIONES DE ELEGIBILIDAD DE 60 DÍAS DURANTE SUS PRIMERAS 52 SEMANAS DE EMPLEO EN ESTA SECCIÓN

Si es un nuevo asociado pagado por hora temporal o a tiempo parcial, la cantidad de horas que trabaje en los primeros 59 días de su empleo, a partir de su fecha de contratación, se contarán el 60.º día de empleo para determinar si ha trabajado la cantidad de horas requerida, que se expresa como un número promedio por semana durante ese periodo de medición a fin de ser elegible para los beneficios médicos y otros beneficios voluntarios. Consulte a continuación la cantidad de horas que necesita.

Si está registrado como asociado pagado por hora a tiempo parcial o temporal* en el sistema de Walmart y es:	**Debe trabajar esta cantidad de horas en un periodo de medición durante sus primeras 52 semanas de empleo:**
• Un farmacéutico pagado por hora contratado a partir del 1 de febrero de 2012**. • Parte de la cadena de suministro de campo	Un promedio de 24 horas por semana
Todos los demás asociados pagados por hora a tiempo parcial y temporales	Un promedio de 30 horas por semana

*Asociados pagados por hora a tiempo parcial en Hawái: consultar el capítulo titulado **Elegibilidad, inscripción y fechas de vigencia para los asociados en Hawái** para obtener más detalles.

**Los farmacéuticos pagados por hora a tiempo parcial contratados antes del 1 de febrero de 2012 no tienen requisito de horas.

Si trabaja la cantidad de horas requerida durante sus primeros 59 días de empleo sin una interrupción de más de 30 días durante el periodo de medición, será elegible para inscribirse en los beneficios médicos y otros beneficios voluntarios que están disponibles para los asociados pagados por hora a tiempo parcial y temporales poco después de que finalice el periodo de medición. Si es elegible, sus beneficios entrarán en vigencia el primer día del mes en el que cumple 89 días de trabajo, suponiendo que se inscriba antes de que finalice el periodo de inscripción inicial. Si trabaja la cantidad de horas requerida en este periodo de medición de 59 días, sus horas no se volverán a medir durante sus primeras 52 semanas de empleo, incluso si no se inscribe en los beneficios durante su periodo de inscripción inicial. La próxima vez que se verifique su derecho a los beneficios médicos será la verificación anual de la elegibilidad que se describe en **Su verificación anual de elegibilidad** en esta sección.

EJEMPLO: Si su fecha de contratación es el 16 de abril de 2025, sus horas trabajadas desde ese día hasta el 13 de junio de 2025 se calcularán el 60º día de empleo, que es el 14 de junio, para determinar si ha trabajado la cantidad de horas requerida durante ese periodo de medición de 59 días. Si trabaja la cantidad de horas requerida durante este primer periodo de medición y no tiene una interrupción en el empleo de más de 30 días durante el periodo de medición, podrá inscribirse en los beneficios que están disponibles para los asociados pagados por hora a tiempo parcial y temporales. Si satisface los requisitos, sus beneficios entrarán en vigencia el primer día del mes en el que cumple 89 días de trabajo, suponiendo que se inscriba antes de que finalice el periodo de inscripción inicial. Dado que su día 89 de trabajo sería el 13 de julio, sus beneficios entrarán en vigencia el 1.º de julio, suponiendo que se inscriba antes de que finalice su periodo de inscripción inicial. No se le volverán a medir las horas durante sus primeras 52 semanas de trabajo, incluso si no se inscribe durante el periodo de inscripción inicial. La próxima vez que se verifique su derecho a los beneficios médicos será la verificación anual de la elegibilidad que se describe en **Su verificación anual de elegibilidad** en esta sección.

Si no trabaja la cantidad de horas requerida durante sus primeros 59 días de empleo, sus horas se medirán durante los siguientes 60 días de empleo, siendo el primer día de este segundo periodo de medición su 60.º día de empleo. Si trabaja la cantidad de horas requerida durante este segundo periodo de medición sin una interrupción en el empleo de más de 30 días durante el periodo de medición, podrá inscribirse en los beneficios médicos y otros beneficios voluntarios que están disponibles para los asociados pagados por hora a tiempo parcial y temporales. Si satisface los requisitos, sus beneficios entrarán en vigencia el primer día del mes en el que cumple 89 días de trabajo, medido a partir del primer día del periodo de medición aplicable (en este caso, el segundo periodo de medición), suponiendo que se inscriba antes de que finalice el periodo de inscripción inicial. No se le volverán a medir las horas durante sus primeras 52 semanas de trabajo, incluso si no se inscribe en los beneficios durante el periodo de inscripción inicial. La próxima vez que se verifique su derecho a los beneficios médicos será la verificación anual de la elegibilidad que se describe en **Su verificación anual de elegibilidad** en esta sección.

EJEMPLO: Si su fecha de contratación es el 16 de abril de 2025, las horas que haya trabajado desde ese día hasta el 13 de junio de 2025 se calcularán el 60.º día de trabajo, el 14 de junio. Si no trabaja la cantidad de horas requerida durante este periodo de medición de 59 días, el siguiente periodo de medición será el del periodo de 60 días que va del 14 de junio al 12 de agosto. Las horas que trabaje durante este periodo de medición de 60 días se medirán el 13 de agosto. Si trabaja la cantidad de horas requerida durante este segundo periodo de medición y no tiene una interrupción en el empleo de más de 30 días durante el periodo de medición, podrá inscribirse en los beneficios disponibles para los asociados pagados por hora a tiempo parcial y temporales, que entrarían en vigencia el primer día del mes en el que cumple 89 días de trabajo, contado a partir del primer día del segundo periodo de medición, suponiendo que se inscriba antes de que finalice su periodo de inscripción inicial. Dado que el día 89 de trabajo, a partir del 14 de junio, sería el 10 de septiembre, sus beneficios entrarían en vigencia el 1.º de septiembre, suponiendo que se inscriba antes de que finalice su periodo de inscripción inicial. No se le volverán a medir las horas durante sus primeras 52 semanas de trabajo, incluso si no se inscribe durante el periodo de inscripción inicial. La próxima vez que se verifique su derecho a los beneficios médicos será la verificación anual de la elegibilidad que se describe en **Su verificación anual de elegibilidad** en esta sección.

Si no trabaja la cantidad de horas requerida durante el segundo periodo de medición, estas verificaciones de elegibilidad de 60 días continuarán durante cada periodo de medición de 60 días posterior, siendo el primer día del tercer periodo de medición el día siguiente al último día de su segundo periodo de medición, y así sucesivamente. Las verificaciones de elegibilidad de 60 días continuarán hasta la primera de las fechas en que se determine que ha trabajado la cantidad de horas requerida durante cualquier periodo de medición de 60 días o la fecha en que haya estado empleado durante 52 semanas. Si no trabaja la cantidad de horas requerida en cualquier periodo de medición durante sus primeras 52 semanas de empleo, sus horas se verificarán a las 52 semanas para determinar si ha trabajado las horas requeridas a lo largo de sus primeras 52 semanas de empleo. Esta verificación única de elegibilidad se describe en **Verificación única de elegibilidad a las 52 semanas de trabajo** en esta sección. Habrá un máximo de 6 verificaciones de elegibilidad de 60 días durante sus primeras 52 semanas de empleo.

Si es elegible para los beneficios durante sus primeras 52 semanas de empleo como resultado de haber trabajado la cantidad de horas requerida en un periodo de medición de 60 días, su elegibilidad para los beneficios médicos continúa hasta el final del segundo año calendario siguiente a la fecha en que haya satisfecho los requisitos de elegibilidad (el "periodo de elegibilidad para la cobertura médica"), suponiendo que siga siendo un asociado temporal o un asociado pagado por hora a tiempo parcial. En el ejemplo anterior, el periodo de elegibilidad de la cobertura médica continuaría hasta el final del año calendario 2026, que es el final del segundo año calendario siguiente a su fecha de contratación en la fecha en que haya satisfecho los requisitos de elegibilidad. Su elegibilidad para los demás beneficios voluntarios que se describen en la sección **Inscripción y fechas efectivas por clasificación laboral** continuará mientras siga siendo asociado temporal o asociado pagado por hora a tiempo parcial, sujeto a los términos del Plan que sean aplicables. No obstante, si no se inscribe en los beneficios médicos cuando reúna los requisitos por primera vez y antes de que finalice el periodo de inscripción inicial, no se le permitirá inscribirse en los beneficios médicos durante el resto de su periodo de elegibilidad de cobertura médica, excepto durante un periodo de Inscripción anual, o si surge un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** más adelante en este capítulo. Asimismo, si no se inscribe en la mayoría de los beneficios voluntarios (a excepción del seguro de vida opcional) durante el periodo de inscripción inicial, tampoco se le permitirá inscribirse a menos que lo haga durante un periodo de Inscripción anual, o si surge un evento de cambio de elección. Una vez que tenga derecho a los beneficios voluntarios, podrá inscribirse en el seguro de vida opcional en cualquier momento. La próxima vez que se verifique su derecho a los beneficios médicos será la verificación anual de la elegibilidad que se describe en **Su verificación anual de elegibilidad** en esta sección.

EJEMPLO: En los ejemplos anteriores, sus beneficios médicos continuarán hasta finales de 2027, a menos que abandone la cobertura durante el periodo de Inscripción anual de 2025 (para el año calendario 2026), o el periodo de Inscripción anual de 2026 (para el año calendario 2027), o si surge un evento de cambio de elección. Si no elige la cobertura médica durante el periodo de inscripción inicial, seguirá teniendo elegibilidad para los beneficios médicos hasta 2027. No obstante, no se le permitirá cambiar de elección e inscribirse en la cobertura médica excepto durante un periodo de Inscripción anual o si surge un evento de cambio de elección. Su elegibilidad para los demás beneficios voluntarios continuará mientras siga siendo asociado temporal o por hora a tiempo parcial, sujeto a los términos del Plan que sean aplicables. Asimismo, si no se inscribe en la mayoría de los beneficios voluntarios durante el periodo de inscripción inicial, tampoco se le permitirá inscribirse a menos que lo haga durante un periodo de Inscripción anual, o si surge un evento de cambio de elección. Una vez que tenga derecho a los beneficios voluntarios, podrá inscribirse en el seguro de vida opcional en cualquier momento.

Si toma tiempo libre durante cualquier periodo de medición de 60 días

Si toma cualquier tipo de licencia sin goce de sueldo durante un periodo de medición de 60 días, la cantidad total de días de licencia sin goce de sueldo en cualquier periodo de medición de 60 días se utilizará para determinar si ha trabajado la cantidad de horas requerida durante ese periodo de medición a fin de ser elegible para la cobertura médica (incluso si no trabaja ninguna hora en uno o más días).

No obstante, si su ausencia se debe a una licencia de ausencia aprobada y registrada en el sistema de Walmart como licencia de ausencia (incluso para actuar como jurado, conforme a la Ley de Licencia Familiar y Médica de 1993 ["FMLA"] o por licencia militar), la cantidad de días durante el periodo de medición de 60 días que estuvo gozando de una licencia aprobada no se considerará en la medición de sus horas. La determinación de si ha satisfecho la cantidad de horas requerida se basará en la cantidad de días durante el periodo de medición de 60 días, menos la cantidad de días que estuvo gozando de una licencia de ausencia aprobada. Por ejemplo, si toma una licencia de ausencia aprobada durante cinco días del periodo de medición de 60 días, su verificación de elegibilidad de 60 días incluirá 55 días en lugar de 60.

Si deja Walmart durante las primeras 52 semanas de trabajo y vuelve a ser contratado

NOTA: Si usted ha cesado en su empleo cuando era asociado pagado por hora a tiempo parcial o asociado temporal y vuelve a ser contratado menos de 13 semanas después de la fecha de cese del empleo en una clasificación laboral diferente, con el fin de determinar la admisibilidad y las fechas de entrada en vigencia, se le tratará como si su empleo nunca hubiera cesado y, en cambio, hubiera sido transferido de una clasificación laboral a otra. Debe revisar la sección **Cambio de una clasificación laboral a otra** más adelante en este capítulo para obtener más información sobre la elegibilidad para los beneficios.

A los fines de las verificaciones de elegibilidad de 60 días durante sus primeras 52 semanas de empleo, si cesa en el empleo como asociado pagado por hora a tiempo parcial o un asociado temporal durante ese periodo de 52 semanas y vuelve a trabajar como asociado temporal o por hora a tiempo parcial dentro de los 30 días siguientes al cese, su elegibilidad para los beneficios médicos u otros beneficios al ser contratado de nuevo se determinará de acuerdo con las reglas que se muestran en la tabla de abajo:

SI SE VA DURANTE LAS PRIMERAS 52 SEMANAS DE TRABAJO Y VUELVE A SER CONTRATADO EN UN PLAZO DE 30 DÍAS	
Si no ha superado una verificación de elegibilidad de 60 días antes de la fecha de cese en el empleo	Las normas aplicables a las verificaciones de elegibilidad de 60 días seguirán aplicándose, en función de su fecha de contratación original, como si no hubiera cesado en el empleo. La verificación de los 60 días de elegibilidad para cada periodo de medición tendrá en cuenta únicamente los días que estuvo empleado durante el periodo de medición. Por ejemplo, si su empleo ha cesado por un periodo de 10 días durante el periodo de verificación de 60 días, la verificación de elegibilidad de 60 días para ese periodo considerará solo los 50 días que estuvo empleado durante el periodo de medición. No obstante, si ha tomado tiempo libre durante el periodo de empleo, consulte **Si toma tiempo libre durante cualquier periodo de medición de 60 días** en esta sección.
Si ha superado una verificación de elegibilidad de 60 días antes de la fecha de cese en el empleo	Mantendrá su estado de elegibilidad anterior para los beneficios médicos hasta el final de su periodo de elegibilidad para la cobertura médica. Su elegibilidad para los demás beneficios voluntarios continuará mientras siga siendo asociado temporal o por hora a tiempo parcial, sujeto a los términos del Plan que sean aplicables. • Si estaba inscrito en beneficios médicos u otros beneficios voluntarios cuando cesó en el empleo, se restablecerá cualquier cobertura que haya estado vigente (o la más similar que ofrezca el Plan) en la fecha de su cese, con una interrupción de la cobertura durante el periodo de su ausencia en el que no se hayan pagado las primas, sujeto a las siguientes condiciones. A excepción de lo dispuesto a continuación y sujeto a los términos del Plan que sean aplicables, no se le permitirá cambiar sus elecciones de beneficios (a excepción del seguro de vida opcional) hasta el siguiente periodo de Inscripción anual o si tiene un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** en este capítulo. • A excepción de lo dispuesto a continuación, y sujeto a los términos del Plan que sean aplicables, si no estaba inscrito en los beneficios médicos u otros beneficios voluntarios en la fecha de cese en su empleo, no podrá inscribirse en esos beneficios (a excepción del seguro de vida opcional) cuando regrese, hasta el siguiente periodo de Inscripción anual, o si surge un evento de cambio de elección. Si cesa en su empleo dentro de un año calendario después de que haya finalizado el periodo de Inscripción anual para el siguiente año calendario y vuelve antes del 31 de diciembre del año del cese en su empleo, se aplicarán los cambios que haya realizado durante la Inscripción anual (o la cobertura predeterminada que le corresponde por no haber realizado ningún cambio durante la Inscripción anual). Si cesa en su empleo dentro de un año calendario y se reincorpora al trabajo en el año calendario siguiente y se encuentra en una de las siguientes categorías, puede llamar a Servicios al Personal al **800-421-1362** para inscribirse en los beneficios médicos u otros beneficios voluntarios dentro de los 60 días siguientes a su reincorporación al trabajo: • Era elegible para inscribirse en los beneficios en el año en que cesó en el empleo, pero no se inscribió. • Era elegible para los beneficios y estaba inscrito en ellos en el año en que cesó en el empleo y desea agregar a un hijo a cargo (si corresponde) para el año en que vuelve a trabajar. Después de este periodo de 60 días, y sujeto a los términos del Plan que sean aplicables, no se le permitirá cambiar sus elecciones de beneficios (a excepción del seguro de vida opcional), hasta el siguiente periodo de Inscripción Anual, o si tiene un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** en este capítulo.
Consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Plan médico** para obtener información sobre su deducible, el desembolso máximo, la HRA y el beneficio máximo de por vida aplicable a los beneficios de fertilidad bajo el programa de formación de familias de los Centros de Excelencia, si deja el empleo y luego vuelve a ser contratado. Para obtener información sobre el periodo mínimo de inscripción, el deducible y el periodo de espera requeridos para la asistencia de ortodoncia si deja su empleo y luego vuelve a ser contratado, consulte la sección **Si deja Walmart y lo contratan nuevamente** en el capítulo **Plan dental**.	

Sujeto a los términos del Plan que sean aplicables, si vuelve a ser contratado más de 30 días después de haberse ido durante las primeras 52 semanas de empleo, se lo tratará como un asociado nuevo para fines de la verificación de 60 días para los beneficios médicos y otros beneficios voluntarios y estará sujeto a las verificaciones de elegibilidad de 60 días que se describen en **Sus verificaciones de elegibilidad de 60 días durante sus primeras 52 semanas de empleo** en esta sección, incluso si había pasado una verificación de elegibilidad de 60 días antes de la fecha de haberse ido. No obstante, si vuelve a trabajar menos de 13 semanas desde la fecha de cese en el empleo, consulte **Verificación única de elegibilidad a las 52 semanas de trabajo** y **Su verificación anual de elegibilidad** en esta sección para obtener información sobre cómo se trata su interrupción del servicio para fines de esas verificaciones de elegibilidad.

Si usted ha cesado en su empleo y vuelve a ser contratado 13 semanas o más después de la fecha de cese en el empleo, independientemente de su clasificación laboral, se considerará como un nuevo asociado, sujeto a las demás condiciones aplicables del Plan.

VERIFICACIÓN ÚNICA DE ELEGIBILIDAD A LAS 52 SEMANAS DE TRABAJO

Si usted es un asociado temporal o por hora a tiempo parcial y no se le ofreció cobertura médica durante sus primeras 52 semanas de empleo porque no trabajó la cantidad de horas requerida en un periodo de medición de 60 días a fin de ser elegible para los beneficios médicos y otros beneficios voluntarios, su elegibilidad para los beneficios médicos se verificará de nuevo a las 52 semanas de empleo. El periodo de medición para la verificación por única vez es la totalidad de las 52 semanas consecutivas a partir de su fecha de contratación y, en esta sección, se denomina el "periodo de medición inicial". Las horas trabajadas durante el periodo de medición inicial se medirán para determinar si ha trabajado la cantidad de horas requerida, que se expresa como una cantidad promedio por semana, a fin de ser elegible para los beneficios médicos. Consulte a continuación la cantidad de horas que necesita.

Si está registrado como un asociado pagado por hora a tiempo parcial o temporal* en el sistema de Walmart y es:	**Debe trabajar esta cantidad de horas durante su periodo de medición inicial:**
• Un farmacéutico pagado por hora contratado a partir del 1 de febrero de 2012**. • Parte de la cadena de suministro de campo	Un promedio de 24 horas por semana
Todos los demás asociados pagados por hora a tiempo parcial y temporales	Un promedio de 30 horas por semana

*Asociados pagados por hora a tiempo parcial en Hawái: consultar el capítulo titulado **Elegibilidad, inscripción y fechas de vigencia para los asociados en Hawái** para obtener más detalles.

**Los farmacéuticos pagados por hora a tiempo parcial contratados antes del 1 de febrero de 2012 no tienen requisito de horas.

Podrá inscribirse en los beneficios médicos si trabaja la cantidad de horas requerida durante su periodo de medición inicial sin una interrupción en el empleo de 13 semanas o más. Si es elegible, sus beneficios entrarán en vigencia el primer día del segundo mes calendario siguiente al día anterior a la fecha de su primer aniversario, suponiendo que se inscriba antes de que finalice el periodo de inscripción inicial. Asimismo, es posible que sea elegible para otros beneficios voluntarios, independientemente de que trabaje la cantidad de horas necesaria a fin de ser elegible para los beneficios médicos, sujeto a los términos del Plan que sean aplicables. Para informarse acerca de los otros beneficios a los que puede tener derecho, consulte la sección **Inscripción y fechas efectivas por clasificación laboral** más adelante en este capítulo.

EJEMPLO: Si su fecha de contratación es el 16 de abril de 2024, se medirán sus horas trabajadas desde ese día hasta el 15 de abril de 2025 para determinar si ha trabajado la cantidad de horas requerida durante el periodo de medición inicial. Será elegible para inscribirse en los beneficios médicos si trabaja la cantidad de horas requerida durante este periodo de medición inicial y no tiene una interrupción en el empleo de 13 semanas o más. Asimismo, podrá inscribirse en otros beneficios voluntarios que están disponibles para los asociados pagados por hora a tiempo parcial y temporales, sujeto a los términos del Plan que sean aplicables. En este ejemplo, todos los beneficios a los que se inscriba entrarán en vigencia el 1.º de junio de 2025, que es el primer día del segundo mes calendario siguiente al día anterior a la fecha de su primer aniversario, 15 de abril de 2025.

Si no trabaja la cantidad de horas requerida durante su periodo de medición inicial para tener derecho a los beneficios médicos, su derecho a los beneficios médicos se verificará de nuevo al realizar la verificación anual de elegibilidad que sigue a su periodo de medición inicial, tal y como se describe en **Su verificación anual de elegibilidad** en esta sección. Si en el ejemplo anterior no hubiera trabajado la cantidad de horas requeridas al momento de la verificación por única vez a las 52 semanas de empleo, su primera verificación anual de elegibilidad para los beneficios médicos para la cobertura médica de 2026 sería durante el otoño de 2025. Puede seguir siendo elegible para otros beneficios voluntarios que están disponibles para los asociados pagados por hora a tiempo parcial y temporales, independientemente de si trabaja la cantidad de horas requerida a fin de ser elegible para los beneficios médicos, sujeto a los términos del Plan que sean aplicables. Para informarse acerca de los otros beneficios a los que puede tener derecho, consulte la sección **Inscripción y fechas efectivas por clasificación laboral** en este capítulo.

Si es elegible para los beneficios como resultado de la verificación por única vez a las 52 semanas de empleo, su elegibilidad para los beneficios médicos continúa hasta el final del segundo año calendario siguiente a la fecha en que haya satisfecho los requisitos de elegibilidad, independientemente de que se inscriba o no en la cobertura médica (su "periodo de elegibilidad para la cobertura médica"), sujeto a los términos del Plan que sean aplicables y suponiendo que su clasificación siga siendo asociado temporal o por hora a tiempo parcial en el sistema de nóminas de Walmart. Por ejemplo, si cumplió con los requisitos de verificación de elegibilidad el 15 de abril de 2025, la cobertura médica continuaría hasta el final del año calendario 2027 en el ejemplo anterior. Su elegibilidad para los demás beneficios voluntarios que se describen en la sección **Inscripción y fechas efectivas por clasificación laboral** más adelante en este capítulo continuará mientras siga siendo asociado temporal o tiempo parcial pagado por hora, sujeto a los términos del

Plan que sean aplicables. No obstante, si no se inscribe en los beneficios médicos cuando reúne los requisitos por primera vez y antes de que finalice el periodo de inscripción inicial, no se le permitirá inscribirse en los beneficios médicos durante el resto de su periodo de elegibilidad de cobertura médica, excepto durante un periodo de Inscripción anual, o si surge un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** más adelante en este capítulo. Asimismo, si no se inscribe en la mayoría de los beneficios voluntarios (a excepción del seguro de vida opcional) durante el periodo de inscripción inicial, tampoco se le permitirá inscribirse a menos que lo haga durante un periodo de Inscripción anual, o si surge un evento de cambio de elección. Una vez que tenga derecho a los beneficios voluntarios, podrá inscribirse en el seguro de vida opcional en cualquier momento. Su derecho a los beneficios médicos no se volverá a verificar hasta la verificación anual que ocurre en el último año de su periodo de derecho a la cobertura médica, tal y como se describe en **Su verificación anual de elegibilidad** en esta sección.

Si toma un tiempo libre durante el periodo de medición inicial

Si toma cualquier tipo de licencia sin goce de sueldo durante un periodo de medición inicial, la cantidad total de semanas de licencia sin goce de sueldo en cualquier periodo de medición inicial se utilizará para determinar si ha trabajado la cantidad de horas requerida durante el periodo de medición inicial a fin de ser elegible para beneficios médicos (incluso si no trabaja ninguna hora una o más semanas).

Si su ausencia se debe a una licencia aprobada y registrada en el sistema de la compañía como licencia de ausencia (incluso para el servicio como jurado, licencia familiar y médica de 1993 [”FMLA”] o licencia militar), la cantidad de semanas durante el periodo de medición inicial que estuvo con licencia aprobada no se considerará en la medición de sus horas. La determinación de si ha satisfecho la cantidad de horas requerida se basará en la cantidad de semanas durante el periodo de medición inicial, menos la cantidad de semanas que estuvo con licencia de ausencia aprobada. Por ejemplo, si toma una licencia de ausencia aprobada de dos semanas durante el periodo de medición inicial de 52 semanas, su promedio de horas trabajadas se calculará sobre 50 semanas en vez de 52.

Si deja Walmart y vuelve a ser contratado

Para fines de la verificación de elegibilidad por única vez a las 52 semanas de empleo, si cesa en su empleo y se reincorpora como asociado temporal o por hora a tiempo parcial menos de 13 semanas después de la fecha de cese en el empleo, su elegibilidad para los beneficios médicos u otros al ser contratado de nuevo se determinará de acuerdo con las reglas que se muestran en la siguiente tabla.

NOTA: Si usted ha cesado en su empleo cuando era asociado pagado por hora a tiempo parcial o asociado temporal y vuelve a ser contratado menos de 13 semanas después de la fecha de cese del empleo en una clasificación laboral diferente, con el fin de determinar la admisibilidad y las fechas de entrada en vigencia, se le tratará como si su empleo nunca hubiera cesado y, en cambio, hubiera sido transferido de una clasificación laboral a otra. Consulte la sección **Cambio de una clasificación laboral a otra** más adelante en este capítulo para obtener más información y elegibilidad para los beneficios.

SI USTED:	Y ES CONTRATADO DE NUEVO EN MENOS DE 13 SEMANAS DESPUÉS DEL CESE EN EL EMPLEO:
Cesó en el empleo durante el periodo de medición inicial	Se le tratará como si no se hubiera ido del empleo durante el resto del periodo de medición inicial. Se utilizarán todas las horas trabajadas durante el periodo de medición inicial para determinar su elegibilidad para los beneficios médicos como resultado de la verificación por única vez de la elegibilidad. Por ejemplo, si hay una interrupción de cuatro semanas en el servicio durante el periodo de medición inicial de 52 semanas, su promedio de horas se calculará utilizando las 48 semanas durante las cuales estuvo empleado, en vez de 52 semanas. Consulte **Si toma un tiempo libre durante el periodo de medición inicial** en esta sección si ha tomado algún tiempo libre durante el periodo de medición inicial.
Fue dado de baja del empleo después de su periodo de medición inicial, *y* Tuvo derecho a los beneficios médicos pero fue contratado de nuevo después de la finalización del periodo de cobertura médica, *o* No era elegible para los beneficios médicos en el momento de cese en el empleo	Su derecho a los beneficios médicos y a otros beneficios voluntarios se determinará como se describe en **Su verificación anual de elegibilidad** en esta sección.

(Continúa en la próxima página)

SI USTED:	Y ES CONTRATADO DE NUEVO EN MENOS DE 13 SEMANAS DESPUÉS DEL CESE EN EL EMPLEO: (CONTINUACIÓN)
Terminación del empleo después de su periodo de medición inicial, *y* Tenía derecho a beneficios médicos al momento de la terminación del empleo, *y* Fue contratado nuevamente antes de que finalice el periodo de cobertura médica	Mantendrá su estado de elegibilidad anterior para los beneficios médicos hasta el final de su periodo de elegibilidad para la cobertura médica. Su elegibilidad para los demás beneficios voluntarios continuará mientras siga siendo asociado temporal o por hora a tiempo parcial, sujeto a los términos del Plan que sean aplicables. Se restablecerá cualquier cobertura que haya estado vigente (o la más similar que ofrezca el Plan) en la fecha de cese en el empleo, con una interrupción de la cobertura durante el periodo de su ausencia en el que no se hayan pagado las primas, sujeto a las siguientes condiciones: Si regresa dentro de los 30 días siguientes a la fecha de cese en el empleo: • A excepción de lo dispuesto a continuación, y sujeto a los términos del Plan que sean aplicables, si estaba inscrito en beneficios médicos u otros beneficios voluntarios cuando cesó en el empleo, no se le permitirá cambiar la cobertura restablecida (a excepción del seguro de vida opcional) hasta el siguiente periodo de Inscripción anual, o si surge un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo. • A excepción de lo dispuesto a continuación, y sujeto a los términos del Plan que sean aplicables, si no estaba inscrito en los beneficios médicos u otros beneficios voluntarios en la fecha de cese en su empleo, no podrá inscribirse en esos beneficios (a excepción del seguro de vida opcional) cuando regrese, hasta el siguiente periodo de Inscripción anual, o si surge un evento de cambio de elección. • Si cesa en su empleo dentro de un año calendario después de que haya finalizado el periodo de Inscripción anual para el siguiente año calendario y vuelve antes del 31 de diciembre del año del cese en su empleo, se aplicarán los cambios que haya realizado durante la Inscripción anual (o la cobertura predeterminada que le corresponde por no haber realizado ningún cambio durante la Inscripción anual). • Si cesa en su empleo dentro de un año calendario y se reincorpora al trabajo en el año calendario siguiente y se encuentra en una de las siguientes categorías, puede llamar a Servicios al Personal al **800-421-1362** para inscribirse en los beneficios médicos u otros beneficios voluntarios dentro de los 60 días siguientes a su reincorporación al trabajo: – No era elegible para inscribirse en los beneficios en el año en que cesó en el empleo, pero sí en el año en que se reincorporó al trabajo – Era elegible para inscribirse en los beneficios en el año en que cesó en el empleo, pero no se inscribió – Era elegible para los beneficios y estaba inscrito en ellos en el año en que cesó en el empleo y desea agregar a un hijo a cargo (si corresponde) para el año en que vuelve a trabajar Si vuelve al trabajo después de 30 días, pero menos de 13 semanas desde la fecha de cese en el empleo, tendrá 60 días después de su regreso para abandonar o modificar de otro modo la cobertura restablecida, sujeto a los términos del Plan que sean aplicables. Después de este periodo de 60 días, y sujeto a los términos del Plan que sean aplicables, no se le permitirá cambiar sus elecciones de beneficios (a excepción del seguro de vida opcional), hasta el siguiente periodo de Inscripción anual, o si tiene un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** en este capítulo.
Consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Plan médico** para obtener información sobre su deducible, el desembolso máximo, la HRA y el beneficio máximo de por vida aplicable a los beneficios de fertilidad bajo el programa de formación de familias de los Centros de Excelencia, si deja el empleo y luego vuelve a ser contratado. Consulte la sección **Si deja Walmart y lo contratan nuevamente** en el capítulo **Plan dental** para obtener información sobre el periodo mínimo de inscripción, el deducible y el periodo de espera requeridos para la asistencia de ortodoncia si cesa en el empleo y luego vuelve a ser contratado.	

Si usted ha cesado en su empleo y vuelve a ser contratado 13 semanas o más después de la fecha de cese en el empleo, independientemente de su clasificación laboral, se considerará como un nuevo asociado, sujeto a las demás condiciones aplicables del Plan.

SU VERIFICACIÓN ANUAL DE ELEGIBILIDAD

Si es asociado a tiempo parcial o temporal y ha estado empleado durante más de 52 semanas consecutivas, sin interrupción en el empleo de 13 semanas o más, sus horas se verificarán anualmente para determinar si ha trabajado la cantidad de horas requerida, que se expresa como un número promedio por semana, a fin de ser elegible para los beneficios médicos en el siguiente año calendario. El periodo de medición para la verificación anual que se describe en esta sección será un periodo de 52 semanas que precede a una fecha designada anualmente a principios de octubre y se denomina “periodo de medición anual”. Se le someterá a la verificación anual de elegibilidad cada año para determinar su elegibilidad para los beneficios médicos en el siguiente año calendario, siempre que siga siendo asociado temporal o asociado pagado por hora a tiempo parcial. Consulte la siguiente página para determinar la cantidad de horas requerida.

Si era elegible para recibir beneficios médicos como resultado de las verificaciones de elegibilidad de 60 días o por única vez descritas anteriormente, su primera verificación de elegibilidad anual será la que se realice el año en que finalice su periodo de elegibilidad para la cobertura médica (como se ha definido anteriormente).

Si usted era asociado pagado por hora a tiempo completo o asociado gerencial que fue transferido a una clasificación laboral de asociado pagado por hora a tiempo parcial o asociado temporal, su primera verificación anual de elegibilidad será la primera que se produzca después de su transferencia.

Si está registrado como asociado* por hora a tiempo parcial en el sistema de Walmart y es:	**Debe trabajar esta cantidad de horas durante el periodo de medición anual:**
• Un farmacéutico pagado por hora contratado a partir del 1 de febrero de 2012** • Parte de la cadena de suministro de campo	Un promedio de 24 horas por semana
Todos los demás asociados pagados por hora a tiempo parcial y temporales	Un promedio de 30 horas por semana

*Asociados a tiempo parcial pagados por hora en Hawái: consulten el capítulo titulado **Elegibilidad, inscripción y fechas de vigencia para los asociados en Hawái** para más detalles.

**Los farmacéuticos pagados por hora a tiempo parcial contratados antes del 1 de febrero de 2012 no tienen requisito de horas.

Podrá inscribirse en los beneficios médicos en la Inscripción anual si trabaja la cantidad de horas requerida durante su periodo de medición anual, sin una interrupción en el empleo de 13 semanas o más. Si satisface los requisitos, sus beneficios entrarán en vigencia el 1.º de enero del siguiente año calendario.

Si es elegible para los beneficios como resultado de la verificación de elegibilidad anual, su elegibilidad para los beneficios médicos continúa hasta el 31 de diciembre del año en que entre en vigencia, independientemente de que se inscriba realmente en los beneficios médicos, sujeto a los términos del Plan que sean aplicables y suponiendo que siga siendo asociado temporal o por hora a tiempo parcial. No obstante, si no se inscribe en los beneficios médicos durante la Inscripción anual, no se le permitirá inscribirse en los beneficios médicos durante el siguiente año calendario a menos que tenga un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** más adelante en este capítulo. Su elegibilidad para los beneficios médicos no se volverá a verificar hasta la siguiente verificación anual de elegibilidad, siempre y cuando siga siendo un asociado temporal o por hora a tiempo parcial.

Si no trabaja la cantidad de horas requerida durante su periodo de medición anual a fin de ser elegible para los beneficios médicos, no se volverá a verificar su elegibilidad para los beneficios médicos hasta la siguiente verificación anual de elegibilidad, siempre que siga siendo asociado temporal o por hora a tiempo parcial.

Si está inscrito en los beneficios médicos en el año calendario en curso, pero no ha trabajado la cantidad de horas requerida para ser elegible para los beneficios médicos en el año calendario siguiente, no será elegible para los beneficios médicos para el año siguiente, a menos que su clasificación laboral cambie y cumpla los requisitos de elegibilidad en función de su nueva clasificación. No obstante, tendrá la opción, en virtud de la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA), de continuar con su cobertura médica cuando finalice el año calendario en curso. Para más información, consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)**.

Asimismo, es posible que reúna los requisitos para otros beneficios voluntarios, independientemente de que trabaje la cantidad de horas necesaria para tener derecho a los beneficios médicos, sujeto a los términos del Plan que sean aplicables. Consulte la sección **Inscripción y fechas efectivas por clasificación laboral** para conocer otros beneficios para los que puede ser elegible.

Si toma un tiempo libre durante el periodo de medición anual

Si toma cualquier tipo de licencia sin goce de sueldo durante el periodo de medición anual, se seguirá utilizando la cantidad total de semanas de licencia sin goce de sueldo en el periodo de medición anual para determinar si ha trabajado la cantidad de horas requerida durante el periodo de medición anual para ser elegible para los beneficios médicos (incluso si no trabaja ninguna hora en una o más semanas).

Si su ausencia se debe a una licencia de ausencia aprobada y registrada en el sistema de la compañía como licencia de ausencia (incluso para el servicio como jurado, licencia familiar y médica de 1993 [”FMLA”] o licencia militar), la cantidad de semanas durante el periodo de medición anual que estuvo en una licencia de ausencia aprobada no se considerará en la medición de sus horas. La determinación de si ha cumplido con la cantidad de horas requerida se basará en la cantidad de semanas durante el periodo de medición anual, menos la cantidad de semanas que estuvo con licencia de ausencia aprobada. Por ejemplo, si toma una licencia de ausencia aprobada de dos semanas durante el periodo de medición anual, su promedio de horas trabajadas se calculará sobre 50 semanas en vez de 52.

Si deja Walmart y vuelve a ser contratado

Para fines de la verificación anual de elegibilidad, si cesa en el empleo como asociado pagado por hora a tiempo parcial o temporal y es contratado de nuevo como asociado a tiempo parcial o temporal en un plazo inferior a 13 semanas después de la fecha de cese en el empleo, se le considerará como si no hubiera dejado el empleo. Todas las horas trabajadas durante un periodo de medición anual se utilizarán para determinar su elegibilidad para los beneficios médicos del año siguiente. Su elegibilidad para los beneficios médicos y otros beneficios voluntarios al ser contratado de nuevo antes de que pasen 13 semanas de la fecha de cese en el empleo se determinará de acuerdo con las reglas que se muestran en la tabla de la siguiente página.

NOTA: Si usted ha cesado en su empleo cuando era asociado pagado por hora a tiempo parcial o asociado temporal y vuelve a ser contratado menos de 13 semanas después de la fecha de cese del empleo en una clasificación laboral diferente, con el fin de determinar la admisibilidad y las fechas de entrada en vigencia, se le tratará como si su empleo nunca hubiera cesado y, en cambio, hubiera sido transferido de una clasificación laboral a otra. Consulte la sección **Cambio de una clasificación laboral a otra** más adelante en este capítulo para obtener más información y elegibilidad para los beneficios.

SI USTED:	Y ES CONTRATADO DE NUEVO EN MENOS DE 13 SEMANAS DESPUÉS DEL CESE EN EL EMPLEO
No es elegible para los beneficios médicos en el año en que vuelva a ser contratado, pero sí a otros beneficios voluntarios	Su elegibilidad para los beneficios médicos no se medirá de nuevo hasta la siguiente verificación anual de elegibilidad. Mantendrá su estado de elegibilidad anterior para beneficios voluntarios (no médicos) mientras siga siendo asociado temporal o por hora a tiempo parcial, sujeto a los términos del Plan que sean aplicables. Se restablecerá cualquier cobertura que haya estado vigente (o la más similar que ofrezca el Plan) en la fecha de cese en el empleo, con una interrupción de la cobertura durante el periodo de su ausencia en el que no se hayan pagado las primas, sujeto a las siguientes condiciones: Si regresa dentro de los 30 días siguientes a la fecha de cese en el empleo: • A excepción de lo dispuesto a continuación, y sujeto a los términos del Plan que sean aplicables, si estaba inscrito en beneficios voluntarios (que no sean médicos) cuando cesó en el empleo, no se le permitirá cambiar la cobertura restablecida (a excepción del seguro de vida opcional) hasta el siguiente periodo de Inscripción anual, o si surge un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo. • A excepción de lo dispuesto a continuación, y sujeto a los términos del Plan que sean aplicables, si no estaba inscrito en los beneficios voluntarios (que no sean médicos) en la fecha de cese en el empleo, no podrá inscribirse en esos beneficios (a excepción del seguro de vida opcional) cuando regrese, hasta el siguiente periodo de Inscripción anual, o si surge un evento de cambio de elección. • Si cesa en su empleo dentro de un año calendario después de que haya finalizado el periodo de Inscripción anual para el siguiente año calendario y vuelve antes del 31 de diciembre del año del cese en su empleo, se aplicarán los cambios que haya realizado durante la Inscripción anual (o la cobertura predeterminada que le corresponde por no haber realizado ningún cambio durante la Inscripción anual). • Si cesa en el empleo dentro de un año calendario y se reincorpora al trabajo en el año calendario siguiente y se encuentra en una de las siguientes categorías, puede llamar a Servicios al Personal al **800-421-1362** para inscribirse en los beneficios voluntarios (que no sean médicos) dentro de los 60 días siguientes a su reincorporación al trabajo: – No era elegible para inscribirse en los beneficios en el año en que cesó en el empleo, pero sí en el año en que se reincorporó al trabajo – Era elegible para inscribirse en los beneficios en el año en que cesó en el empleo, pero no se inscribió – Era elegible para los beneficios y estaba inscrito en ellos en el año en que cesó en el empleo y desea agregar a un hijo a cargo (si corresponde) para el año en que vuelve a trabajar Si vuelve al empleo después de 30 días, pero antes de 13 semanas después de su fecha de cese en el empleo, sujeto a los términos del Plan que sean aplicables, dispondrá de 60 días después de su regreso para abandonar o modificar de otro modo la cobertura restablecida. Después de este periodo de 60 días, y sujeto a los términos del Plan que sean aplicables, no se le permitirá cambiar sus elecciones de beneficios (a excepción del seguro de vida opcional), hasta el siguiente periodo de Inscripción anual, o si tiene un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** en este capítulo.

(Continúa en la próxima página)

SI USTED:	Y ES CONTRATADO DE NUEVO EN MENOS DE 13 SEMANAS DESPUÉS DEL CESE EN EL EMPLEO: (CONTINUACIÓN)
Es elegible para los beneficios médicos y otros beneficios voluntarios en el año de su nueva contratación	Mantendrá su estado de elegibilidad anterior para los beneficios médicos hasta el final de su periodo de elegibilidad para la cobertura médica. Su elegibilidad para los demás beneficios voluntarios continuará mientras siga siendo asociado temporal o por hora a tiempo parcial, sujeto a los términos del Plan que sean aplicables. Se restablecerá cualquier cobertura que haya estado vigente (o la más similar que ofrezca el Plan) en la fecha de cese en el empleo, con una interrupción de la cobertura durante el periodo de su ausencia en el que no se hayan pagado las primas, sujeto a las siguientes condiciones: Si regresa dentro de los 30 días siguientes a la fecha de cese en el empleo: • A excepción de lo dispuesto a continuación, y sujeto a los términos del Plan que sean aplicables, si estaba inscrito en beneficios médicos u otros beneficios voluntarios cuando cesó en el empleo, no se le permitirá cambiar la cobertura restablecida (a excepción del seguro de vida opcional) hasta el siguiente periodo de Inscripción anual, o si surge un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo. • A excepción de lo dispuesto a continuación, y sujeto a los términos del Plan que sean aplicables, si no estaba inscrito en los beneficios médicos u otros beneficios voluntarios en la fecha de cese en su empleo, no podrá inscribirse en esos beneficios (a excepción del seguro de vida opcional) cuando regrese, hasta el siguiente periodo de Inscripción anual, o si surge un evento de cambio de elección. • Si cesa en su empleo dentro de un año calendario después de que haya finalizado el periodo de Inscripción anual para el siguiente año calendario y vuelve antes del 31 de diciembre del año del cese en su empleo, se aplicarán los cambios que haya realizado durante la Inscripción anual (o la cobertura predeterminada que le corresponde por no haber realizado ningún cambio durante la Inscripción anual). – Si cesa en su empleo dentro de un año calendario y se reincorpora al trabajo en el año calendario siguiente y se encuentra en una de las siguientes categorías, puede llamar a Servicios al Personal al 800-421-1362 para inscribirse en los beneficios médicos u otros beneficios voluntarios dentro de los 60 días siguientes a su reincorporación al trabajo: – No era elegible para inscribirse en los beneficios en el año en que cesó en el empleo, pero sí en el año en que se reincorporó al trabajo – Era elegible para inscribirse en los beneficios en el año en que cesó en el empleo, pero no se inscribió – Era elegible para los beneficios y estaba inscrito en ellos en el año en que cesó en el empleo y desea agregar a un hijo a cargo (si corresponde) para el año en que vuelve a trabajar Si vuelve al empleo después de 30 días, pero antes de 13 semanas después de su fecha de cese en el empleo, sujeto a los términos del Plan que sean aplicables, dispondrá de 60 días después de su regreso para abandonar o modificar de otro modo la cobertura restablecida. Después de este periodo de 60 días, y sujeto a los términos del Plan que sean aplicables, no se le permitirá cambiar sus elecciones de beneficios (a excepción del seguro de vida opcional), hasta el siguiente periodo de Inscripción anual, o si tiene un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** en este capítulo.
Consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Plan médico** para obtener información sobre su deducible, el desembolso máximo, la HRA y el beneficio máximo de por vida aplicable a los beneficios de fertilidad bajo el programa de formación de familias de los Centros de Excelencia, si deja el empleo y luego vuelve a ser contratado. Consulte la sección **Si deja Walmart y lo contratan nuevamente** en el capítulo **Plan dental** para obtener información sobre el periodo mínimo de inscripción, el deducible y el periodo de espera requeridos para la asistencia de ortodoncia si cesa en el empleo y luego vuelve a ser contratado.	

Si usted ha cesado en su empleo y vuelve a ser contratado 13 semanas o más después de la fecha de cese en el empleo, independientemente de su clasificación laboral, se considerará como un nuevo asociado, sujeto a las demás condiciones aplicables del Plan.

Si tiene preguntas acerca del cálculo de horas para las verificaciones de elegibilidad, comuníquese con Servicios al Personal al **800-421-1362**.

Elegibilidad de los dependientes

Si es un gerente o asociado pagado por hora a tiempo completo y es elegible para los beneficios del Plan, también puede inscribir a todos los dependientes que reúnan los requisitos, como se describe a continuación. Para fines del *Libro de beneficios para asociados*, el término "dependiente" incluye a su cónyuge/pareja. Si es asociado temporal o asociado pagado por hora a tiempo parcial, o conductor de camión a tiempo parcial, y es elegible para los beneficios del Plan, solo puede inscribir a sus hijos dependientes además de inscribirse usted, no puede inscribir a su cónyuge/pareja.

CLASIFICACIÓN LABORAL	DEPENDIENTES ELEGIBLES (SEGÚN SE DEFINE A CONTINUACIÓN)
• Gerencia (incluidos los conductores de camiones por hora a tiempo completo) • Asociados pagados por hora a tiempo completo (incluidos los gerentes del Centro de visión por hora a tiempo completo)	**Puede elegir cobertura para:** • Cónyuge/pareja • Hijos dependientes
• Por hora a tiempo parcial • Temporal • Conductor de camión a tiempo parcial	**Puede elegir cobertura para:** • Hijos dependientes Pero *no* cónyuge/pareja

DEFINICIONES. DEPENDIENTES QUE REÚNEN LOS REQUISITOS* **Los dependientes que no se describen en esta tabla son dependientes que no reúnen los requisitos.**	
CÓNYUGE/PAREJA Los asociados pagados por hora a tiempo parcial, los asociados temporales y los conductores de camión a tiempo parcial no podrán cubrir a un cónyuge/pareja	• Su cónyuge, mientras no estén legalmente separados. • Su pareja de hecho (o "pareja"), siempre que su pareja y usted: – Vivan y mantengan una relación exclusiva y comprometida, similar al matrimonio, durante 12 meses, como mínimo – No estén casados entre sí ni con otras personas – Tengan la edad para contraer matrimonio en el estado en el que viven y sean mentalmente competentes para celebrar un contrato; – No estén relacionados de manera tal que esto impida un matrimonio legal en el estado en el que viven, y – No mantengan la relación únicamente a los fines de obtener la cobertura de beneficios. • Cualquier otra persona con la que esté unido mediante una relación legal reconocida por crear algunos o todos los derechos del matrimonio en el estado o país en el cual se estableció la relación (también denominada "pareja").
HIJOS DEPENDIENTES	• A excepción de lo que se indica a continuación, sus hijos dependientes hasta el final del mes en el cual cumplan 26 años. Los hijos dependientes deben: – Ser sus hijos naturales – Ser sus hijos adoptivos o niños entregados a usted en adopción – Ser sus hijastros o hijos de su pareja elegible, con las siguientes condiciones: • La elegibilidad finalizará en caso de divorcio o cambio en el estado de pareja, incluso si su hijo es menor de 26 años • La elegibilidad finalizará en caso de muerte de su cónyuge o pareja, si su hijo es menor de 18, o • La elegibilidad continuará hasta los 26 años en caso de muerte de su cónyuge o pareja, si al momento de la muerte: i) el niño ha cumplido los 18 años, y ii) el niño está inscrito en el Plan. – Ser niños en adopción temporal – Ser un dependiente del cual usted tenga la custodia o tutela legal siempre que viva como miembro de su grupo familiar y usted esté a cargo de más de la mitad de su sostén.

*Incluso si su dependiente está incluido en una de las categorías de esta tabla, puede haber casos en los que ese dependiente no sea elegible para la cobertura por otros motivos. Consulte la sección titulada **Dependientes que no son elegibles** más adelante en este capítulo.

Si una persona es su dependiente elegible y deja de cumplir con la definición de dependiente elegible, esa persona dejará de ser elegible para la cobertura del Plan y usted está obligado a informar el cambio de condición. Para más información, consulte **En qué momento el dependiente pierde la elegibilidad** más adelante en este capítulo. Si no comunica el cambio, puede sufrir la pérdida de los beneficios y/o la terminación del empleo.

Si una orden judicial le obliga a proporcionar cobertura médica, dental, y/o de la vista a su hijo, este debe ser un dependiente que reúne los requisitos tal y como se ha definido anteriormente. Para obtener más información sobre cómo el Plan gestiona una orden de manutención médica, consulte **Órdenes de manutención de los hijos por razones médicas** más adelante en este capítulo.

Si está inscrito para la cobertura médica en una opción del plan local, en la opción HMO o en la opción del plan PPO, debe tener en cuenta que estas opciones no ofrecen cobertura fuera de la red y no ofrecen redes de proveedores a nivel nacional. Si tiene un dependiente elegible que vive fuera del área de servicio de la opción de su Plan médico para asociados (AMP), igualmente puede inscribir a sus dependientes elegibles, pero no tendrán acceso a los proveedores de la red del área geográfica en la que vivan y solo tendrán acceso a la cobertura de emergencia. Si no está seguro de que su dependiente elegible viva fuera del área de servicio de su opción del AMP, llame a su asesor de atención médica al número que figura en su tarjeta de identificación del plan.

SI SU HIJO TIENE MÁS DE 26 AÑOS Y NO PUEDE MANTENERSE SOLO

Si su hijo tiene 26 años o más y es incapaz de mantenerse solo, puede inscribirlo en la cobertura más allá del final del mes en que cumpla 26 años si:

- Su hijo es física o mentalmente incapaz de mantenerse a sí mismo y depende principalmente de usted para su manutención financiera, y
- El médico de su hijo proporciona evidencia médica por escrito de la discapacidad su hijo.

Si su hijo tiene 26 años o más y es incapaz de mantenerse solo según lo descrito anteriormente, puede inscribirlo en la cobertura durante su periodo de inscripción inicial, durante cualquier periodo de Inscripción anual o si tiene un evento de cambio de elección que permita la inscripción de un hijo dependiente.

Es posible que se requieran comprobantes médicos de la discapacidad permanente. Usted es responsable de notificar al Plan si su hijo tiene más de 26 años y es incapaz de mantenerse solo.

Documentación legal para la cobertura de los dependientes

El Plan se reserva el derecho de realizar una auditoría de verificación de elegibilidad de los dependientes. Se le puede pedir que presente documentación legal para demostrar la elegibilidad de su dependiente. Es su responsabilidad presentar documentación por escrito si el Plan se lo exige. Si no proporciona la documentación necesaria de manera oportuna, el Plan tiene derecho a cancelar la cobertura del dependiente. Es su responsabilidad informar al Plan, de manera oportuna, sobre todos los cambios en la elegibilidad de sus dependientes.

A continuación, se detallan algunos ejemplos de documentación válida:

Cónyuge: Copia del certificado de matrimonio o registro del matrimonio informal a través del condado o del estado. Si no contrajo matrimonio en el año calendario en curso, también puede requerirse, si se solicita, una copia de su declaración de impuestos federales presentada conjuntamente en el periodo de declaración de impuestos más reciente, o de las declaraciones de impuestos de ambos si declaran por separado.

Pareja de hecho: Copia de la declaración jurada de la pareja de hecho (firmada por usted y su pareja) o del registro de la unión civil o de la pareja de hecho y uno de los siguientes documentos como comprobante de su relación:

- Constancia de residencia compartida a través de una declaración de hipoteca conjunta o un contrato de alquiler conjunto
- Título o registro del automóvil que demuestre la propiedad conjunta del vehículo
- Extracto de cuenta corriente, bancaria o de inversión conjunta*
- Extracto de cuenta de crédito conjunta*
- Factura de servicios públicos conjunta*
- Testamento o póliza de seguro de vida que designe al otro como beneficiario principal

*Estos documentos deben estar fechados dentro de los 60 días siguientes a la solicitud de documentación.

Niños: Copia de los siguientes documentos, según corresponda:

- **Hijo natural o hijo legalmente adoptado:** Certificado de nacimiento emitido por el estado o el condado en el que figure el nombre del asociado o una orden judicial firmada.
- **Hijastro:** Certificado de nacimiento emitido por el estado o el condado en el que figuren los nombres de los padres y copia del certificado de matrimonio. Si no contrajo matrimonio en el año calendario en curso, también se requiere una copia de su declaración de impuestos federales presentada conjuntamente de la temporada de impuestos más reciente, o de las declaraciones de impuestos de ambos si declaran por separado.
- **Hijo de su pareja:** Certificado de nacimiento emitido por el estado o el condado y prueba de que la pareja está establecida.
- **Niño de acogida:** Carta firmada por el agente de los servicios sociales en la que se confirma que el niño ha sido puesto a su cargo.
- **Niño del que tiene la tutela legal:** Orden judicial firmada.
- **El niño para el que un tribunal o una agencia le ordena tener cobertura:** Orden de manutención médica calificada firmada. Consulte **Órdenes de manutención de los hijos por razones médicas** más adelante en este capítulo.
- **Hijo mayor de 26 años incapaz de mantenerse solo:** Pruebas médicas de discapacidad permanente.

NOTA: En algunos casos, también se le puede pedir que complete una declaración jurada.

Dependientes que no son elegibles

Su dependiente no es elegible para recibir la cobertura del Plan en los siguientes casos:

- Residir fuera de los EE. UU. (no se aplica al seguro de vida opcional para dependientes, seguro por muerte accidental y desmembramiento (“AD&D”), seguro por enfermedad grave ni al seguro de accidentes, y tampoco si el dependiente asiste a la universidad a tiempo completo fuera de los EE. UU.)
- Está cubierto por un plan para expatriados
- No es un dependiente elegible como se definió bajo **Elegibilidad de los dependientes** anteriormente en este capítulo
- Es un asociado de Walmart que ya está inscrito en el Plan (no se aplica al seguro de vida opcional para dependientes, AD&D, enfermedades graves ni seguro contra accidentes)
- Es dependiente de otro asociado de Walmart y ya está inscrito en la cobertura del Plan (no se aplica al seguro de vida opcional para dependientes, AD&D, enfermedades graves y seguro contra accidentes)
- Está inscrito en un plan Medicare de medicamentos recetados (solo aplicable para quienes reúnan los requisitos para opciones de AMP y beneficios de farmacia, incluidas las opciones de planes HMO y PPO)
- Está en servicio activo en las fuerzas armadas de cualquier país (solo se aplica al seguro de vida opcional o al seguro de muerte y desmembramiento accidental).

En qué momento el dependiente pierde la elegibilidad

Si el dependiente está inscrito en la cobertura del Plan y deja de ser elegible para la cobertura, debe notificar a Servicios al Personal al **800-421-1362** dentro de los 60 días a partir de la fecha en que el dependiente deja de ser elegible. Si su dependiente está inscrito en la cobertura médica, dental o de la visión y usted notifica a Servicios al Personal dentro de este plazo, el Plan enviará un aviso de elección para que su dependiente pueda elegir continuar con la cobertura conforme a la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA). La elección del dependiente de inscribirse en la cobertura de la ley COBRA se debe recibir dentro de los 60 días a partir de la fecha en que el dependiente pierde la cobertura o la fecha de notificación de elección, si es más tarde. Consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** para obtener más información.

Si no llama a Servicios al Personal al **800-421-1362** para notificar al Plan cuando su dependiente deja de ser elegible para la cobertura, puede considerarse una tergiversación intencional de hechos relevantes, lo que podría causar la cancelación de la cobertura. Si el dependiente deja de ser elegible para la cobertura y usted no llama a Servicios al Personal para notificar al Plan, puede ser responsable de cualquier costo que el Plan pague por error después de la fecha en que el dependiente dejó de ser elegible.

Cuándo puede inscribirse en los beneficios

NOTA: A menos que esté categorizado como asociado de la gerencia o gerente de un Centro de visión a tiempo completo, debe inscribirse en *antes* de su fecha de entrada en vigencia. Consulte **En qué momento entra en vigencia la cobertura** en la página siguiente, y la sección **Inscripción y fechas efectivas por clasificación laboral** más adelante en este capítulo para más detalles.

Debe inscribirse en la cobertura de beneficios durante el "periodo de inscripción inicial". El "periodo de inscripción inicial" es la primera vez que es elegible para inscribirse. Los plazos de los periodos de inscripción inicial varían según la clasificación laboral y pueden cambiar si esta se modifica, siempre que no haya tenido ya un "periodo de inscripción inicial" mientras se encontraba dentro de la clasificación anterior. Para más información, consulte **Inscripción y fechas efectivas por clasificación laboral** más adelante en este capítulo y consulte la tabla que se aplica a su clasificación laboral. Si no se inscribe durante el periodo de inscripción inicial, no podrá inscribirse en los siguientes beneficios hasta el siguiente periodo de Inscripción anual, a menos que surja un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo:

- Cobertura médica, incluidas las opciones del plan HMO y PPO (sujeto a las verificaciones de elegibilidad que se describen en la sección anterior de este capítulo titulada **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos**)
- Dental
- De la vista
- Plan mejorado de discapacidad a corto plazo
- Discapacidad a largo plazo (LTD) o LTD para conductores de camión (véase la importante excepción relativa a "inscripción tardía" en esta página)
- Seguro por enfermedades graves
- Seguro contra accidentes
- Seguro por muerte accidental y desmembramiento (AD&D)

Puede agregar o cancelar el seguro de vida opcional para asociados y el seguro de vida opcional para dependientes (o agregar cobertura adicional) en cualquier momento luego de ser elegible. Consulte las excepciones importantes relativas a la "Certificado de buena salud" y a la "inscripción tardía" que se indican a continuación.

Certificado de buena salud. Si se inscribe en el seguro de vida opcional para asociados o en el seguro de vida opcional para dependientes para su cónyuge/pareja durante el periodo de inscripción inicial por un monto superior al garantizado o por el monto garantizado y luego aumenta la cobertura para usted o su cónyuge/pareja, si es elegible, en una fecha posterior, estará sujeto a los requisitos del Certificado de buena salud. Para más información, consulte **Inscripción y fechas efectivas por clasificación laboral** más adelante en este capítulo y consulte la tabla que se aplica a su clasificación laboral. No es necesario presentar un Certificado de buena salud para el seguro de vida opcional para hijos dependientes, independientemente de la fecha de inscripción.

Inscripción tardía. Si no se inscribe en el plan de discapacidad para conductores de camión, el seguro de vida por discapacidad a largo plazo o discapacidad a largo plazo para conductores de camión durante el periodo de inscripción inicial y luego opta por la cobertura en una fecha posterior, según lo permitido por el Plan, se considerará una "inscripción tardía" y tendrá que presentar Certificado de buena salud. Si se inscribe en el seguro de vida opcional para asociados o en el seguro de vida opcional para dependientes durante el periodo de inscripción inicial por un monto superior al garantizado o por el monto garantizado y luego aumenta la cobertura para usted o su cónyuge/pareja, si es elegible, en una fecha posterior, también deberá presentar un Certificado de buena salud. No es necesario presentar un Certificado de buena salud para el seguro de vida opcional para hijos dependientes, independientemente de la fecha de inscripción. Para más información, consulte **Inscripción y fechas efectivas por clasificación laboral** más adelante en este capítulo y consulte la tabla que se aplica a su clasificación laboral.

SELECCIÓN DE UN NIVEL DE COBERTURA

Si inscribe a sus dependientes que reúnen los requisitos en el Plan, deben tener la misma cobertura que usted elige para usted mismo (es decir, estarán inscritos en la misma opción de plan médico en la que usted está inscrito). Puede cambiar su cobertura durante la Inscripción anual o si surge un evento de cambio de elección. Consulte la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** más adelante en este capítulo.

CONFIRMACIÓN DE LA INSCRIPCIÓN

Una vez que se inscriba en la cobertura, puede ver su declaración de confirmación en **One.Walmart.com/Enroll**. Se facilitará una declaración de confirmación tan pronto como sea administrativamente posible, generalmente dentro de uno o dos días. Asegúrese de verificar su declaración de confirmación en cuanto esté disponible. Asimismo, debe verificar la nómina de su primer periodo de pago tras la entrada en vigencia de su elección para confirmar que se deducen las primas correctas.

NOTA: Es una buena idea guardar una copia de su declaración de confirmación junto con sus documentos importantes para futuras consultas.

Si encuentra un error en su estado de confirmación o su recibo de pago con respecto a los beneficios en los que se inscribió, debe comunicarse de inmediato con Servicios al Personal al **800-421-1362**. Los Servicios al Personal solo pueden corregir errores internos del sistema relativos a las elecciones de inscripción y retirar de la cobertura a los dependientes que no reúnan los requisitos.

Los errores del sistema relativos a la inscripción solo pueden corregirse durante el año del Plan en el que se hizo efectiva la elección de inscripción. Un dependiente no admisible solo puede ser dado de baja de la cobertura hasta el año del Plan anterior a la fecha en la que solicita la corrección.

Si el Administrador del Plan determina que no hubo un error o usted solicita la corrección de un error fuera de los plazos descritos anteriormente, puede apelar tal determinación siguiendo el proceso descrito en la sección **Cómo apelar una decisión sobre inscripciones o estados de elegibilidad** del capítulo **Reclamaciones y apelaciones** de este *Libro de beneficios para asociados* de 2025.

Consulte la sección **Cómo se pagan las primas** más adelante en este capítulo para obtener información detallada sobre cómo se gestionan los errores en las deducciones de primas.

SU TARJETA DE IDENTIFICACIÓN DEL PLAN

Cuando se inscriba en las opciones de cobertura médica según lo establecido en el Plan médico para asociados (AMP), recibirá una tarjeta de identificación del plan en su domicilio. Las tarjetas de identificación del Plan para dependientes cuya dirección sea diferente de la suya se enviarán directamente a la dirección del dependiente. Su tarjeta de identificación del plan también funciona como su tarjeta de identificación de farmacia.

Si se inscribe en cualquiera de las opciones de cobertura médica del Plan AMP o del Plan PPO (si corresponde) y también se inscribe en el Plan dental para asociados (el "plan dental") y/o en el Plan de visión para asociados (el "plan de la visión"), su tarjeta de identificación del plan servirá también como tarjeta de identificación dental y/o tarjeta de identificación de la visión.

Si se inscribe en una HMO y también en el plan dental y/o el plan de la visión, recibirá tarjetas de identificación separadas para ambos planes.

Si se inscribe para el plan dental o el plan de la visión únicamente, recibirá tarjetas de identificación separadas para esos planes. Las tarjetas de identificación se enviarán por correo a su domicilio.

Puede actualizar la dirección de sus dependientes menores de 18 años cuando se inscribe en línea o en cualquier momento en **One.Walmart.com/Enroll**. Si su dependiente tiene 18 años o más, deberá comunicarse con Servicios al Personal al **800-421-1362** para actualizar su dirección. Como recordatorio, los asociados deben actualizar sus direcciones a través de Workday.

En qué momento entra en vigencia la cobertura

Para obtener más información sobre las fechas de entrada en vigencia de la cobertura, consulte la sección **Inscripción y fechas efectivas por clasificación laboral** de este capítulo. Si bien debería inscribirse tan pronto como se abra el periodo de inscripción inicial, incluso después de inscribirse, es posible que tenga que completar un periodo de espera de elegibilidad aplicable o los requisitos de trabajo activo antes de que su cobertura entre en vigencia.

"TRABAJO ACTIVO" O "ACTIVAMENTE EN EL TRABAJO"

Recursos de asistencia médica, dental, de la vista, de enfermedades graves, accidentes, muerte accidental y desmembramiento ("AD&D") y asociados: Siempre y cuando se haya inscrito y las primas aplicables estén al día, la cobertura entrará en vigencia, aunque no se encuentre en el trabajo el día en que de otro modo entraría en vigencia (por ejemplo: por enfermedad), si se ha presentado a su primer día de trabajo en Walmart. No es necesario inscribirse ni pagar primas para los recursos de asistencia para los asociados.

Seguro contra accidentes durante viajes de negocios, seguro de vida pagado por la compañía, seguro de vida opcional para asociados y dependientes y todo tipo de discapacidad: Si se encuentra de licencia de ausencia en la fecha en que su cobertura entraría en vigencia, tal cobertura se aplazará hasta que se encuentre en el empleo activamente y no de licencia de ausencia, siempre y cuando se haya inscrito y las primas aplicables estén al día. No se requiere inscripción ni pago de primas para el seguro contra accidentes durante viajes de negocios, el seguro de vida pagado por la compañía o la cobertura básica de discapacidad a corto plazo.

REINSCRIPCIÓN AUTOMÁTICA

Si actualmente está inscrito en los beneficios y es elegible para esos mismos beneficios durante el siguiente año calendario, pero no hace una elección afirmativa relacionada con esos beneficios durante el periodo de Inscripción anual, usted y cualquier dependiente para el que tenga cobertura se reinscribirán automáticamente en las opciones de cobertura más parecidas a las que tiene actualmente. Para obtener más información, consulte el material de Inscripción anual que se le ha proporcionado y que está publicado en línea **One.Walmart.com**. Llame a Servicios al Personal al **800-421-1362** para obtener información.

Si no realiza una elección afirmativa durante la Inscripción anual y está inscrito automáticamente en la cobertura que se describe anteriormente, no podrá cambiar esta cobertura excepto durante el periodo de Inscripción anual, a menos que surja un evento de cambio de elección.

Si no realiza una elección afirmativa durante el periodo de Inscripción anual, como se ha descrito anteriormente, se considerará que ha dado su consentimiento a la reinscripción automática, y sus deducciones de nómina se ajustarán en consecuencia.

Si deja Walmart y lo contratan nuevamente

NOTA: Si usted ha cesado en el empleo en una clasificación laboral en particular y vuelve a ser contratado menos de 13 semanas después de la fecha de cese en una clasificación laboral diferente, para fines de determinar la admisibilidad y las fechas de entrada en vigencia, se le tratará como si su empleo nunca hubiera cesado en el empleo y, en cambio, hubiera pasado de una clasificación laboral a otra. Debe revisar la sección **Cambio de una clasificación laboral a otra** más adelante en este capítulo para obtener más información sobre la elegibilidad para los beneficios.

Si cesa en el empleo como asociado pagado por hora a tiempo completo antes de cumplir los requisitos de elegibilidad aplicables y vuelve a Walmart como asociado pagado por

hora a tiempo completo menos de 13 semanas después de su fecha de cese, para fines de determinar la elegibilidad y las fechas de entrada en vigencia, se considerará como si nunca hubiera cesado en el empleo. Por ejemplo, si es contratado el 1.º de enero, cesa en el empleo el 15 de febrero y vuelve a ser contratado el 10 de marzo, su elegibilidad se determinará como si nunca hubiera cesado en el empleo. Si hubiera seguido trabajando, habría sido elegible para los beneficios el 1.º de marzo, ya que ese habría sido el primer día del mes en el que hubiera trabajado 89 días. Si lo vuelven a contratar el 10 de marzo, será elegible para los beneficios inmediatamente porque su fecha de entrada en vigencia habría sido el 1.º de marzo.

GERENTES, EMPLEADOS POR HORA A TIEMPO COMPLETO Y CONDUCTORES DE CAMIÓN A TIEMPO COMPLETO Y PARCIAL

Si cesa en el empleo (independientemente de si es gerente, empleado por hora a tiempo completo, gerente por hora a tiempo completo del Centro de Visión o asociado conductor de camión a tiempo completo o parcial) después de cumplir los requisitos de elegibilidad aplicables para los beneficios, y vuelve a Walmart en la misma clasificación laboral que cuando cesó en el empleo, su elegibilidad para los beneficios se determinará de acuerdo con las reglas que se muestran en la tabla siguiente:

SI USTED	
Es contratado de nuevo en menos de 13 semanas después de la fecha de cese en el empleo	Mantendrá su estado de elegibilidad anterior para los beneficios médicos y otros beneficios voluntarios mientras siga siendo un asociado que sea gerente, por hora a tiempo completo, gerente del Centro de visión a tiempo completo o conductor de camión a tiempo completo o parcial, sujeto a los términos del Plan que sean aplicables. Se restablecerá cualquier cobertura que haya estado vigente (o la más similar que ofrezca el Plan) en la fecha de cese en el empleo, con una interrupción de la cobertura durante el periodo de su ausencia en el que no se hayan pagado las primas, sujeto a las siguientes condiciones: Si regresa dentro de los 30 días siguientes a la fecha de cese en el empleo: • A excepción de lo dispuesto a continuación, y sujeto a los términos del Plan que sean aplicables, si estaba inscrito en beneficios médicos u otros beneficios voluntarios cuando cesó en el empleo, no se le permitirá cambiar la cobertura restablecida (a excepción del seguro de vida opcional) hasta el siguiente periodo de Inscripción anual, o si surge un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo. • A excepción de lo dispuesto a continuación, y sujeto a los términos del Plan que sean aplicables, si no estaba inscrito en los beneficios médicos u otros beneficios voluntarios en la fecha de cese en su empleo, no podrá inscribirse en esos beneficios (a excepción del seguro de vida opcional) cuando regrese, hasta el siguiente periodo de Inscripción anual, o si surge un evento de cambio de elección. • Si cesa en su empleo dentro de un año calendario después de que haya finalizado el periodo de Inscripción anual para el siguiente año calendario y vuelve antes del 31 de diciembre del año del cese en su empleo, se aplicarán los cambios que haya realizado durante la Inscripción anual (o la cobertura predeterminada que le corresponde por no haber realizado ningún cambio durante la Inscripción anual). • Si cesa en su empleo dentro de un año calendario y se reincorpora al trabajo en el año calendario siguiente y se encuentra en una de las siguientes categorías, puede llamar a Servicios al Personal al **800-421-1362** para inscribirse en los beneficios médicos u otros beneficios voluntarios dentro de los 60 días siguientes a su reincorporación al trabajo: – Era elegible para inscribirse en los beneficios en el año en que cesó en el empleo, pero no se inscribió – Era elegible para los beneficios y estaba inscrito en ellos en el año en que cesó en el empleo y desea agregar a un hijo a cargo (si corresponde) para el año en que vuelve a trabajar Si vuelve al empleo después de 30 días, pero antes de 13 semanas después de su fecha de cese en el empleo, sujeto a los términos del Plan que sean aplicables, dispondrá de 60 días después de su regreso para abandonar o modificar de otro modo la cobertura restablecida. Después de este periodo de 60 días, y sujeto a los términos del Plan que sean aplicables, no se le permitirá cambiar sus elecciones de beneficios (a excepción del seguro de vida opcional), hasta el siguiente periodo de Inscripción anual, o si tiene un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** en este capítulo.
Consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Plan médico** para obtener información sobre su deducible, el desembolso máximo, la HRA y el beneficio máximo de por vida aplicable a los beneficios de fertilidad bajo el programa de formación de familias de los Centros de Excelencia, si deja el empleo y luego vuelve a ser contratado. Para obtener información sobre el periodo mínimo de inscripción, el deducible y el periodo de espera requeridos para la asistencia de ortodoncia si deja su empleo y luego vuelve a ser contratado, consulte la sección **Si deja Walmart y lo contratan nuevamente** en el capítulo **Plan dental**.	

Si se reincorpora como gerente, empleado por hora a tiempo completo, gerente del Centro de visión a tiempo completo o conductor de camión a tiempo completo o parcial 13 semanas o más después de su fecha de cese en el empleo, se lo considerará como un asociado nuevo, sujeto a las demás condiciones aplicables del Plan.

ASOCIADOS PAGADOS POR HORA A TIEMPO PARCIAL Y TEMPORALES

Para obtener información sobre los beneficios si deja Walmart y vuelve a ser contratado, consulte la sección **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** que aparece anteriormente en este capítulo.

Fechas de entrada en vigencia de los beneficios del Plan

Las siguientes tablas **Inscripción y fechas efectivas por clasificación laboral** indican las fechas de entrada en vigencia de su cobertura si se inscribe y trabaja activamente, como se ha definido anteriormente, en la fecha de entrada en vigencia de la cobertura. Si no está trabajando activamente en la fecha en que la cobertura entraría en vigencia, dicha cobertura entrará en vigencia cuando vuelva a trabajar activamente. Consulte **"Trabajo activo" o "activamente en el trabajo"** más arriba en este capítulo para obtener más información. Si cesa en el empleo antes de inscribirse en los beneficios durante el periodo de inscripción inicial, no será elegible para inscribirse tras su fecha de cese en el empleo. Cada beneficio está sujeto a términos y condiciones específicos. Para obtener más información, consulte el capítulo correspondiente de este *Libro de beneficios para asociados*.

Si usted es un asociado pagado por hora a tiempo completo, por hora a tiempo parcial o temporal en Hawái, existen normas especiales que rigen la elegibilidad y la inscripción de los beneficios médicos y de discapacidad a corto plazo. Consulte el capítulo titulado **Elegibilidad, inscripción y fechas de vigencia para los asociados en Hawái**.

Inscripción y fechas efectivas por clasificación laboral

ASOCIADOS A TIEMPO COMPLETO PAGADOS POR HORA

Incluye a los farmacéuticos pagados por hora a tiempo completo (excepto los farmacéuticos pagados por hora a tiempo completo de California), los asociados de la cadena de suministro de campo por hora a tiempo completo y los supervisores de campo por hora a tiempo completo en tiendas y clubes; excluye a los gerentes de centros de visión por hora a tiempo completo.

NOTA: *No debe confundirse el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura* ***antes*** *de la fecha de vigencia de la cobertura.*

Plan	Periodos de inscripción y fechas efectivas de la cobertura	
• Médico • Planes HMO • Dental – La inscripción es por dos años calendario consecutivos • De la vista • Seguro por enfermedades graves • Seguro contra accidentes • AD&D	**Periodo de inscripción inicial:** Debe inscribirse en la cobertura entre la fecha del primer cheque de pago y el día *anterior* a la fecha de entrada en vigencia de la cobertura. **Cuándo entra en vigencia la cobertura:** Su cobertura entra en vigencia el primer día del mes calendario durante el cual se cumplen 89 días de empleo a tiempo completo continuos.	Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.
• Seguro de vida pagado por la compañía	Se le inscribe automáticamente el primer día del mes calendario en el que cumple 89 días de trabajo continuo a tiempo completo y su cobertura entra en vigencia en esa fecha.	
• Recursos de asistencia para los asociados • Seguro contra accidentes durante viajes de negocios	Su inscripción es automática en la fecha de contratación y su cobertura entra en vigencia en esa fecha.	

(Continúa en la próxima página)

ASOCIADOS A TIEMPO COMPLETO PAGADOS POR HORA (CONTINUACIÓN)
Incluye a los farmacéuticos pagados por hora a tiempo completo (excepto los farmacéuticos pagados por hora a tiempo completo de California), los asociados de la cadena de suministro de campo por hora a tiempo completo y los supervisores de campo por hora a tiempo completo en tiendas y clubes; excluye a los gerentes de centros de visión por hora a tiempo completo.

NOTA: *No debe confundirse el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura* ***antes*** *de la fecha de vigencia de la cobertura.*

Plan	Periodos de inscripción y fechas efectivas de la cobertura
• Seguro de vida opcional para asociados • Seguro de vida opcional para dependientes	**Periodo de inscripción inicial:** Su periodo de inscripción inicial comienza en su primer día de pago y termina el día *anterior* al primer día del mes calendario que contenga su 89.º día de trabajo continuo a tiempo completo. Asimismo, puede inscribirse, aumentar o cancelar la cobertura en cualquier momento una vez finalizado el periodo de inscripción inicial. **Cuándo entra en vigencia la cobertura:**** **Si se inscribe durante el periodo de inscripción inicial:** • Si se inscribe por el monto garantizado, la cobertura entra en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscribe, o 2) el primer día del mes calendario en el que se cumplen 89 días de empleo a tiempo completo continuo. • Si se inscribe por un monto superior al monto garantizado, la cobertura para usted y/o su cónyuge/pareja estará sujeta a la aprobación de Prudential. Deberá presentar un Certificado de buena salud para usted y/o su cónyuge/pareja y posiblemente deba someterse a un examen médico. Si se aprueba, su cobertura entrará en vigencia en la última de las siguientes fechas: 1) la fecha en que Prudential apruebe su cobertura, o 2) el primer día del mes calendario en el que se cumplen 89 días de empleo a tiempo completo continuo. Si no se aprueba ninguna cobertura por encima del monto garantizado y usted (o su cónyuge/pareja) no está ya inscrito en una cobertura por el monto garantizado, usted (o su cónyuge/pareja) quedará inscrito en una cobertura por el monto garantizado y la cobertura entrará en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscriba, o 2) el primer día del mes calendario en el que cumpla 89 días de trabajo continuo a tiempo completo. **Si se inscribe en la cobertura o aumenta la cobertura después del periodo de inscripción inicial:** • La cobertura para usted y/o su cónyuge/pareja (incluido un aumento de la cobertura elegida anteriormente) está sujeta a la aprobación de Prudential. Deberá presentar un Certificado de buena salud para usted y/o su cónyuge/pareja y posiblemente deba someterse a un examen médico. Si se aprueba, su cobertura entrará en vigencia en la fecha en que Prudential la apruebe. • No es necesario presentar un Certificado de buena salud para los hijos que inscriba en la cobertura opcional para dependientes. Si debe facilitar un Certificado de buena salud, las retenciones en nómina de sus primas no comenzarán hasta que su cobertura entre en vigencia, como se ha descrito anteriormente.
• Plan básico de discapacidad a corto plazo – Cobertura básica (no disponible para los asociados que trabajan en California, Hawái, Nueva Jersey y Rhode Island; en Nueva York se ofrece una cobertura diferente) – Beneficios de maternidad *Para obtener información general sobre los beneficios estatales, consulte el capítulo* **Discapacidad a corto plazo para asociados a tiempo completo pagados por hora**.	Su inscripción es automática en el aniversario de 12 meses de la fecha de contratación y su cobertura entra en vigencia en esa fecha.

(Continúa en la próxima página)

ASOCIADOS A TIEMPO COMPLETO PAGADOS POR HORA (CONTINUACIÓN)

Incluye a los farmacéuticos pagados por hora a tiempo completo (excepto los farmacéuticos pagados por hora a tiempo completo de California), los asociados de la cadena de suministro de campo por hora a tiempo completo y los supervisores de campo por hora a tiempo completo en tiendas y clubes; excluye a los gerentes de centros de visión por hora a tiempo completo.

NOTA: *No debe confundirse el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura* ***antes*** *de la fecha de vigencia de la cobertura.*

Plan	Periodos de inscripción y fechas efectivas de la cobertura
• Plan mejorado por discapacidad a corto plazo (no disponible para los asociados que trabajan en California, Hawái, Nueva Jersey y Rhode Island; el plan mejorado por discapacidad a corto plazo de Nueva York está disponible en Nueva York) *Para obtener información general sobre los beneficios estatales, consulte el capítulo* **Discapacidad a corto plazo para asociados a tiempo completo pagados por hora**.	**Periodo de inscripción inicial:** Debe inscribirse en la cobertura entre su primer día de pago y el día *previo* al primer día del mes calendario en el que se cumplen 89 días de empleo a tiempo completo continuo. **Cuándo entra en vigencia la cobertura:** • **Si se inscribe en la cobertura durante el periodo de inscripción inicial:** La cobertura entra en vigencia en el aniversario de 12 meses de su fecha de contratación. • **Si se inscribe en la cobertura después del periodo de inscripción inicial:** La cobertura entra en vigencia 12 meses después de la fecha en que se inscribe en la cobertura durante la Inscripción anual o, en el caso de un evento de cambio de elección, 12 meses después de la fecha del evento. Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.
• Plan por discapacidad a largo plazo (LTD) (incluidos los beneficios mejorados)	**Periodo de inscripción inicial:** Debe inscribirse en la cobertura entre su primer día de pago y el día *previo* al primer día del mes calendario en el que se cumplen 89 días de empleo a tiempo completo continuo. **Cuándo entra en vigencia la cobertura:** • **Si se inscribe en la cobertura durante el periodo de inscripción inicial:** La cobertura entra en vigencia en el aniversario de 12 meses de su fecha de contratación. • **Si se inscribe en la cobertura o aumenta la cobertura después del periodo de inscripción inicial:** – Si usted se inscribe en la cobertura o la aumenta después de un evento de cambio de elección, su cobertura entra en vigencia en la última de las siguientes fechas: 1) el primer día del periodo de pago siguiente a la fecha en que se inscriba, o 2) en el aniversario de 12 meses de su fecha de contratación. – Si se inscribe en la cobertura o la aumenta durante la Inscripción anual para el próximo año del Plan, su cobertura entrará en vigencia en la última de las siguientes fechas: 1) el 1.º de enero de ese año o 2) el aniversario de 12 meses de su fecha de contratación. Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.

*Consulte la tabla de asociados gerenciales si está clasificado como "farmacéutico de California por hora a tiempo completo" en los sistemas de nóminas de Walmart.

**Si su cónyuge/pareja o hijo dependiente está limitado porque debe recibir tratamiento médico (en su hogar o en otro lugar), la cobertura se retrasa hasta que su cónyuge/pareja o hijo tenga el alta médica (no se aplica a un recién nacido).

NOTA: Algunos beneficios requieren que se cumpla la definición de trabajo activo. Para más información, consulte la sección **"Trabajo activo" o "activamente en el trabajo"** de este capítulo.

GERENTES DEL CENTRO DE VISIÓN A TIEMPO COMPLETO PAGADOS POR HORA
NOTA: *No debe confundirse el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura* ***antes*** *de la fecha de vigencia de la cobertura.*

Plan	Periodos de inscripción y fechas efectivas de la cobertura	
• Médico • Planes HMO • Dental – La inscripción es por dos años calendario consecutivos • De la vista • Seguro por enfermedades graves • Seguro contra accidentes • AD&D	**Periodo de inscripción inicial:** Debe inscribirse en la cobertura entre su primer día de pago y el día *anterior* al 60.º día de trabajo, el cual se cuenta a partir de su fecha de contratación. **Cuándo entra en vigencia la cobertura:** Su cobertura entrará en vigencia a partir de la fecha de contratación.	Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.
• Recursos de asistencia para los asociados • Seguro de vida pagado por la compañía • Seguro contra accidentes durante viajes de negocios	Su inscripción es automática en la fecha de contratación y su cobertura entra en vigencia en esa fecha.	
• Seguro de vida opcional para asociados • Seguro de vida opcional para dependientes	**Periodo de inscripción inicial:** Su periodo de inscripción inicial comienza su primer día de pago y termina el día *anterior* al 60° día de trabajo, el cual se cuenta a partir de su fecha de contratación. Asimismo, puede inscribirse, aumentar o cancelar la cobertura en cualquier momento una vez finalizado el periodo de inscripción inicial. **Cuándo entra en vigencia la cobertura:*** **Si se inscribe durante el periodo de inscripción inicial:** • Si se inscribe por el monto garantizado, la cobertura entra en vigencia a partir de la fecha de inscripción. • Si se inscribe por un monto superior al monto garantizado, la cobertura para usted y/o su cónyuge/pareja estará sujeta a la aprobación de Prudential. Deberá presentar un Certificado de buena salud para usted y/o su cónyuge/pareja y posiblemente deba someterse a un examen médico. Si se aprueba, su cobertura entrará en vigencia en la fecha en que Prudential la apruebe. Si no se aprueba la cobertura por encima del monto garantizado, usted (o su cónyuge/pareja) quedará inscrito en la cobertura por el monto garantizado y la cobertura entrará en vigencia en la fecha en que se inscriba. **Si se inscribe en la cobertura o aumenta la cobertura después del periodo de inscripción inicial:** • La cobertura para usted y su cónyuge/pareja (incluido un aumento de la cobertura elegida anteriormente) está sujeta a la aprobación de Prudential. Deberá presentar un Certificado de buena salud para usted y/o su cónyuge/pareja y posiblemente deba someterse a un examen médico. Si se aprueba, su cobertura entrará en vigencia en la fecha en que Prudential la apruebe. • No es necesario presentar un Certificado de buena salud para los hijos que inscriba en la cobertura opcional para dependientes. Si debe facilitar un Certificado de buena salud, las retenciones en nómina de sus primas no comenzarán hasta que su cobertura entre en vigencia, como se ha descrito anteriormente.	
• Plan básico de discapacidad a corto plazo – Cobertura básica (no disponible para los asociados que trabajan en California, Hawái, Nueva Jersey y Rhode Island; en Nueva York se ofrece una cobertura diferente) – Beneficios de maternidad *Para obtener información general sobre los beneficios estatales, consulte el capítulo* **Discapacidad a corto plazo para asociados a tiempo completo pagados por hora**.	Su inscripción es automática en la fecha de contratación y su cobertura entra en vigencia en esa fecha.	

(Continúa en la próxima página)

GERENTES DEL CENTRO DE VISIÓN A TIEMPO COMPLETO PAGADOS POR HORA (CONTINUACIÓN) **NOTA:** *No debe confundirse el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura **antes** de la fecha de vigencia de la cobertura.*	
Plan	**Periodos de inscripción y fechas efectivas de la cobertura**
• Plan mejorado por discapacidad a corto plazo (no disponible para los asociados que trabajan en California, Hawái, Nueva Jersey y Rhode Island; el plan mejorado por discapacidad a corto plazo de Nueva York está disponible en Nueva York) *Para obtener información general sobre los beneficios estatales, consulte el capítulo* **Discapacidad a corto plazo para asociados a tiempo completo pagados por hora**.	**Periodo de inscripción inicial:** Debe inscribirse en la cobertura entre su primer día de pago y el día *anterior* al 60.º día de trabajo, que se cuenta a partir de su fecha de contratación. **Cuándo entra en vigencia la cobertura:** • **Si se inscribe durante el periodo de inscripción inicial:** La cobertura es vigente en la fecha de contratación. • **Si se inscribe en la cobertura después del periodo de inscripción inicial:** La cobertura entra en vigencia 12 meses después de la fecha en que se inscribe en la cobertura durante la Inscripción anual o, en el caso de un evento de cambio de elección, 12 meses después de la fecha del evento. Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.
• Plan por discapacidad a largo plazo (LTD) (incluidos los beneficios mejorados)	**Periodo de inscripción inicial:** Debe inscribirse en la cobertura entre su primer día de pago y el día *anterior* al 60.º día siguiente a su fecha de contratación. **Cuándo entra en vigencia la cobertura:** • **Si se inscribe en la cobertura durante el periodo de inscripción inicial:** La cobertura es vigente en la fecha de contratación. • **Si se inscribe en la cobertura después del periodo de inscripción inicial:** – Si usted se inscribe en la cobertura después de un evento de cambio de elección, su cobertura entra en vigencia el primer día del periodo de pago siguiente a la fecha en que usted se inscriba. – Si se inscribe en la cobertura durante la Inscripción Anual para el próximo año del Plan, su cobertura entrará en vigencia el 1.º de enero de ese año. Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.
*Si su cónyuge/pareja o hijo dependiente está limitado porque debe recibir tratamiento médico (en su hogar o en otro lugar), la cobertura se retrasa hasta que su cónyuge/pareja o hijo tenga el alta médica (no se aplica a un recién nacido). **NOTA:** Algunos beneficios requieren que se cumpla la definición de trabajo activo. Para más información, consulte la sección **"Trabajo activo" o "activamente en el trabajo"** de este capítulo.	

ASOCIADOS PAGADOS POR HORA A TIEMPO PARCIAL Y ASOCIADOS TEMPORALES
Excluye a los conductores de camión a tiempo parcial
NOTA: *No debe confundirse el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura* ***antes*** *de la fecha de vigencia de la cobertura.*

Plan	Periodos de inscripción y fechas efectivas de la cobertura
• Médico* • Planes HMO • Dental – La inscripción es por dos años calendario consecutivos • De la vista • Seguro por enfermedades graves • Seguro contra accidentes • AD&D	**Periodo de inscripción inicial:** **Si tiene derecho a los beneficios médicos u otro tipo de beneficios durante las primeras 52 semanas de trabajo como resultado de haber trabajado la cantidad de horas requerida en un ciclo de 60 días:** Debe inscribirse en la cobertura entre la fecha en que se le notifica por primera vez que satisface los requisitos de elegibilidad y el día *anterior* al 60.º día posterior a la notificación. Consulte la sección titulada **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos**.* **Si tiene derecho a beneficios médicos como resultado de la verificación anual de elegibilidad que surge a las 52 semanas de empleo:** Debe inscribirse en la cobertura entre la fecha siguiente a la semana 52 de aniversario y el día *anterior* al 60.º día de trabajo, que se cuenta a partir de la semana 52 de aniversario. **Independientemente de si tiene derecho al beneficio médico como resultado de las verificaciones de elegibilidad que se describen anteriormente:** Podrá seguir inscribiéndose en todos los otros beneficios disponibles para los asociados pagados por hora a tiempo parcial y los asociados temporales después de 52 semanas de empleo. Debe inscribirse entre la fecha siguiente a la semana 52 de aniversario y el día *anterior* al 60.º día de trabajo, que se cuenta a partir de la semana 52 de aniversario.* **Cuándo entra en vigencia la cobertura:** **Si tiene derecho al beneficio durante las primeras 52 semanas de trabajo como resultado de haber trabajado la cantidad de horas requerida en un ciclo de 60 días:** Su cobertura entra en vigencia el primer día del mes en el que ocurre su 89.º día de trabajo, contado desde la fecha en la que se inició el ciclo de medición de 60 días con éxito. Consulte la sección titulada **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos**. **Si reúne los requisitos como resultado de la verificación anual de elegibilidad que se produce a las 52 semanas de empleo (para los beneficios médicos)* o en su aniversario de 52 semanas (para el resto de los beneficios):** Su cobertura entra en vigencia el primer día del segundo mes calendario siguiente al día *anterior* a la fecha de su aniversario de 52 semanas. Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo. *A fin de ser elegible para la cobertura médica, los asociados temporales y los asociados pagados por hora a tiempo parcial deben trabajar la cantidad de horas requerida y pasar una de las verificaciones de elegibilidad que se describieron en **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** anteriormente en este capítulo. Los farmacéuticos pagados por hora a tiempo parcial contratados antes del 1 de febrero de 2012 están exentos de este requisito
• Recursos de asistencia para los asociados • Seguro contra accidentes durante viajes de negocios	Su inscripción es automática en la fecha de contratación y su cobertura entra en vigencia en esa fecha.

(Continúa en la próxima página)

ASOCIADOS PAGADOS POR HORA A TIEMPO PARCIAL Y ASOCIADOS TEMPORALES (CONTINUACIÓN)
Excluye a los conductores de camión a tiempo parcial

NOTA: *No debe confundirse el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura* ***antes*** *de la fecha de vigencia de la cobertura.*

Plan	Periodos de inscripción y fechas efectivas de la cobertura
• Seguro de vida opcional para asociados • Seguro de vida opcional para dependientes	**Periodo de inscripción inicial:** **Si tiene derecho durante las primeras 52 semanas de trabajo como resultado de haber trabajado la cantidad de horas requerida en un ciclo de 60 días:** Su periodo de inscripción inicial comienza a la fecha en que se le notifica por primera vez que satisface los requisitos de elegibilidad y termina el día *anterior* al 60.º día posterior a la notificación. **Si reúne los requisitos a las 52 semanas de aniversario:** Su periodo de inscripción inicial comienza a la fecha siguiente a la semana 52 de aniversario y termina el día *anterior* al 60.º día de trabajo, que se cuenta a partir de la semana 52 de aniversario. Asimismo, puede inscribirse, aumentar o cancelar la cobertura en cualquier momento una vez finalizado el periodo de inscripción inicial. **Cuándo entra en vigencia la cobertura:**** Para determinar la fecha de entrada en vigencia de su seguro de vida opcional, deberá consultar el análisis de elegibilidad para la cobertura médica. Si es elegible para la cobertura médica antes de su primer aniversario de 52 semanas porque ha trabajado la cantidad de horas requerida en un periodo de medición de 60 días, la fecha de entrada en vigencia de su cobertura médica es la "fecha aplicable" para determinar la fecha de entrada en vigencia del seguro de vida opcional. Si no es elegible para la cobertura médica antes de su aniversario de 52 semanas y, en cambio, es elegible en su aniversario de 52 semanas, la "fecha aplicable" para determinar la fecha de entrada en vigencia del seguro de vida opcional es el primer día del segundo mes calendario siguiente al día anterior a su aniversario de 52 semanas. **Si se inscribe durante el periodo de inscripción inicial:** • Si se inscribe por el monto garantizado, la cobertura entrará en vigencia en la última de las siguientes fechas: 1) la fecha de inscripción, o 2) la "fecha aplicable". • Si se inscribe por un monto superior al monto garantizado, la cobertura para usted y/o su cónyuge/pareja estará sujeta a la aprobación de Prudential. Deberá presentar un Certificado de buena salud para usted y su cónyuge/pareja y posiblemente deba someterse a un examen médico. Si se aprueba, su cobertura entrará en vigencia en la última de las siguientes fechas: 1) la fecha en que Prudential apruebe su cobertura, o 2) la "fecha aplicable". Si no se aprueba ninguna cobertura por encima del monto garantizado y usted no está ya inscrito en una cobertura por el monto garantizado, usted quedará inscrito en una cobertura por el monto garantizado y la cobertura entrará en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscriba, o 2) la "fecha aplicable". **Si se inscribe en la cobertura o aumenta la cobertura después del periodo de inscripción inicial:** • La cobertura para usted y/o su cónyuge/pareja (incluido un aumento de la cobertura elegida anteriormente) está sujeta a la aprobación de Prudential. Deberá presentar un Certificado de buena salud para usted y/o su cónyuge/pareja y posiblemente deba someterse a un examen médico. Si se aprueba, su cobertura entrará en vigencia en la fecha en que Prudential la apruebe. • No es necesario presentar un Certificado de buena salud para los hijos que inscriba en la cobertura opcional para dependientes. Si debe facilitar un Certificado de buena salud, las retenciones en nómina de sus primas no comenzarán hasta que su cobertura entre en vigencia, como se ha descrito anteriormente.

**Si su hijo dependiente está limitado porque debe recibir tratamiento médico (en su hogar o en otro lugar), la cobertura se retrasa hasta que su hijo tenga el alta médica (no se aplica a un recién nacido).

Los asociados pagados por hora a tiempo parcial y los asociados temporales solo pueden agregar a la cobertura a sus hijos dependientes elegibles, pero no a sus cónyuges/parejas. La cobertura por discapacidad y el seguro de vida pagado por la compañía no están disponibles para los asociados pagados por hora a tiempo parcial y los asociados temporales.

NOTA: Algunos beneficios requieren que se cumpla la definición de trabajo activo. Para más información, consulte la sección **"Trabajo activo" o "activamente en el trabajo"** de este capítulo.

CONDUCTORES DE CAMIÓN A TIEMPO PARCIAL

NOTA: *No debe confundirse el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura **antes** de la fecha de vigencia de la cobertura.*

<table>
<tr><th>Plan</th><th colspan="2">Periodos de inscripción y fechas efectivas de la cobertura</th></tr>
<tr><td>• Médico
• Planes HMO
• Dental
– La inscripción es por dos años calendario consecutivos
• De la vista
• Seguro por enfermedades graves
• Seguro contra accidentes
• AD&D</td><td>Periodo de inscripción inicial:
Debe inscribirse en la cobertura entre su primer día de pago y el día de trabajo 60.º, el cual se cuenta a partir de su fecha de contratación.
Cuándo entra en vigencia la cobertura:
Su cobertura entra en vigencia el primer día del mes calendario en el que cumple 89 días de trabajo continuo a tiempo completo.</td><td>Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la sección Cambios de elección permitidos fuera del periodo de Inscripción anual de este capítulo.</td></tr>
<tr><td>• Recursos de asistencia para los asociados
• Seguro contra accidentes durante viajes de negocios</td><td colspan="2">Su inscripción es automática en la fecha de contratación y su cobertura entra en vigencia en esa fecha.</td></tr>
<tr><td>• Seguro de vida opcional para asociados
• Seguro de vida opcional para dependientes</td><td colspan="2">Periodo de inscripción inicial:
El periodo de inscripción inicial comienza su primer día de pago y termina el día anterior al primer día del mes calendario en el que caiga su 89.º día de trabajo continuo.
Asimismo, puede inscribirse, aumentar o cancelar la cobertura en cualquier momento una vez finalizado el periodo de inscripción inicial.
Cuándo entra en vigencia la cobertura:*
Si se inscribe durante el periodo de inscripción inicial:
• Si se inscribe por el monto garantizado, la cobertura entra en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscribe, o 2) el primer día del mes calendario en el que se cumplen 89 días de empleo continuo.
• Si se inscribe por un monto superior al garantizado, su cobertura estará sujeta a la aprobación de Prudential. Deberá proporcionar un Certificado de buena salud y posiblemente deba someterse a un examen médico. Si se aprueba, su cobertura entrará en vigencia en la última de las siguientes fechas: 1) la fecha en que Prudential apruebe su cobertura, o 2) el primer día del mes calendario en el que se cumplen 89 días de empleo continuo. Si no se aprueba ninguna cobertura por encima del monto garantizado, usted quedará inscrito en una cobertura por el monto garantizado y la cobertura entrará en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscriba, o 2) el primer día del mes calendario en el que cumpla 89 días de trabajo continuo.
Si se inscribe en la cobertura o aumenta la cobertura después del periodo de inscripción inicial:
• La cobertura (incluido un aumento de la cobertura elegida anteriormente) está sujeta a la aprobación de Prudential. Deberá proporcionar un Certificado de buena salud y posiblemente deba someterse a un examen médico. Si se aprueba, su cobertura entrará en vigencia en la fecha en que Prudential la apruebe.
• No es necesario presentar un Certificado de buena salud para los hijos dependientes que inscriba en la cobertura opcional para dependientes.
Si debe facilitar un Certificado de buena salud, las retenciones en nómina de sus primas no comenzarán hasta que su cobertura entre en vigencia, como se ha descrito anteriormente.</td></tr>
</table>

*Si su hijo dependiente está limitado porque debe recibir tratamiento médico (en su hogar o en otro lugar), la cobertura se retrasa hasta que su hijo tenga el alta médica (no se aplica a un recién nacido).

Los conductores de camión a tiempo parcial no están sujetos a las verificaciones de elegibilidad para los beneficios descritos antes en este capítulo.

Los conductores de camión a tiempo parcial solo pueden agregar a la cobertura a sus hijos dependientes elegibles, pero no a sus cónyuges/parejas. La cobertura por discapacidad y el seguro de vida pagado por la compañía no están disponibles para los conductores de camión a tiempo parcial.

NOTA: Algunos beneficios requieren que se cumpla la definición de trabajo activo. Para más información, consulte la sección **"Trabajo activo" o "activamente en el trabajo"** de este capítulo.

ASOCIADOS A LA GERENCIA

Incluye asociados gerenciales en formación, farmacéuticos de California por hora a tiempo completo* y conductores de camión a tiempo completo.

NOTA: *No debe confundirse el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura* ***antes*** *de la fecha de vigencia de la cobertura.*

Plan	Periodos de inscripción y fechas efectivas de la cobertura	
• Médico • Planes HMO • Dental – La inscripción es por dos años calendario consecutivos • De la vista • Seguro por enfermedades graves • Seguro contra accidentes • AD&D	**Periodo de inscripción inicial:** Debe inscribirse en la cobertura entre su primer día de pago y el 60.º día de trabajo, el cual se cuenta a partir de su fecha de contratación. **Cuándo entra en vigencia la cobertura:** Su cobertura entrará en vigencia a partir de la fecha de contratación.	Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.
• Recursos de asistencia para los asociados • Seguro de vida pagado por la compañía • Seguro contra accidentes durante viajes de negocios • Plan de discapacidad a corto plazo**	Su inscripción es automática en la fecha de contratación y su cobertura entra en vigencia en esa fecha.	
• Seguro de vida opcional para asociados • Seguro de vida opcional para dependientes	**Periodo de inscripción inicial:** Su periodo de inscripción inicial comienza en la fecha de su primer día de pago y termina el día 60.º de empleo, el cual se cuenta a partir de su fecha de contratación. Asimismo, puede inscribirse, aumentar o cancelar la cobertura en cualquier momento una vez finalizado el periodo de inscripción inicial. **Cuándo entra en vigencia la cobertura:***** **Si se inscribe durante el periodo de inscripción inicial:** • Si se inscribe por el monto garantizado, la cobertura entra en vigencia a partir de la fecha de inscripción. • Si se inscribe por un monto superior al monto garantizado, la cobertura para usted y/o su cónyuge/pareja estará sujeta a la aprobación de Prudential. Deberá presentar un Certificado de buena salud para usted y/o su cónyuge/pareja y posiblemente deba someterse a un examen médico. Si se aprueba, su cobertura entrará en vigencia en la fecha en que Prudential la apruebe. Si no se aprueba alguna cobertura por encima del monto garantizado, usted (o su cónyuge/pareja) no está ya inscrito en una cobertura por el monto de emisión garantizado, usted (o su cónyuge/pareja) quedará inscrito en una cobertura por el monto garantizado y la cobertura entrará en vigencia en su fecha de contratación. **Si se inscribe en la cobertura o aumenta la cobertura después del periodo de inscripción inicial:** • La cobertura para usted y/o su cónyuge/pareja (incluido un aumento de la cobertura elegida anteriormente) está sujeta a la aprobación de Prudential. Deberá presentar un Certificado de buena salud para usted y/o su cónyuge/pareja y posiblemente deba someterse a un examen médico. Si se aprueba, su cobertura entrará en vigencia en la fecha en que Prudential la apruebe. • No es necesario presentar un Certificado de buena salud para los hijos dependientes que inscriba en la cobertura de seguro de vida para dependientes. Si debe facilitar un Certificado de buena salud, las retenciones en nómina de sus primas no comenzarán hasta que su cobertura entre en vigencia, como se ha descrito anteriormente.	

(Continúa en la próxima página)

ASOCIADOS A LA GERENCIA (CONTINUACIÓN)
Incluye asociados gerenciales en formación, farmacéuticos de California por hora a tiempo completo* y conductores de camión a tiempo completo.

NOTA: *No debe confundirse el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura **antes** de la fecha de vigencia de la cobertura.*

Plan	Periodos de inscripción y fechas efectivas de la cobertura
• Plan de discapacidad a largo plazo (LTD), incluidos los beneficios mejorados (para asociados gerenciales que no sean conductores de camión a tiempo completo)	**Periodo de inscripción inicial:** Debe inscribirse en la cobertura entre su primer día de pago y el día de trabajo 60.º, el cual se cuenta a partir de su fecha de contratación. **Cuándo entra en vigencia la cobertura:** • **Si se inscribe en la cobertura durante el periodo de inscripción inicial:** La cobertura es vigente en la fecha de contratación. • **Si se inscribe en la cobertura o aumenta la cobertura después del periodo de inscripción inicial:** – Si usted se inscribe en la cobertura o la aumenta después de un evento de cambio de elección, su cobertura entra en vigencia el primer día del periodo de pago siguiente a la fecha en que usted se inscriba. – Si se inscribe en la cobertura o la aumenta durante la Inscripción anual para el próximo año del Plan, su cobertura entrará en vigencia el 1.º de enero de ese año. Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el próximo periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.
• Plan de discapacidad a largo plazo para conductores de camión a tiempo completo (con beneficios mejorados)	**Periodo de inscripción inicial:** Debe inscribirse en la cobertura entre su primer día de pago y el día de trabajo 60.º, el cual se cuenta a partir de su fecha de contratación. **Cuándo entra en vigencia la cobertura:** • **Si se inscribe en la cobertura durante el periodo de inscripción inicial:** La cobertura es vigente en la fecha de contratación. • **Si se inscribe en la cobertura o aumenta la cobertura después del periodo de inscripción inicia:** Su cobertura está sujeta a la aprobación de Lincoln. Deberá presentar un Certificado de buena salud y posiblemente deba someterse a un examen médico a su propio cargo. – Si usted se inscribe en la cobertura o la aumenta después de un evento de cambio de elección y recibe aprobación, su cobertura entra en vigencia el primer día del periodo de pago siguiente a la fecha en que se reciba su aprobación. – Si usted se inscribe en la cobertura o la aumenta durante el periodo de Inscripción anual para el próximo año del Plan y recibe aprobación, su cobertura entrará en vigencia a más tardar 1) el 1 de enero de ese año, o 2) si es aprobado el 1 de enero de ese año en curso o después, el primer día del periodo de pago siguiente a la fecha en que se reciba la aprobación. – Si no obtiene aprobación, podrá inscribirse durante el siguiente periodo de Inscripción anual o después de un evento de cambio de elección, pero estará sujeto a los mismos requisitos del Certificado de buena salud. Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.

*Los farmacéuticos que trabajan en California y tienen la designación de "farmacéutico de California por hora a tiempo completo" en los sistemas de nómina son elegibles para los beneficios que se indican aquí para los asociados gerenciales.

**Los planes de discapacidad a corto plazo para asociados asalariados y conductores de camión no están cubiertos por ERISA y no forman parte del Plan de Salud y Bienestar de los Asociados.

***Si su cónyuge/pareja o hijo dependiente está limitado porque debe recibir tratamiento médico (en su hogar o en otro lugar), la cobertura se retrasa hasta que su cónyuge/pareja o hijo tenga el alta médica (no se aplica a un recién nacido).

NOTA: Algunos beneficios requieren que se cumpla la definición de trabajo activo. Para más información, consulte **"Trabajo activo" o "activamente en el trabajo"** más adelante en este capítulo.

Pago de los beneficios

Tiene que pagar las primas de cualquier beneficio al que decida inscribirse (por ejemplo, cobertura médica, dental, de la visión, seguro de vida opcional, etc.) para que la cobertura del beneficio siga vigente. Si su cobertura cambia durante el año, sus primas se ajustarán en consecuencia. No está obligado a pagar las primas de ningún beneficio en el que esté inscrito automáticamente (es decir, recursos de asistencia para asociados, discapacidad básica a corto plazo para los asociados pagados por hora, discapacidad a corto plazo para los asociados asalariados, discapacidad a corto plazo para los conductores de camión, cobertura de seguro de vida pagada por la compañía y seguro contra accidentes durante viajes de negocios).

En el caso de los beneficios que tienen una prima correspondiente, las primas que pague dependerán de una serie de factores, por ejemplo, los beneficios que seleccione, los dependientes que cubra y si es elegible para las tarifas para no fumadores. En el capítulo específico de cada beneficio se explican los factores que influyen en el monto de la prima de ese beneficio, incluido si tiene derecho a las tarifas para no fumadores. No obstante, su elegibilidad para las tarifas para no fumadores dependerá de las preguntas que responda durante el proceso de inscripción.

TARIFAS POR CONSUMO DE TABACO

Puede recibir tarifas para no fumadores que son más bajas para la cobertura de servicios médicos y medicamentos recetados, el seguro de vida opcional para asociados, el seguro de vida opcional para dependientes para un cónyuge y el seguro de enfermedad grave si:

- Usted y/o su cónyuge/pareja cubiertos no consumen productos del tabaco, o
- Usted y/o su cónyuge/pareja cubierto consumen tabaco y usted y/o su cónyuge/pareja cubierto aceptan inscribirse y participar en un programa para dejar de fumar de su elección antes de que finalice el año del Plan para el que se inscribe. Como alternativa, si usted/ellos llaman al programa para dejar de fumar de Walmart al **855-955-1905**, el programa trabajará con usted (y, si lo desea, con el médico de usted/ellos) para determinar el programa adecuado para usted/ellos.

No consumir productos de tabaco quiere decir que usted y/o su cónyuge/pareja cubierto no ha consumido ningún tipo de producto de tabaco en los últimos 30 días y que usted y/o su cónyuge/pareja cubierto se compromete a no consumir ningún producto de tabaco en 2025. Los "productos de tabaco" incluyen cigarrillos, puros, pipas, rapé, tabaco de mascar y cigarrillos electrónicos o cualquier otro dispositivo de suministro de nicotina.

IMPORTANTE

Si usted se inscribe por primera vez, debe completar una sesión de inscripción en línea en **One.Walmart.com/Enroll**, a fin de recibir las tarifas para no fumadores.

A fin de determinar su elegibilidad a las tarifas sin tabaco, se le pedirá que dé fe de su consumo de tabaco, del consumo de tabaco de su cónyuge/pareja cubierta y de si usted y/o su cónyuge/pareja cubierta aceptan inscribirse y participar en un programa para dejar de fumar. Se le pedirá que haga esta declaración en su inscripción inicial para el resto del año calendario y cada año durante la Inscripción anual para el año calendario siguiente. Tenga en cuenta que su elegibilidad para las tarifas para no fumadores se puede establecer solo en su inscripción inicial y durante la Inscripción anual. Si usted y/o su cónyuge/pareja cubierta no atestiguan durante la inscripción inicial o la Inscripción anual que aceptan inscribirse y participar en un programa para dejar de fumar, pero a pesar de ello dejan de consumir tabaco durante el año del plan, no podrán acogerse a las tarifas para dejar de consumir tabaco hasta el siguiente año calendario.

La siguiente declaración aparece en la pantalla cuando se inscribe en los beneficios y responde a las preguntas sobre el consumo de tabaco:

"Esperamos que cuando solicite o se inscriba en beneficios, proporcione información correcta y precisa. De lo contrario, podrá perder los beneficios o el empleo".

Consulte el Código de Conducta, que puede encontrar en **One.Walmart.com** para revisar la política de Walmart sobre la deshonestidad intencionada. Si recibimos un informe de abuso, llevaremos a cabo una investigación ética.

Para más información, consulte **Programa Quit Tobacco para dejar el tabaco** en el capítulo **Plan médico**.

CÓMO SE PAGAN LAS PRIMAS

Generalmente, las primas se deducen de cada periodo de pago. Las deducciones de su sueldo por beneficios en cualquier periodo de pago pagan la cobertura que se le proporcionó durante ese periodo de pago.

EJEMPLO: Si recibe un pago quincenal, sus retenciones pagan la cobertura de las dos semanas de ese periodo de pago. Supongamos que un periodo de pago va del 1 al 14 de abril, siendo el día de pago de ese periodo el 20 de abril. Las retenciones efectuadas sobre la nómina que recibirá el 20 de abril se destinarán a la cobertura de sus beneficios del 1 al 14 de abril.

EJEMPLO: Si recibe un pago semanal, sus retenciones pagan la cobertura de la semana de ese periodo de pago. Supongamos que un periodo de pago va del 1 al 7 de abril, siendo el día de pago de ese periodo el 13 de abril. Las retenciones de la nómina que recibirá el 13 de abril se destinarán a la cobertura de sus beneficios del 1 al 7 de abril.

Las primas no se deducen de su salario hasta que la cobertura elegida entre en vigencia.

Su pago por el periodo de pago posterior a la fecha de entrada en vigencia de su cobertura reflejará las deducciones para cada uno de los días que tuvo cobertura durante ese periodo de pago. Si un periodo de pago abarca dos años calendario, las deducciones reflejarán el importe para el año anterior hasta el 31 de diciembre y el nuevo importe para el año nuevo, prorrateados según la cantidad de días de cobertura desde el 1.° de enero hasta el final del periodo de pago.

Asegúrese de revisar su recibo de pago lo antes posible después de la fecha de vigencia de su cobertura para verificar que se estén realizando las deducciones adecuadas. Recuerde que puede ver el recibo de su nómina en línea el lunes anterior al día de pago ingresando a **One.Walmart.com**.

Si considera que la cobertura o las deducciones no son correctas en el recibo de pago, llame de inmediato a Servicios al Personal al **800-421-1362**. Las solicitudes de revisión de las primas pagadas se consideran si se envían dentro de un año desde la fecha de un posible pago en exceso. Se realizará una conciliación de primas por un máximo de un año. Para obtener información detallada sobre cómo solicitar la corrección de un error de inscripción, incluidos los plazos para hacerlo, consulte la sección **Confirmación de la inscripción** anterior de este capítulo.

IMPUESTOS

Algunos tipos de cobertura se pagan con dinero antes de impuestos. Esto significa que las primas se deducen de su pago quincenal antes de que se retengan los impuestos federales y, en la mayoría de los casos, estatales. Debido a que los impuestos de la Seguridad Social no se retienen en dinero antes de impuestos que destina al pago de los beneficios, los montos que paga para los beneficios con dinero antes de impuestos no se consideran como parte del salario a los fines de la Seguridad Social. Como resultado, es posible que sus futuros beneficios de Seguridad Social se reduzcan un poco. Otros tipos de cobertura se pagan usando dólares después de impuestos, lo que significa que las primas se pagan con montos que ya han estado sujetos a impuestos.

Las primas de los siguientes tipos de cobertura se pagan antes de impuestos, con algunas excepciones que se comentan a continuación:

- Gastos médicos (excepto las primas para la opción de asegurado PPO, y para las parejas e hijos de parejas en todas las opciones, que se pagan después de impuestos, a menos que el pareja/hijo sea su dependiente fiscal).
- Dental
- De la vista
- Seguro por enfermedades graves
- Seguro contra accidentes
- Seguro por muerte accidental y desmembramiento (AD&D)

Si está inscrito en el Plan Saver, también puede ser elegible para contribuir a la cuenta de ahorro de salud mediante una modalidad antes de impuestos. Para obtener más información, consulte el capítulo **Cuenta de ahorro de salud (HSA)**.

Las primas de los siguientes tipos de cobertura se pagan después de impuestos:

- Cobertura médica para la pareja y sus hijos, a menos que la pareja/hijo sea su dependiente fiscal.
- Todos los tipos de cobertura de discapacidad
- Seguro de vida opcional para el asociado y los dependientes

En algunos casos, las primas que normalmente se pagan antes de impuestos se pagan con dólares después de impuestos, tales como:

- Deducciones por cobertura con efecto retroactivo. Esto puede ocurrir cuando se le permite inscribirse después de la fecha de entrada en vigencia de su cobertura (por ejemplo, cuando ha experimentado un evento de cambio de elección o es un asociado recién contratado con beneficios vigentes a partir de su fecha de contratación). Consulte la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.
- Deducción de las primas vencidas.

CONSECUENCIAS FISCALES DE LOS BENEFICIOS PARA PAREJAS

Las primas que paga por la cobertura médica en la que se inscribe para usted y sus dependientes elegibles representan parte del costo total de tal cobertura. Walmart aporta el resto del costo. De acuerdo con la legislación federal, la parte del costo que Walmart paga por su cobertura médica, y la cobertura médica que elija para su cónyuge e hijos dependientes que reúnan los requisitos, no está sujeta a impuestos.

Por lo general, las parejas que no son cónyuges y sus hijos no son elegibles para ser considerados cónyuges o dependientes en virtud del Código de Rentas Internas (o la ley estatal del impuesto sobre la renta, si corresponde). En ese caso, el aporte de Walmart para la cobertura de su pareja y/o de sus hijos se considerará ingresos imponibles para usted. Esta base imponible suele denominarse "ingresos imputados". Los ingresos imputados están sujetos a los impuestos y retenciones federales, estatales, locales, del Seguro Social y de Medicare aplicables. En consecuencia, los ingresos imputados se incluyen en su nómina y en el formulario W-2.

Cómo se determinan sus ingresos imputados

El aporte de Walmart por el costo de la cobertura médica para la cobertura del asociado + cónyuge/pareja o asociado + familia menos el aporte de Walmart por la cobertura médica para la cobertura de asociado solo es el monto de sus ingresos imputados. Abajo se presenta un ejemplo de cómo se determinan los ingresos imputados para la cobertura de asociado + pareja:

INGRESOS IMPUTADOS: UN EJEMPLO	
Aporte de Walmart por periodo de pago:	
Cobertura de asociados + parejas	$700
Cobertura del asociado solo	- $300
El monto por periodo de pago que se imputa a los ingresos (agregado a su salario imponible)	$400

Cómo se ven los ingresos imputados en su nómina

Si ha inscrito a su pareja y/o a los hijos de su pareja a la cobertura médica y tiene ingresos imputados, su nómina reflejará los ingresos imputados como una partida, con un monto en dólares, tanto en la columna de ingresos de su nómina como en la columna de deducciones. Los ingresos imputados pueden aumentar su base imponible y afectar el monto de los impuestos retenidos de su nómina, pero no aumentan su salario neto.

Si eligió la cobertura médica para su pareja y/o sus hijos pero usted no recibe remuneración de Walmart, Walmart puede cobrarle directamente su parte de la obligación tributaria del Seguro Social y Medicare por sus ingresos imputados.

Estas reglas no se aplican si su pareja y/o sus hijos cumplen con los requisitos como dependientes a los fines fiscales conforme al Código Fiscal.

Es importante mantener actualizados los datos de sus dependientes y sus beneficios. Algunos acontecimientos de la vida pueden afectar sus impuestos y otras retenciones de su nómina. Consulte la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.

Mantener las primas al día

Si recibe un pago de Walmart (es decir, cualquier pago que se procese a través del sistema de nóminas de Walmart), cualquier prima que deba actualmente (incluidas las primas vencidas) se deducirá de ese pago en la medida en que lo permita la ley. Puede haber ocasiones en las que su pago no sea suficiente para cubrir los pagos de las primas adeudadas. En ese caso, usted es responsable de pagar las primas no pagadas en la medida en que las primas se hubieran pagado si se retuvieran como deducciones de la nómina. Los pagos de las primas correspondientes a un periodo de pago deben realizarse antes del cierre de ese periodo.

Si recibe un pago que se procesa a través del sistema de nóminas de Walmart (independientemente de si se trata de salarios, pagos de incentivos, tiempo libre con goce de sueldo, licencias con goce de sueldos, etc.), cualquier prima vencida que deba se deducirá de ese pago antes de las primas que se deban para el periodo actual. Las primas vencidas se pagarán después de impuestos.

Si alguna de las primas de cualquier beneficio permanece vencida durante más de 30 días, toda la cobertura que haya seleccionado se cancelará con efecto retroactivo a la fecha en que las primas estén al día. Esto quiere decir que la cancelación de su cobertura tendrá efecto retroactivo. Si se cancela su cobertura por falta de pago de las primas, se le dará de baja como si se hubiera dado de baja voluntariamente, y:

- Si usted es asociado activo, no podrá volver a inscribirse hasta el próximo periodo de Inscripción anual a menos que surja un evento de cambio de elección válido y siga siendo elegible. Usted podrá volver a inscribirse en el seguro de vida opcional en cualquier momento, siempre que sea elegible. Es posible que deba presentar un Certificado de buena salud para reinscribirse. Consulte la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.
- Si tiene una licencia de ausencia y se reincorpora al trabajo activo en el plazo de un año a partir del primer día de la licencia de ausencia, se le inscribirá en la misma cobertura que estaba en vigencia inmediatamente antes de su licencia de ausencia (o en la cobertura más similar ofrecida por el Plan), a menos que haya elegido otra cobertura según lo permitido por el Plan. La cobertura entrará en vigencia el primer día del periodo de pago en que usted se reincorpore al trabajo activo.
- Si tiene una licencia de ausencia y vuelve a trabajar activamente después de un año a partir del primer día del permiso, se lo considerará asociado nuevo y deberá cumplir con todos los requisitos de elegibilidad correspondientes antes de que pueda inscribirse en la cobertura.

Para evitar la interrupción o cancelación de la cobertura, los pagos de las primas pueden realizarse con antelación a la fecha de vencimiento accediendo al portal de pagos en **One.Walmart.com/Enroll**.

También puede llamar a Servicios al Personal al **800-421-1362** y decir “make a payment” (realizar un pago). Para confirmar el monto adeudado de la prima, llame a Servicios al Personal.

Los pagos que se realicen a través del portal de pagos o llamando al Servicios al Personal pueden realizarse con una tarjeta de crédito o débito VISA, MasterCard, American Express o Discover. Las primas también se pueden pagar con un cheque o giro postal pagaderos al Fondo de Salud y Bienestar para Asociados y enviados por correo postal a la siguiente dirección:

Walmart People Services
P.O. Box 1039
Department 3001
Lowell, Arkansas 72745

Para garantizar la correcta acreditación cuando envíe el pago, incluya su nombre y WIN en el pago. El procesamiento demorará entre 10 y 14 días.

Si no puede realizar los pagos de su prima, el Plan aceptará los pagos que otra persona realice en su nombre.

Las primas se deducirán de su pago final, ya que con las deducciones se paga la cobertura que tuvo durante ese periodo de pago.

CUANDO ESTÁ DE LICENCIA

Mientras esté de licencia conforme a la Ley de Licencia Familiar y Médica (FMLA), de licencia personal o de licencia militar, puede conservar la mayoría de los beneficios voluntarios en los que estaba inscrito el día inmediatamente anterior al primer día de licencia, siempre y cuando se hayan pagado todas las primas puntualmente.

Las coberturas que puede retener incluyen seguro médico, dental, de la vista, de enfermedad grave, de accidentes, de vida opcional para asociados, de vida opcional para dependientes y de AD&D. Asimismo, conservará los recursos de asistencia para los asociados, pero no se requieren primas para ese beneficio. Para estos beneficios voluntarios, por lo general, la cobertura se mantiene en los mismos términos y condiciones como si hubiese seguido trabajando durante el periodo de licencia. Comuníquese con un miembro de su equipo de administración o Sedgwick, el administrador de licencias de Walmart, para obtener más información acerca de la licencia conforme a la ley FMLA, por motivos personales o militar. También puede consultar la Política de Permisos de Ausencia de Walmart en **One.Walmart.com** para obtener información específica. También puede comunicarse con su representante de personal si tiene preguntas acerca de la política sobre la licencia conforme a la FMLA, por motivos personales o militar. Las decisiones sobre la licencia de ausencia son responsabilidad de Walmart, no del Plan.

También tiene la opción de darse de baja de la cobertura en caso de estar de licencia. Para obtener más información, incluido el plazo en el que puede abandonar la cobertura, consulte la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** más adelante en este capítulo.

Si deja su cobertura durante su licencia FMLA, licencia personal o militar y vuelve a reincorporarse al trabajo, puede volver a inscribirse en su cobertura anterior. Para obtener más información, incluido el plazo en el que puede volver inscribirse en la cobertura, consulte la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** más adelante en este capítulo.

PAGO DE LAS PRIMAS EN CASO DE LICENCIA SIN GOCE DE SUELDO O SI ESTÁN VENCIDAS

Usted es responsable de asegurarse de que las primas se paguen a tiempo para que su cobertura de beneficios permanezca activa. Cuando las primas están vencidas, independientemente del motivo, debe tomar medidas para mantenerlas al día o arriesgarse a que se cancele su cobertura. Como se mencionó anteriormente, si alguna de las primas de cualquier beneficio permanece vencida durante más de 30 días, toda la cobertura que haya seleccionado se cancelará con efecto retroactivo a la fecha en que las primas estén al día.

Cuando esté de licencia, puede recibir un pago del que se deduzcan algunas o todas las primas vencidas. No obstante, es posible que los pagos que reciba no sean suficientes para abonar todas las primas vencidas actualmente y que queden montos pendientes de pago. Cuando esté de licencia (independientemente del motivo) es su responsabilidad asegurarse de que todas las primas se pagan a tiempo para que su cobertura de beneficios siga activa.

PAGO DE LAS PRIMAS CUANDO ESTÁ DE LICENCIA CON GOCE DE SUELDO

Como se ha comentado anteriormente, si recibe un pago de Walmart (es decir, cualquier pago que se procese a través del sistema de nóminas de Walmart), cualquier prima que deba actualmente (incluidas las primas vencidas) se deducirá de ese pago en la medida en que lo permita la ley. Esto incluye el pago de los salarios, los beneficios por discapacidad a corto plazo y otras licencias con goce de sueldo procesadas a través del sistema de nóminas de Walmart, los pagos de incentivos, el tiempo libre con goce de sueldo, etc. Deberá hacer los arreglos necesarios para pagar las primas que aún se deban tras las deducciones de nómina, de lo contrario se arriesgará a la cancelación de la cobertura.

Si está recibiendo pagos de cualquier otra fuente (tal como, beneficios por discapacidad a largo plazo pagados por Lincoln o beneficios por discapacidad a corto plazo que no se procesan a través del sistema de nóminas de Walmart), no se deducirá ninguna prima de esos pagos. Para más información, consulte la sección **Pagar las primas al recibir beneficios por discapacidad** de este capítulo.

PAGO DE LAS PRIMAS CUANDO ESTÁ DE LICENCIA CON GOCE DE SUELDO

Si se ha inscrito en algún tipo de cobertura por discapacidad, la cobertura puede continuar durante un periodo de tiempo limitado si se encuentra de licencia o cesantía temporal. En la medida en que se le exija el pago de primas para mantener la cobertura de discapacidad, seguirá debiendo primas mientras dure la cobertura. Para obtener información sobre el periodo durante el que continúa la cobertura de discapacidad en esta circunstancia, consulte la sección **Si está con licencia de ausencia o sujeto a cesantía temporal** del capítulo **Discapacidad a corto plazo para asociados a tiempo completo pagados por hora**, el capítulo **Discapacidad a largo plazo para asociados asalariados y a tiempo completo pagados por hora**, o el capítulo **Discapacidad a largo plazo para conductores de camión**, según corresponda.

Si ha elegido una cobertura de discapacidad por la que debe pagar primas (es decir, un plan mejorado de discapacidad a corto plazo para los trabajadores por hora a tiempo completo o cualquier cobertura de discapacidad a largo plazo), es importante entender cuándo se deducirán las primas de esa cobertura de discapacidad del pago procesado a través del sistema de nóminas de Walmart. Uno de los factores que determinan las primas por discapacidad que debe pagar es el tipo de pago que recibe. El hecho de que las primas para la cobertura de discapacidad se deduzcan del pago procesado a través del sistema de nóminas de Walmart depende del tipo de pago que sea. No todos los pagos que recibe son admisibles para fines del cálculo de los beneficios de discapacidad, por lo que no todos los pagos que recibe tienen su correspondiente deducción por primas de discapacidad. Por ejemplo, en ciertos casos, si está discapacitado y recibe beneficios por discapacidad a corto plazo tramitados a través del sistema de nóminas de Walmart porque se ha determinado que está discapacitado en virtud de un plan de discapacidad a corto plazo, no se retendrá ninguna prima por cobertura de discapacidad de esos pagos de beneficios por discapacidad. Por otro lado, las primas de la cobertura de discapacidad se descontarán de su pago que no sea por discapacidad.

Puede haber ocasiones en las que se deduzcan las primas por discapacidad del pago que, de otro modo, no estaría sujeto a las primas por discapacidad. Por ejemplo, si está discapacitado y recibe beneficios por discapacidad procesados a través del sistema de nóminas de Walmart cuando las primas (incluidas las primas por discapacidad) de un periodo de nóminas anterior siguen estando vencidas, esas primas vencidas pueden deducirse de los beneficios por discapacidad, a pesar de que no se deban primas por discapacidad actuales con respecto a esos beneficios por discapacidad actuales, distintos de los asociados gerenciales de salud y bienestar durante los primeros 90 días de incapacidad.

PAGAR LAS PRIMAS AL RECIBIR BENEFICIOS POR DISCAPACIDAD

Los beneficios por discapacidad se tramitan de forma diferente, dependiendo del plan en el que esté inscrito y del estado en el que trabaje. La finalidad de la tabla que aparece abajo y en la siguiente página es ayudarle a comprender cómo se gestionan las primas cuando se reciben pagos por discapacidad y otras remuneraciones conforme a un programa de licencias con goce de sueldo de Walmart.

Cuando esté de licencia (independientemente del motivo) es su responsabilidad asegurarse de que todas las primas se pagan a tiempo para que su cobertura de beneficios siga activa. Si no puede realizar los pagos de su prima, el Plan aceptará los pagos que otra persona realice en su nombre.

PARA MANTENER LA COBERTURA CONFORME A ESTOS BENEFICIOS	
• Médico • Dental • De la vista • Seguro por enfermedades graves • Seguro contra accidentes	• Seguro de vida opcional para asociados • Seguro de vida opcional para dependientes • AD&D • Discapacidad a corto plazo • Discapacidad de largo plazo

MIENTRAS RECIBE…	
Beneficios por discapacidad a corto plazo en virtud del plan de discapacidad a corto plazo para asociados a tiempo completo pagados por hora (excepto para los asociados que trabajan en California, Hawái, Nueva Jersey, Nueva York y Rhode Island)	Los beneficios por discapacidad a corto plazo se tramitan a través del sistema de nóminas de Walmart. Asimismo, puede recibir un pago por tiempo libre con goce de sueldo, incentivos, etc., que también se procesa a través del sistema de nóminas de Walmart. • Las primas vencidas (incluidas las primas vencidas de la cobertura de discapacidad) se deducirán de los pagos por discapacidad a corto plazo y de otras remuneraciones que reciba. Esto quiere decir que si debe alguna prima atrasada por la cobertura de discapacidad, esas primas atrasadas se deducirán de los beneficios por discapacidad a corto plazo. No se deducirá ninguna prima por discapacidad actual de los beneficios por discapacidad a corto plazo. • Cualquier otra prima de beneficios (que no sea por discapacidad) adeudada por el periodo de pago actual se deducirá de los pagos por discapacidad a corto plazo y de otras remuneraciones que reciba a través del sistema de nóminas de Walmart (tiempo libre con goce de sueldo, incentivos, etc.). • Deberá hacer los arreglos necesarios para pagar las primas que aún se deban tras las deducciones de nómina, de lo contrario se arriesgará a la cancelación de su cobertura .
Beneficios por discapacidad a corto plazo en virtud del plan de discapacidad a corto plazo para asociados a tiempo completo pagados por hora (asociados que trabajan en California, Hawái, Nueva Jersey, Nueva York o Rhode Island)	Los beneficios por discapacidad a corto plazo no se tramitan a través del sistema de nóminas de Walmart.* No obstante, puede recibir un pago por tiempo libre con goce de sueldo, incentivos, etc., que se procesa a través del sistema de nóminas de Walmart. • No se deducirá ninguna prima por discapacidad a corto o largo plazo de los beneficios por discapacidad a corto plazo. Las primas vencidas (incluidas las primas vencidas de la cobertura de discapacidad a corto o a largo plazo) se deducirán de los pagos por discapacidad a corto plazo y de otras remuneraciones que reciba a través del sistema de nóminas de Walmart. • Cualquier otra prima de beneficios (que no sea por discapacidad) adeudada por el periodo de pago actual se deducirá de otras remuneraciones que reciba a través del sistema de nóminas de Walmart (tiempo libre con goce de sueldo, incentivos, etc.). • Deberá hacer los arreglos necesarios para pagar las primas que aún se deban tras las deducciones de nómina, de lo contrario se arriesgará a la cancelación de su cobertura . *En algunos estados, su beneficio por maternidad puede complementarse con pagos tramitados a través del sistema de nóminas de Walmart. En ese caso, se deducirían de esos pagos las primas vencidas y las actuales (no por discapacidad).

(Continúa en la próxima página)

MIENTRAS RECIBE... (CONTINUACIÓN)	
Beneficios por discapacidad a largo plazo bajo: • Plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo • Plan de discapacidad a largo plazo para conductores de camión	Los beneficios por discapacidad a largo plazo se tramitan a través del sistema de nóminas de Walmart. No obstante, puede recibir un pago por tiempo libre con goce de sueldo, incentivos, etc., que se procesa a través del sistema de nóminas de Walmart. • No se deducirá ninguna prima por discapacidad a corto o largo plazo de los beneficios por discapacidad a largo plazo. Las primas vencidas (incluidas las primas vencidas de la cobertura de discapacidad a corto o a largo plazo) se deducirán de otras remuneraciones que reciba a través del sistema de nóminas de Walmart. • Cualquier otra prima de beneficios (que no sea por discapacidad) adeudada por el periodo de pago actual se deducirá de otras remuneraciones que reciba a través del sistema de nóminas de Walmart (tiempo libre con goce de sueldo, incentivos, etc.). • Deberá hacer los arreglos necesarios para pagar las primas que aún se deban tras las deducciones de nómina, de lo contrario se arriesgará a la cancelación de su cobertura .
Beneficios de discapacidad a corto plazo con el plan de discapacidad a corto plazo para asalariados o el plan de discapacidad a corto plazo para conductores de camión	Los beneficios por discapacidad a corto plazo se tramitan a través del sistema de nóminas de Walmart. Asimismo, puede recibir un pago por tiempo libre con goce de sueldo, incentivos, etc., que también se procesa a través del sistema de nóminas de Walmart. En estos planes, no paga primas por la cobertura de discapacidad a corto plazo. • Si queda clasificado como asociado gerencial de salud y el bienestar, las primas de discapacidad a largo plazo vigentes no se le deducirán de los beneficios de discapacidad a corto plazo. Las primas vencidas (incluidas las primas vencidas de la cobertura de discapacidad a largo plazo) se deducirán de los pagos por discapacidad a corto plazo y de otras remuneraciones que reciba a través del sistema de nóminas de Walmart. • Si es conductor de camión a tiempo completo o asociado gerencial que no sea asociado de salud y bienestar, las primas por discapacidad a largo plazo se deducirán de los beneficios por discapacidad a corto plazo durante los primeros 90 días de discapacidad. Tras los 90 días, no se deducirá ninguna prima por discapacidad a largo plazo de los beneficios por discapacidad a corto plazo. Las primas vencidas (incluidas las primas vencidas de la cobertura de discapacidad a largo plazo) se deducirán de todos los pagos por discapacidad a corto plazo y de otras remuneraciones que reciba a través del sistema de nóminas de Walmart. • Cualquier otra prima de beneficios (que no sea por discapacidad) adeudada por el periodo de pago actual se deducirá de los pagos por discapacidad a corto plazo y de otras remuneraciones que reciba a través del sistema de nóminas de Walmart (tiempo libre con goce de sueldo, incentivos, etc.). • Deberá hacer los arreglos necesarios para pagar las primas que aún se deban tras las deducciones de nómina, de lo contrario se arriesgará a la cancelación de su cobertura .
Licencia con goce de sueldo (no por discapacidad) conforme a un programa de licencia con goce de sueldo de una compañía	La licencia con goce de sueldo se tramita a través del sistema de nóminas de Walmart. Asimismo, puede recibir un pago (incentivos, etc.) que también se procesa a través del sistema de nóminas de Walmart. • Las primas para beneficios vencidas se deducirán de los pagos que reciba. • Las primas de beneficios adeudadas por el periodo de pago en curso se deducirán de los pagos que reciba. • Deberá hacer los arreglos necesarios para pagar las primas que aún se deban tras las deducciones de nómina, de lo contrario se arriesgará a la cancelación de su cobertura .

Cambios de elección permitidos fuera del periodo de Inscripción anual

Ciertos beneficios pueden modificarse en cualquier momento del año, pero otros pueden modificarse solo durante la Inscripción anual a menos que surja un evento de cambio de elección, según se describe a continuación:

- Las opciones del plan médico (incluidas las opciones del Plan HMO y PPO), plan dental, de la visión, seguro por muerte accidental y desmembramiento (AD&D), seguro por enfermedades graves, seguro contra accidentes, seguro mejorado por discapacidad a corto plazo, seguro mejorado por discapacidad a corto plazo de Nueva York, discapacidad a largo plazo y discapacidad a largo plazo para conductores de camiones pueden cambiarse solo durante la Inscripción anual, a menos que surja un evento de cambio de elección.
- El seguro de vida opcional para asociados y el seguro de vida opcional para dependientes pueden agregarse o eliminarse en cualquier momento y pueden estar sujetos a requisitos del Certificado de buena salud. Para obtener información, consulte el capítulo de beneficios.

Por lo general, la legislación fiscal federal exige que sus elecciones de beneficios antes de impuestos sigan vigentes durante todo el año calendario en que se realizó la elección, excepto en el caso de eventos de vida o algunos otros eventos descritos en la normativa federal. En este *Libro de beneficios para asociados*, utilizamos el término “eventos de cambio de elección” para referirnos a toda la variedad de circunstancias descritas en la normativa federal que le permiten cambiar sus elecciones antes de impuestos. Esto no se aplica a los aportes antes de impuestos a una cuenta de ahorro de salud, las cuales pueden cambiarse en cualquier momento.

Si experimenta un evento de cambio de elección, puede realizar ciertos cambios de cobertura en sus opciones de beneficios antes y después de impuestos. Un evento de cambio de elección para los propósitos de este *Libro de beneficios para asociados* es un evento en la vida u otro evento descrito en la normativa federal que le permite realizar cambios en su cobertura fuera del periodo de inscripción anual o inicial. Los cambios que realice a partir de un evento en la vida deben estar directamente relacionados con la consecuencia del evento sobre sus beneficios y su elegibilidad. En otras palabras, debe existir una relación lógica entre el evento de vida y el cambio que usted solicita, y el evento en la vida que se produce también debe hacer que una persona sea elegible o no para la cobertura. Esto se denomina en la normativa federal “regla de coherencia”. Por ejemplo, si usted (el asociado) y su cónyuge se divorcian, su cónyuge pierde la elegibilidad para los beneficios del Plan en la fecha del divorcio, pero sus otros dependientes siguen siendo elegibles para los beneficios del Plan. Por ello, usted solo puede dar de baja la cobertura de su cónyuge. No se permitiría cambiar la cobertura de otro dependiente debido a este evento en la vida.

En caso de un evento de cambio de elección (incluido un evento en la vida o la obtención o pérdida de cobertura como se describe en esta sección), los cambios en su cobertura se deben hacer dentro de los 60 días a partir de la fecha del evento.

Los eventos de cambio de elección incluyen eventos en la vida, ganancia de cobertura, pérdida de cobertura, cambio de costo, orden legal y derecho a Medicare o Medicaid.

El término “evento de cambio de elección” se usa frecuentemente en este *Libro de beneficios para asociados* y se refiere a un evento en la vida u otro tipo de evento descrito en la normativa federal que le permite realizar cambios en su cobertura fuera del periodo de inscripción anual o inicial. Es posible que haya visto que estos eventos se denominan en otras publicaciones relacionadas con los beneficios como *eventos de cambio de estado*, *cambios de estado familiar* o *eventos calificadores*. En esta página puede encontrar información detallada sobre los eventos de cambio de elección.

ACONTECIMIENTOS DE LA VIDA

- Eventos que cambian su estado civil:
  - Matrimonio
  - Muerte del cónyuge
  - Divorcio (incluida la disolución de un concubinato en los estados donde se exige una sentencia de divorcio para disolver un concubinato reconocido)
  - Anulación del matrimonio o
  - Separación legal.
- Eventos que cambian el estado de pareja de hecho:
  - Inicio de una pareja de hecho
  - Finalización de relación con la pareja de hecho o
  - Muerte de la pareja de hecho.
- Eventos que cambian el estado de una relación legal con una persona que no sea el cónyuge o la pareja de hecho, según se especifica en la definición de “pareja”:
  - Inicio de una relación legal
  - Finalización de una relación legal o
  - Muerte de la otra persona a la cual está unido en una relación legal.
- Eventos que cambian la cantidad de dependientes:
  - Nacimiento
  - Adopción
  - Entrega en adopción
  - Muerte de un dependiente
  - Obtención de la custodia o tutoría legal de un dependiente
  - Pérdida de la custodia legal o tutoría legal de un dependiente cuya custodia o tutoría legal le había sido otorgada anteriormente por un juez
  - Resultado del examen de paternidad
  - Pérdida de la elegibilidad de un dependiente, por ejemplo, al final del mes en el que cumple 26 años, o

  - Recepción de documentación válida que establece la elegibilidad de un dependiente que anteriormente se consideró que no era elegible.

- Cambios de empleo suyos, de su cónyuge/pareja o de su dependiente:
  - Tomarse o regresar de una licencia de ausencia aprobada
  - Obtener o perder la cobertura por inicio o finalización del empleo
  - Obtener o perder la cobertura debido a un cambio de empleo que afecte su elegibilidad
  - Cambio en el lugar de trabajo que afecta la cobertura médica. Si el cambio afecta sus opciones de cobertura médica (por ejemplo: si se ofrece una nueva opción de plan HMO, plan local, plan PPO), dispondrá de 60 días calendario a partir de su transferencia para presentar una solicitud de cambio de cobertura. Si lo trasladan a un lugar de trabajo donde su cobertura médica se ve afectada y no presenta una solicitud, quedará inscrito automáticamente en un plan predeterminado.

OBTENCIÓN DE COBERTURA

- Obtención de cobertura conforme al plan de cualquier otro empleador.
- Si usted es asociado temporal o por hora a tiempo parcial y sus horas se reducen de manera que usted trabaja un promedio de menos de 30 horas por semana (independientemente de que la reducción de las horas afecte su elegibilidad para la cobertura médica) y tiene intención de inscribirse en otro plan que ofrezca la cobertura esencial mínima que entre en vigencia el primer día del segundo mes siguiente al mes en que terminaría la cobertura médica de su Plan (en este caso, puede dar de baja la cobertura médica; esto incluye una opción del plan HMO o PPO).
- Adiciones/mejoras de una opción de beneficios en virtud de este Plan. El Plan determina qué cambios de elección, si los hubiera, puede realizar en respuesta a la adición o mejora de una opción de beneficio. Se le informará si hay una oportunidad para cambiar la elección.
- Ser beneficiario de Medicare, Medicaid, TRICARE o de un plan estatal de seguro médico para menores. (Si usted o sus dependientes que reúnan los requisitos obtienen cobertura de cualquier otro plan del gobierno, no podrá darse de baja de la cobertura médica (incluida una opción del plan HMO o PPO), del seguro por accidentes ni de la cobertura del seguro por enfermedades graves, salvo durante la Inscripción anual).
- Si usted es elegible para inscribirse en un plan de salud calificado en un periodo de inscripción especial por medio del mercado de seguros de salud, o usted busca inscribirse en un plan de salud calificado por medio del mercado de seguros de salud durante el periodo de inscripción anual, según se describe en **Cambios en su cobertura tras un evento de cambio de elección**, podrá cancelar la cobertura médica (incluidas las opciones del plan HMO o PPO), según lo establecido por el Departamento de Salud y Servicios Humanos. Usted y sus dependientes que cesen la cobertura del Plan deben presentar prueba de su derecho de inscripción y declarar su intención de inscribirse en un plan de salud calificado por medio del Mercado de seguros de salud con vigencia el día inmediatamente posterior al último día de su cobertura médica (incluida una opción del plan HMO o PPO).

PÉRDIDA DE LA COBERTURA

- Pérdida de la cobertura conforme al plan de cualquier otro empleador.
- Reducción de la cobertura conforme a este Plan.
- Pérdida importante de la cobertura, por ejemplo, si un plan HMO en su área deja de prestar servicio. El Plan determina cuándo se produce una pérdida importante de cobertura. Se le informará si hay una oportunidad para cambiar la elección.
- Si usted o sus dependientes que reúnen los requisitos necesarios pierden la cobertura de un plan gubernamental, incluido Medicaid o un plan estatal de seguro médico para niños, un plan de una institución educativa o un plan de un gobierno tribal, puede agregar una cobertura médica (incluida una opción de plan HMO o PPO), un seguro de accidentes o un seguro de enfermedades graves en un plazo de 60 días a partir de la pérdida de cobertura. (Esto no se aplica a la pérdida de la cobertura de un plan del Mercado de Seguros Médicos, aunque la pérdida de la cobertura de un plan del Mercado de Seguros Médicos puede resultar en que tenga derecho de inscripción especial de la HIPAA si originalmente rechazó la cobertura del AMP porque tenía cobertura a través de un plan del Mercado de Seguros Médicos).
- Puede agregar cobertura médica, dental o de la vista para usted o sus dependientes elegibles en los siguientes casos:
  - Originalmente rechazó la cobertura porque usted o sus dependientes tenían cobertura de la ley COBRA que ha finalizado (la falta de pago de las primas no es suficiente para este propósito).
  - Usted y/o sus dependientes no tenían cobertura médica conforme a la ley COBRA y la otra cobertura terminó debido a la pérdida de elegibilidad, o
  - El empleador ya no aporta a la otra cobertura.

CAMBIO EN LOS COSTOS

Si el costo de la cobertura de este Plan o de otro plan cambia significativamente, es posible que pueda cambiar su elección en consecuencia. El Plan determina cuándo se ha producido un cambio importante en el costo y qué cambios de elección puede realizar en respuesta. Se le informará si hay una oportunidad para cambiar la elección.

ORDEN JUDICIAL

Si, debido a una orden judicial después de un divorcio, separación legal, anulación o cambio en la custodia legal (incluidas las orden de cobertura médica para menores; consulte **Órdenes de manutención de los hijos por razones médicas** más adelante en este capítulo), debe brindar cobertura médica, dental o de la vista para sus hijos dependientes elegibles, puede agregar cobertura para ellos (y para usted, si todavía no tiene cobertura). Si la orden exige que su cónyuge, excónyuge u otra persona proporcionen cobertura médica, dental y/o de la visión para sus hijos dependientes y esa otra cobertura ya se proporciona, puede dar de baja la cobertura para el dependiente.

AUTORIZACIÓN DE MEDICARE O MEDICAID

Si usted o sus dependientes son elegibles para la cobertura médica (incluida una opción del plan HMO o PPO), un seguro contra accidentes o por enfermedades graves, puede dar de baja esa cobertura si usted o sus dependientes sean elegibles para recibir los beneficios de Medicare o Medicaid, o la cobertura del plan de seguro de salud del estado para menores. Si usted o sus dependientes elegibles son elegibles para recibir asistencia de Medicaid o de un plan de salud del estado para niños para que pueda pagar la cobertura del Plan, debe solicitar cobertura del Plan dentro de los 60 días a partir de la fecha en que sean elegibles para recibir la asistencia.

Para obtener información sobre las circunstancias en las que puede cambiar sus beneficios, comuníquese con Servicios al Personal al **800-421-1362**.

CAMBIOS EN SU COBERTURA TRAS UN EVENTO DE CAMBIO DE ELECCIÓN

Si se produce un evento de cambio de elección, debe solicitar el cambio dentro de los 60 días a partir de la fecha del evento.

A menos que el Plan lo disponga de otra manera, si usted agrega a su cónyuge/pareja u otro dependiente elegible debido a un evento en la vida, cada persona debe cumplir individualmente con el periodo de espera de los beneficios correspondiente (por ejemplo, cirugía para pérdida de peso) y estará sujeto a todas las limitaciones aplicables del Plan. Si usted cambia de plan médico debido a un evento de cambio de elección, se restablecerán sus deducibles anuales y el gasto máximo en efectivo,* y usted deberá alcanzar los nuevos deducibles y gasto máximo en efectivo nuevo en su totalidad. Si cambia de un Plan Contribution a otro plan, perderá el saldo de la cuenta HRA del Plan Contribution. Consulte el capítulo **Plan médico** para obtener información.

Si tiene cobertura como dependiente y pasa a tener cobertura como asociado durante el año del Plan, o si está cubierto como asociado y pasa a tener cobertura como dependiente durante el año del Plan, por lo general, no recibirá crédito conforme al AMP por los gastos realizados antes de la fecha del cambio.* Sin embargo, si tiene cobertura como dependiente y se produce un evento calificador que afecte su estado como dependiente y lo haga elegible para continuar su propia cobertura de la ley COBRA, recibirá crédito para sus deducibles y gasto máximo en efectivo conforme al AMP por gastos realizados como dependiente cubierto. También recibirá crédito para cualquier periodo de espera que corresponda.

El Plan se reserva el derecho de solicitar la documentación adicional necesaria en la que se certifique el evento de cambio de elección.

*Si usted o un dependiente elegible estaba inscrito en el Plan médico de los asociados (AMP) y había acumulado montos para alcanzar el beneficio máximo de por vida, o lo había alcanzado, aplicable a los beneficios de fertilidad conforme al programa de formación de familias de los Centros de Excelencia, ninguna porción del beneficio máximo de por vida se restablecerá por ninguna razón.

INSCRIPCIÓN ESPECIAL PARA LA COBERTURA MÉDICA CONFORME A LA LEY HIPAA

Conforme a la Ley de Portabilidad y Responsabilidad del Seguro Médico de 1996 (HIPAA), puede tener derecho a una inscripción especial en la cobertura médica del Plan si pierde otra cobertura o agrega un dependiente. Estos eventos (algunos de los cuales son también eventos en la vida) incluyen:

- Si rechaza la inscripción para usted o sus dependientes debido a la cobertura de otro seguro de salud o plan de salud grupal, puede inscribirse usted y, si lo elige, a sus dependientes en este Plan si usted o sus dependientes pierden elegibilidad para dicha cobertura (o si el empleador deja de realizar contribuciones para su cobertura o la de sus dependientes). Debe solicitar la inscripción dentro de los 60 días posteriores a la finalización de su otra cobertura o la de sus dependientes (o después que el empleador deje de contribuir a la otra cobertura). Dicha cobertura entrará en vigencia después de la fecha de inscripción en el Plan.
- Si tiene un nuevo dependiente como consecuencia de matrimonio, nacimiento, adopción o entrega en adopción, puede inscribirse usted y/o sus dependientes elegibles. Debe solicitar la inscripción dentro de los 60 días. Dicha cobertura entrará en vigencia en la fecha del evento.
- Si usted o un dependiente dejan de ser elegibles para la cobertura de Medicaid o de un plan de salud del estado para menores, o bien si usted o un dependiente son elegibles para recibir asistencia para la cobertura del Plan de Medicaid o de un plan de salud del estado para menores, debe solicitar la inscripción dentro de un periodo de 60 días antes de que finalice la cobertura o que comiencen a ser elegibles para la asistencia. Dicha cobertura entrará en vigencia después de la fecha de inscripción en el Plan.

Para solicitar una inscripción especial o conocer más detalles, consulte la información en este capítulo sobre los eventos de cambio de elección o comuníquese con Servicios al Personal al **800-421-1362**.

CÓMO CAMBIAR SUS OPCIONES DEBIDO A UN EVENTO DE CAMBIO DE ELECCIÓN

Puede hacer cambios en Internet dentro de los 60 días posteriores al evento en **One.Walmart.com/Enroll** si se produce uno de los siguientes eventos de cambio de elección:

- Adopción
- Nacimiento
- Inicio de una pareja de hecho
- Inicio de una relación legal con una persona que no sea su cónyuge o pareja de hecho
- Muerte del cónyuge/pareja
- Divorcio o separación legal
- Obtención o pérdida de la custodia legal o de la tutela legal
- Obtención o pérdida de cobertura por parte de usted, sus dependientes o su cónyuge/pareja elegible

- Goce de una licencia de ausencia
- Matrimonio
- Regreso de una licencia
- periodo de inscripción especial
- Finalización de relación con la pareja de hecho o
- Finalización de una relación legal con una persona que no sea el cónyuge o la pareja de hecho

Para todos los demás tipos de eventos de cambio de elección, llame a Servicios al Personal al **800-421-1362**.

Si el evento de cambio de elección es el nacimiento de un dependiente, el Plan aceptará los cargos facturados por los proveedores relacionados al nacimiento como aviso de que el recién nacido se agregará como dependiente en su cobertura, en tanto los cambios se envíen dentro de los 60 días del nacimiento.

Si suma un dependiente como resultado del matrimonio, inicio de una pareja de hecho o inicio de una relación legal con una persona que no sea cónyuge ni pareja de hecho, pero la persona que se va a agregar como dependiente fallece antes de que usted avise del evento de cambio de elección, la persona no se agregará a su cobertura como dependiente.

Si su cobertura por discapacidad a largo plazo finaliza porque se encuentra de licencia o despido temporal superior a 90 días, no podrá optar por volver a inscribirse en la cobertura por discapacidad a largo plazo hasta que regrese de la licencia o despido, incluso si experimenta un evento de cambio de elección mientras se encuentra de licencia o despido temporal. Consulte el capítulo **Discapacidad a largo plazo para asociados asalariados y a tiempo completo pagados por hora** y el capítulo **Discapacidad a largo plazo para conductores de camión** de este *Libro de beneficios para asociados*, según corresponda, para obtener más información sobre su cobertura por discapacidad a largo plazo si su licencia o despido temporal excede los 90 días.

Si agrega cobertura como resultado de un evento de cambio de elección, dicha cobertura entrará en vigencia en la fecha del evento. Si se da de baja de la cobertura como resultado de un evento de cambio de elección, dicha cobertura continuará hasta la fecha del evento. Si se realiza un cambio debido a que está en goce de una licencia de ausencia no remunerada, el cambio entra en vigencia a partir de la fecha de vigencia de su licencia de ausencia. Esto no se aplica al seguro de vida opcional para asociados, el seguro de vida opcional para dependientes, la cobertura del plan mejorado por discapacidad a corto plazo, por discapacidad a largo plazo (incluyendo los beneficios mejorados) o por discapacidad a largo plazo para conductores de camión (incluyendo los beneficios mejorados); consulte los cuadros **Inscripción y fechas efectivas por clasificación laboral** en este capítulo para obtener información sobre las fechas de entrada en vigencia.

Si el cambio de elección produce un aumento en los costos de la cobertura, por ejemplo, si cambia de una cobertura para asociado solo a una cobertura para asociado + dependiente, el aumento de la prima se deducirá de su pago luego de que notifique a Servicios al Personal de su evento de cambio de elección y será retroactivo a la fecha de vigencia de su nueva cobertura. Estas deducciones retroactivas se realizarán después de impuestos.

Si no lo informa a Servicios al Personal ni ingresa al sitio para realizar los cambios dentro de los 60 días posteriores al evento de cambio de elección, no podrá agregar cobertura ni darla de baja hasta el próximo periodo de Inscripción anual o hasta que tenga un evento de cambio de elección diferente. No obstante, como se ha descrito anteriormente en esta sección **Cambios de elección permitidos fuera del periodo de Inscripción anual**, cualquier cambio que realice en relación con un evento de cambio de elección debe estar directamente relacionado con el impacto del evento en sus beneficios. Además, si el evento de cambio de elección se debe a que su dependiente pierde la elegibilidad, este perderá el derecho de optar por la cobertura de la ley COBRA para los beneficios médicos, dental y/o de la visión si usted no informa el caso a Servicios al Personal dentro de los 60 días. Del mismo modo, si el evento de cambio de elección se debe al divorcio, la finalización de una relación de pareja de hecho o la finalización de una relación legal con una persona que no sea su cónyuge o pareja de hecho, su excónyuge/expareja perderá el derecho a elegir la cobertura de la ley COBRA para beneficios médicos, dental y/o de la visión si no se notifica el evento a Servicios al Personal dentro de los 60 días. Consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** para obtener más información.

Si cambia de lugar de trabajo

Si cambia de lugar de trabajo, sus opciones de beneficios médicos pueden cambiar. Si esto sucede, se le notificarán sus nuevas opciones.

Ciertos estados y localidades ofrecen beneficios de discapacidad a corto plazo obligatorios por ley. Si usted es un asociado pagado por hora a tiempo completo que trabaja en uno de esos estados o localidades, las variaciones en las leyes y procedimientos administrativos pueden afectar su capacidad para participar en el plan de discapacidad a corto plazo por hora a tiempo completo de Walmart, así como el monto de cualquier beneficio por discapacidad. Consulte el capítulo **Discapacidad a corto plazo para asociados a tiempo completo pagados por hora** para obtener más información.

La tabla a continuación describe los efectos sobre su derecho a recibir el beneficio de discapacidad a corto plazo pagado por hora a tiempo completo cuando se traslada de un lugar de trabajo en un estado con beneficios obligatorios a otro sin beneficios obligatorios, y viceversa.

TRANSFERENCIAS INTERESTATALES

Si se traslada de un lugar de trabajo en un estado o localidad con beneficios obligatorios por discapacidad a corto plazo a un lugar de trabajo en un estado sin beneficios obligatorios por discapacidad a corto plazo, se le inscribirá automáticamente en el plan mejorado de discapacidad a corto plazo, porque es el plan más parecido a su beneficio obligatorio estatal o local anterior.

Si se traslada de un lugar de trabajo en un estado sin beneficios obligatorios por discapacidad a corto plazo a un estado o localidad con beneficios obligatorios por discapacidad a corto plazo, no será elegible para el plan de Walmart básico o mejorado de discapacidad a corto plazo anterior porque puede tener derecho a beneficios por discapacidad a través del estado.

Para más información sobre los beneficios obligatorios por ley, consulte la tabla **Beneficios exigidos por ley** del capítulo **Discapacidad a corto plazo para asociados a tiempo completo pagados por hora**.

Lugar de trabajo original	Lugar de trabajo nuevo	Beneficios
Todas las ubicaciones ***excepto*** California, Hawái, Nueva Jersey o Rhode Island	Todas las ubicaciones ***excepto*** California, Hawái, Nueva Jersey o Rhode Island	Sin cambios en la inscripción al plan de discapacidad a corto plazo
California, Hawái, Nueva Jersey o Rhode Island.	Todas las ubicaciones ***excepto*** California, Hawái, Nueva Jersey o Rhode Island	Se le inscribirá automáticamente en el beneficio de discapacidad a corto plazo mejorado porque es el plan más parecido a su beneficio estatal anterior. La cobertura entra en vigencia en la última de las siguientes fechas: 1) el primer día del periodo de pago siguiente a la fecha en que se inscriba, o 2) el aniversario de 12 meses de su fecha de contratación. Si desea cambiar del plan de discapacidad a corto plazo mejorado al plan de discapacidad a corto plazo básico, debe ponerse en contacto con el Servicios al Personal para solicitar el cambio en un plazo de 60 días a partir de la fecha de la transferencia. Si no solicita el cambio durante ese tiempo, no podrá realizar el cambio hasta el periodo de Inscripción anual del siguiente año, a menos que surja un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** de este capítulo.
California, Hawái, Nueva Jersey o Rhode Island.	California, Hawái, Nueva Jersey o Rhode Island.	No será elegible para el plan básico o mejorado de discapacidad a corto plazo de Walmart porque puede ser elegible para beneficios por discapacidad a través del estado.
Todas las ubicaciones ***excepto*** California, Hawái, Nueva Jersey o Rhode Island	California, Hawái, Nueva Jersey o Rhode Island.	No será elegible para el plan básico o mejorado de discapacidad a corto plazo de Walmart porque puede ser elegible para beneficios por discapacidad a través del estado. Su beneficio de discapacidad a corto plazo de Walmart finalizará el último día del periodo de pago en el que se produzca su transferencia.

Si cambia su clasificación laboral

La transición de una clasificación laboral a otra puede afectar su elegibilidad para ciertos beneficios. Las tablas que aparecen en las siguientes páginas analizan los cambios que se producirán como consecuencia del cambio de clasificación. Puede tener que satisfacer requisitos adicionales si no se inscribe en algunos beneficios voluntarios cuando es elegible para ellos por primera vez, pero lo hace más adelante. Para más información, consulte **Inscripción y fechas efectivas por clasificación laboral** anteriormente en este capítulo y consulte la tabla que se aplica a su nueva clasificación laboral.

Si su clasificación laboral cambia de asociado de la gerencia o por hora a tiempo completo a asociado pagado por hora a tiempo parcial, asociado temporal o conductor de camión a tiempo parcial, su cónyuge/pareja perderá la elegibilidad para el seguro médico, dental, de la visión, de seguro de vida para dependientes, por AD&D, por enfermedades graves o contra accidentes. Usted perderá la elegibilidad para la cobertura del seguro de vida pagado por la compañía o el seguro por discapacidad. Si este cambio ocasiona que su cónyuge/pareja u otro dependiente pierda la cobertura, consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** para obtener información sobre cómo usted o sus dependientes elegibles pueden continuar con la cobertura médica, dental y de la vista.

Salvo que se disponga lo contrario en una de las tablas de la siguiente sección **Cambio de una clasificación laboral a otra** de este capítulo, los cambios de elegibilidad entran en vigencia cuando se produce la transferencia (es decir, cuando se ingresa a los sistemas de registro de Walmart).

NOTA: Si su clasificación laboral cambia a asociado pagado por hora a tiempo parcial o asociado temporal, consulte **Su verificación anual de elegibilidad**, que puede encontrar anteriormente en este capítulo en la sección titulada **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos**.

Cambio de una clasificación laboral a otra

ASOCIADO PAGADO POR HORA A TIEMPO PARCIAL O ASOCIADO TEMPORAL TRANSFERIDO AL PUESTO DE CONDUCTOR DE CAMIÓN POR HORA A TIEMPO PARCIAL

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Conductores de camión a tiempo parcial*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado pagado por hora a tiempo parcial o asociado temporal, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado pagado por hora a tiempo parcial o asociado temporal hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente
Como conductor de camión a tiempo parcial, usted es elegible para cobertura de seguro médico, dental, de la visión, AD&D, por enfermedad grave y por accidente, y puede obtener cobertura para sus hijos dependientes. No es elegible para la cobertura de cónyuge/pareja.

Si era elegible para la cobertura en la fecha de su transferencia, no puede realizar cambios como consecuencia de la transferencia porque ya tuvo la oportunidad de inscribirse usted y a sus hijos dependientes que son elegibles para la cobertura como asociado pagado por hora a tiempo parcial o asociado temporal.

Si no era elegible para cobertura en la fecha de su transferencia, puede inscribirse en la cobertura de asociado solo o de asociado + hijos.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se inscribe en línea, la cobertura entra en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscribe, o en 2) el primer día del mes en el que se cumplen 89 días de empleo continuo.
- Si se inscribe llamando a Servicios al Personal, la cobertura entrará en vigencia en la última de las siguientes fechas:
  - del primer día del mes en el cual se cumple su día 89 de empleo continuo; o
  - de su elección entre 1) la fecha de inscripción, o 2) el primer día del periodo de pago en el que se produce la transferencia. Si elige una fecha de entrada en vigencia distinta a la fecha de inscripción, las primas retroactivas hasta esa fecha se deducirán de su pago después de impuestos.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes (hijos)
Como conductor de camión a tiempo parcial, puede reunir los requisitos para la cobertura del seguro de vida opcional para asociados y la cobertura del seguro de vida opcional para dependientes para los hijos dependientes que sean elegibles. Los requisitos del Certificado de buena salud pueden aplicarse a usted, pero no se aplican a sus hijos. Usted no es elegible para la cobertura opcional del seguro de vida para dependientes para su cónyuge/pareja.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:
Si era elegible para la cobertura en la fecha de su transferencia, puede elegir o cambiar la cobertura opcional del seguro de vida para el asociado y dependiente en cualquier momento. Consulte la tabla titulada **Conductores de camión a tiempo parcial** en la sección **Inscripción y fechas efectivas por clasificación laboral** de este capítulo para conocer las reglas que se aplican si cambia de cobertura para usted o para su hijo después del periodo de inscripción inicial.

Si no era elegible para cobertura en la fecha de su transferencia:

- Si usted se inscribe por el monto garantizado, o a su hijo por cualquier monto, la cobertura entra en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscribe, o 2) el primer día del mes en el que se cumplen 89 días de empleo continuo.
- Si se inscribe por un monto superior al garantizado para usted, la cobertura estará sujeta a la aprobación de Prudential. Deberá proporcionar un Certificado de buena salud y posiblemente deba someterse a un examen médico. Si se aprueba, la cobertura que exceda el monto garantizado entrará en vigencia en la última de las siguientes fechas: 1) la fecha en que Prudential apruebe su cobertura, o 2) el primer día del mes en el que cumplen 89 días de empleo continuo.

  Si no se aprueba la cobertura por encima del monto garantizado, usted se inscribirá en el monto garantizado y la cobertura entrará en vigencia como si usted se hubiera inscrito solamente por el monto garantizado cuando fue elegible por primera vez.

ASOCIADO PAGADO POR HORA A TIEMPO PARCIAL O ASOCIADO TEMPORAL TRANSFERIDO AL PUESTO DE ASOCIADO PAGADO POR HORA A TIEMPO COMPLETO

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados pagados por hora a tiempo completo*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las reglas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado pagado por hora a tiempo parcial o asociado temporal, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado pagado por hora a tiempo parcial o asociado temporal hasta el final de su periodo de inscripción inicial. Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente
Como asociado pagado por hora a tiempo completo, es elegible para cobertura médica, dental, de la visión, AD&D, enfermedad grave y seguro por accidentes, y puede cubrir a sus hijos dependientes y a su cónyuge/pareja.

Si era elegible para la cobertura en la fecha de su transferencia, no puede inscribirse en la cobertura de asociado solo o de asociado + hijos como consecuencia de su transferencia porque ya tuvo la oportunidad de inscribirse usted y a sus hijos en la cobertura como asociado pagado por hora a tiempo parcial o asociado temporal. No obstante, puede inscribirse en la cobertura de asociado + cónyuge/pareja o de asociado + familia para agregar a su cónyuge/pareja.

Si no era elegible para cobertura en la fecha de su transferencia, puede inscribirse en cualquier nivel de cobertura.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:
Si era elegible para cobertura en la fecha de su transferencia:

- Si se inscribe por Internet, la cobertura entra en vigencia a partir de la fecha de inscripción.
- Si se inscribe llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que se inscribe o 2) el primer día del periodo de pago en el que se produce la transferencia. Si elige una fecha de entrada en vigencia distinta a la fecha de inscripción, las primas retroactivas hasta esa fecha se deducirán de su pago después de impuestos.

Si no era elegible para cobertura en la fecha de su transferencia:

- Si se inscribe en línea, la cobertura entra en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscribe, o 2) el primer día del mes en el que se cumplen 89 días de empleo continuo.
- Si se inscribe llamando a Servicios al Personal, la cobertura entrará en vigencia en la última de las siguientes fechas:
  - del primer día del mes en el cual se cumple su día 89 de empleo continuo; o
  - de su elección entre 1) la fecha de inscripción, o 2) el primer día del periodo de pago en el que se produce la transferencia. Si elige una fecha de entrada en vigencia distinta a la fecha de inscripción, las primas retroactivas hasta esa fecha se deducirán de su pago después de impuestos.

Seguro de vida pagado por la compañía
Como asociado pagado por hora a tiempo completo, se le inscribe automáticamente en la cobertura del seguro de vida pagado por la compañía, que entra en vigencia a partir de la última de las siguientes fechas: 1) el primer día del periodo de pago en el que se produce su transferencia, o 2) el primer día del mes en el que cumple 89 días de empleo continuo.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como asociado pagado por hora a tiempo completo, es elegible para la cobertura opcional del seguro de vida para asociados. Asimismo, puede obtener cobertura para sus hijos dependientes y su cónyuge/pareja en virtud de la cobertura opcional del seguro de vida para dependientes. Los requisitos del Certificado de buena salud pueden aplicarse a usted y a su cónyuge/pareja, pero no se aplica a sus hijos.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:
Si era elegible para la cobertura en la fecha de su transferencia, puede elegir o cambiar la cobertura opcional del seguro de vida para el asociado y dependiente en cualquier momento. Consulte la tabla titulada **Asociados a tiempo parcial** en la sección **Inscripción y fechas efectivas por clasificación laboral** de este capítulo para conocer las reglas que se aplican si cambia de cobertura para usted o para su hijo después del periodo de inscripción inicial.

Si en la fecha de su transferencia no era elegible para la cobertura, puede inscribirse en la cobertura opcional del seguro de vida de los asociados para usted y en la cobertura opcional del seguro de vida de los dependientes para su hijo y su cónyuge/pareja. Usted y su cónyuge/pareja pueden estar sujetos a los requisitos del Certificado de buena salud.

- Si usted se inscribe o a su cónyuge/pareja por el monto garantizado, o a su hijo por cualquier monto, la cobertura entra en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscribe, o 2) el primer día del mes en el que se cumplen 89 días de empleo continuo.
- Si se inscribe por un monto superior al garantizado para usted o para usted o su cónyuge/pareja, la cobertura estará sujeta a la aprobación de Prudential. Deberá proporcionar un Certificado de buena salud y posiblemente deba someterse a un examen médico. Si se aprueba, la cobertura que exceda el monto garantizado entrará en vigencia en la última de las siguientes fechas: 1) la fecha en que Prudential apruebe la cobertura para usted o de su cónyuge/pareja, o 2) el primer día del mes calendario en el que cumplen 89 días de empleo continuo.

  Si no se aprueba la cobertura por encima del monto garantizado, usted o su cónyuge/pareja se inscribirán en el monto garantizado y la cobertura entrará en vigencia como si usted o su cónyuge/pareja se hubieran inscrito solamente por el monto garantizado cuando cumplieron los requisitos por primera vez.

(Continúa en la próxima página)

ASOCIADO PAGADO POR HORA A TIEMPO PARCIAL O ASOCIADO TEMPORAL TRANSFERIDO AL PUESTO DE ASOCIADO PAGADO POR HORA A TIEMPO COMPLETO (CONTINUACIÓN)

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados pagados por hora a tiempo completo*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las reglas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado pagado por hora a tiempo parcial o asociado temporal, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado pagado por hora a tiempo parcial o asociado temporal hasta el final de su periodo de inscripción inicial. Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Discapacidad a corto plazo
Como asociado pagado por hora a tiempo completo, es elegible para una cobertura por discapacidad a corto plazo.

Queda automáticamente inscrito en la cobertura básica y de maternidad del **plan básico de discapacidad a corto plazo para asociados a tiempo completo pagados por hora**, a menos que trabaje en California, Hawái, Nueva Jersey o Rhode Island. Los asociados de estos estados pueden acogerse a los programas de discapacidad establecidos por ley. Los asociados de Nueva York se inscribirán al **plan básico por discapacidad a corto plazo de Nueva York**. La cobertura entra en vigencia en la última de las siguientes fechas: 1) el primer día del periodo de pago siguiente a la fecha en que se inscriba, o 2) el aniversario de 12 meses de su fecha de contratación.

Puede inscribirse en el **plan mejorado de discapacidad a corto plazo para asociados a tiempo completo pagados por hora** a menos que trabaje en California, Hawái, Nueva Jersey o Rhode Island. Los asociados de estos estados pueden acogerse a los programas de discapacidad establecidos por ley. Los asociados de Nueva York pueden inscribirse en el **plan mejorado por discapacidad a corto plazo de Nueva York**.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se inscribe en línea, la cobertura entra en vigencia en la última de las siguientes fechas: 1) la fecha en la que se inscribe, o 2) el aniversario de 12 meses de su fecha de contratación.
- Si se inscribe llamando a Servicios al Personal, la cobertura entrará en vigencia en la última de las siguientes fechas:
  - el aniversario de 12 meses de su fecha de contratación, o
  - su elección entre 1) la fecha de inscripción, o 2) el primer día del periodo de pago en el que se produce la transferencia.

Discapacidad de largo plazo
Como asociado pagado por hora a tiempo completo, es elegible para la cobertura por discapacidad a largo plazo en virtud del **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si usted se inscribe en línea, la cobertura entra en vigencia en la última de las siguientes fechas: 1) el primer día del periodo de pago siguiente a la fecha en que se inscriba, o 2) el aniversario de 12 meses de su fecha de contratación.
- Si se inscribe llamando a Servicios al Personal, la cobertura entrará en vigencia en la última de las siguientes fechas:
  - el aniversario de 12 meses de su fecha de contratación, o
  - su elección entre 1) la fecha de inscripción, o 2) el primer día del periodo de pago en el que se produce la transferencia.

ASOCIADO PAGADO POR HORA A TIEMPO PARCIAL O ASOCIADO TEMPORAL TRANSFERIDO AL PUESTO DE GERENTE DEL CENTRO DE VISIÓN POR HORA A TIEMPO COMPLETO

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Gerentes del Centro de visión por hora a tiempo completo*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado pagado por hora a tiempo parcial o asociado temporal, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado pagado por hora a tiempo parcial o asociado temporal hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente
Como gerente del centro de visión por hora a tiempo completo, es elegible para cobertura médica, dental, de la visión, AD&D, enfermedad grave y seguro por accidentes, y puede cubrir a sus hijos dependientes y a su cónyuge/pareja.

Si era elegible para la cobertura en la fecha de su transferencia, no puede inscribirse en la cobertura de asociado solo o de asociado + hijos como consecuencia de su transferencia porque ya tuvo la oportunidad de inscribirse usted y a sus hijos en la cobertura como asociado pagado por hora a tiempo parcial o asociado temporal. No obstante, puede inscribirse a la cobertura de asociado + cónyuge/pareja o de asociado + familia para agregar a su cónyuge/pareja a la cobertura.

Si no era elegible para cobertura en la fecha de su transferencia, puede inscribirse en cualquier nivel de cobertura.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se inscribe por Internet, la cobertura entra en vigencia a partir de la fecha de inscripción.
- Si se inscribe llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que se inscribe o 2) el primer día del periodo de pago en el que se produce la transferencia. Si elige una fecha de entrada en vigencia distinta a la fecha de inscripción, las primas retroactivas hasta esa fecha se deducirán de su pago después de impuestos.

Seguro de vida pagado por la compañía
Como gerente del centro de visión a tiempo completo y por hora, se le inscribe automáticamente en la cobertura del seguro de vida pagado por la compañía, que entra en vigencia a partir del primer día del periodo de pago en el que se produce su transferencia.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como gerente del centro de visión por hora a tiempo completo, es elegible para la cobertura opcional del seguro de vida para asociados. Asimismo, puede obtener cobertura para sus hijos dependientes y su cónyuge/pareja en virtud de la cobertura opcional del seguro de vida para dependientes. Los requisitos del Certificado de buena salud pueden aplicarse a usted y a su cónyuge/pareja, pero no se aplica a sus hijos.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:
Si era elegible para la cobertura en la fecha de su transferencia, puede inscribirse o realizar cambios en cualquier momento. Consulte la tabla titulada **Gerentes del centro de visión por hora a tiempo completo** en la sección **Inscripción y fechas efectivas por clasificación laboral** de este capítulo para conocer las reglas que se aplican si cambia de cobertura para usted o para su hijo después del periodo de inscripción inicial.

Si en la fecha de su transferencia no era elegible para la cobertura, puede inscribirse en la cobertura opcional del seguro de vida de los asociados para usted y en la cobertura opcional del seguro de vida de los dependientes para su hijo y su cónyuge/pareja. Usted y su cónyuge/pareja pueden estar sujetos a los requisitos del Certificado de buena salud.

- Si se inscribe por el monto garantizado para usted o su cónyuge/pareja, o por cualquier monto para su hijo, la cobertura entra en vigencia en la fecha de inscripción.
- Si se inscribe por un monto superior al garantizado para usted o para usted o su cónyuge/pareja, la cobertura estará sujeta a la aprobación de Prudential. Usted o su cónyuge/pareja deberán proporcionar un Certificado de buena salud y posiblemente deba someterse a un examen médico. Si se aprueba, la cobertura que exceda el monto garantizado para usted o su cónyuge/pareja entrará en vigencia cuando Prudential la apruebe. Si no se aprueba la cobertura por encima del monto garantizado, usted o su cónyuge/pareja se inscribirán en el monto garantizado y la cobertura entrará en vigencia como si usted o su cónyuge/pareja se hubieran inscrito solamente por el monto garantizado cuando cumplieron los requisitos por primera vez.

(Continúa en la próxima página)

ASOCIADO PAGADO POR HORA A TIEMPO PARCIAL O ASOCIADO TEMPORAL TRANSFERIDO AL PUESTO DE GERENTE DEL CENTRO DE VISIÓN POR HORA A TIEMPO COMPLETO (CONTINUACIÓN)

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Gerentes del Centro de visión por hora a tiempo completo*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado pagado por hora a tiempo parcial o asociado temporal, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado pagado por hora a tiempo parcial o asociado temporal hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Discapacidad a corto plazo
Como gerente del Centro de visión por hora a tiempo completo, es elegible para una cobertura por discapacidad a corto plazo.

Queda automáticamente inscrito en la cobertura básica y de maternidad del **plan básico de discapacidad a corto plazo para asociados a tiempo completo pagados por hora**, a menos que trabaje en California, Hawái, Nueva Jersey o Rhode Island. Los asociados de estos estados pueden acogerse a los programas de discapacidad establecidos por ley. Los asociados de Nueva York se inscribirán al **plan básico por discapacidad a corto plazo de Nueva York**. La cobertura entra en vigencia a partir del primer día del periodo de pago en que tuvo lugar la transferencia.

Puede inscribirse en el **plan mejorado de discapacidad a corto plazo para asociados a tiempo completo pagados por hora** a menos que trabaje en California, Hawái, Nueva Jersey o Rhode Island. Los asociados de estos estados pueden acogerse a los programas de discapacidad establecidos por ley. Los asociados de Nueva York pueden inscribirse en el **plan mejorado por discapacidad a corto plazo de Nueva York**.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se inscribe en línea, la cobertura es efectiva a partir del primer día del periodo de pago en que tuvo lugar la transferencia.
- Si se inscribe llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que se inscribe o 2) el primer día del periodo de pago en el que se produce la transferencia.

Discapacidad de largo plazo
Como gerente del Centro de visión por hora a tiempo completo, es elegible para la cobertura por discapacidad a largo plazo en virtud del **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se inscribe en línea, la cobertura es efectiva a partir del primer día del periodo de pago en que tuvo lugar la transferencia.
- Si se inscribe llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que se inscribe o 2) el primer día del periodo de pago en el que se produce la transferencia.

ASOCIADO PAGADO POR HORA A TIEMPO PARCIAL O ASOCIADO TEMPORAL TRANSFERIDO AL PUESTO DE ASOCIADO GERENCIAL (INCLUIDO CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO)

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados gerenciales*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado pagado por hora a tiempo parcial o asociado temporal, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado pagado por hora a tiempo parcial o asociado temporal hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente
Como asociado gerencial, sigue siendo elegible para la cobertura de seguro médico, dental, de la visión, AD&D, enfermedad grave y por accidente, y puede obtener cobertura para sus hijos dependientes y para su cónyuge/pareja. Además, el monto máximo de la cobertura del seguro AD&D aumenta a $1,000,000.

Si era elegible para la cobertura en la fecha de su transferencia, no puede inscribirse en la cobertura de asociado solo o de asociado + hijos como consecuencia de su transferencia porque ya tuvo la oportunidad de inscribirse usted y a sus hijos en la cobertura como asociado pagado por hora a tiempo parcial o asociado temporal. No obstante, puede inscribirse en la cobertura de asociado + cónyuge/pareja o de asociado + familia para agregar a su cónyuge.

Si no era elegible para cobertura en la fecha de su transferencia, puede inscribirse en cualquier nivel de cobertura.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se inscribe por Internet, la cobertura entra en vigencia a partir de la fecha de inscripción.
- Si se inscribe llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que se inscribe o 2) el primer día del periodo de pago en el que se produce la transferencia. Si elige una fecha de entrada en vigencia distinta a la fecha de inscripción, las primas retroactivas hasta esa fecha se deducirán de su pago después de impuestos.

Seguro de vida pagado por la compañía
Como asociado gerencial, se le inscribe automáticamente en la cobertura del seguro de vida pagado por la compañía, que entra en vigencia a partir del primer día del periodo de pago en el que se produce su transferencia.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como asociado gerencial, sigue siendo elegible para la cobertura opcional del seguro de vida para asociados, pero el monto máximo de la cobertura aumenta a $1,000,000. Se aplican los requisitos del Certificado de buena salud si aumenta su cobertura.

Como asociado gerencial, puede cubrir a sus hijos dependientes y a su cónyuge/pareja con la cobertura opcional del seguro de vida para dependientes. Los requisitos del Certificado de buena salud pueden aplicarse a su cónyuge/pareja, pero no a sus hijos.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:
Si era elegible para la cobertura en la fecha de su transferencia, puede elegir o cambiar la cobertura opcional del seguro de vida para el asociado y dependiente en cualquier momento. Consulte la tabla titulada **Asociados gerenciales** en la sección **Inscripción y fechas efectivas por clasificación laboral** de este capítulo para conocer las reglas que se aplican si cambia de cobertura para usted (incluido el aumento en el monto de la cobertura) o para su hijo después del periodo de inscripción inicial.

Si en la fecha de su transferencia no era elegible para la cobertura, puede inscribirse en la cobertura opcional del seguro de vida de los asociados para usted y en la cobertura opcional del seguro de vida de los dependientes para sus hijos dependientes elegibles y su cónyuge/pareja. Usted y su cónyuge/pareja pueden estar sujetos a los requisitos del Certificado de buena salud.

- Si se inscribe por el monto garantizado para usted o su cónyuge/pareja, o por cualquier monto para su hijo, la cobertura entra en vigencia en la fecha de inscripción.
- Si se inscribe por un monto superior al garantizado para usted o para usted o su cónyuge/pareja, la cobertura estará sujeta a la aprobación de Prudential. Usted o su cónyuge/pareja deberán proporcionar un Certificado de buena salud y posiblemente deba someterse a un examen médico. Si se aprueba, la cobertura que exceda el monto garantizado para usted o su cónyuge/pareja entrará en vigencia cuando Prudential la apruebe.

  Si no se aprueba la cobertura por encima del monto garantizado, usted o su cónyuge/pareja se inscribirán en el monto garantizado y la cobertura entrará en vigencia como si usted o su cónyuge/pareja se hubieran inscrito solamente por el monto garantizado cuando cumplieron los requisitos por primera vez.

(Continúa en la próxima página)

ASOCIADO PAGADO POR HORA A TIEMPO PARCIAL O ASOCIADO TEMPORAL TRANSFERIDO AL PUESTO DE ASOCIADO GERENCIAL (INCLUIDO CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO) (CONTINUACIÓN)

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados gerenciales*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado pagado por hora a tiempo parcial o asociado temporal, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado pagado por hora a tiempo parcial o asociado temporal hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Discapacidad a corto plazo
Asociado gerencial (que no sea conductor de camión): Queda automáticamente inscrito a la cobertura básica y de maternidad del **plan de discapacidad a corto plazo para asociados asalariados**. La cobertura es efectiva a partir del primer día del periodo de pago en que tuvo lugar la transferencia.

Asociado gerencial (conductor de camión a tiempo completo): Queda automáticamente inscrito a la cobertura básica y de maternidad del **plan de discapacidad a corto plazo para conductores de camión**. La cobertura es efectiva a partir del primer día del periodo de pago en que tuvo lugar la transferencia.

Discapacidad de largo plazo
Asociado gerencial (que no sea conductor de camión): Es elegible para la cobertura por discapacidad a largo plazo en virtud del **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**.

Asociado gerencial (conductor de camión a tiempo completo): Tiene derecho a la cobertura por discapacidad a largo plazo del **plan de discapacidad a largo plazo para conductores de camión**.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia como se indica a continuación:

- Si se inscribe en línea, la cobertura es efectiva a partir del primer día del periodo de pago en que tuvo lugar la transferencia.
- Si se inscribe llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que se inscribe o 2) el primer día del periodo de pago en el que se produce la transferencia.

CONDUCTOR DE CAMIÓN A TIEMPO PARCIAL TRANSFERIDO AL PUESTO DE ASOCIADO PAGADO POR HORA A TIEMPO PARCIAL O ASOCIADO TEMPORAL

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados pagados por hora a tiempo parcial y asociados temporales*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios clasificado como conductor de camión a tiempo parcial, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como conductor de camión a tiempo parcial hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente
Como asociado pagado por hora a tiempo parcial o asociado temporal que se trasfiere desde una clasificación de conductor de camión a tiempo parcial, será elegible para cobertura médica, dental, de la visión, AD&D, por enfermedad grave y accidente, y podrá cubrir a sus hijos dependientes elegibles. No obstante, consulte la sección **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** de este capítulo para obtener información importante sobre el periodo de tiempo durante el que será elegible para los beneficios médicos y las verificaciones futuras de elegibilidad para acceder a los beneficios médicos.

No puede realizar cambios en su cobertura como consecuencia de su transferencia porque ya tuvo la oportunidad de inscribirse como conductor de camión a tiempo parcial.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes (hijos)
Como asociado pagado por hora a tiempo parcial o asociado temporal, sigue siendo elegible para la cobertura opcional del seguro de vida de asociado y de dependiente opcional para su hijo dependiente que reúna los requisitos.

CONDUCTOR DE CAMIÓN A TIEMPO PARCIAL TRANSFERIDO AL PUESTO DE ASOCIADO PAGADO POR HORA A TIEMPO COMPLETO

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados pagados por hora a tiempo completo*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las reglas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios clasificado como conductor de camión a tiempo parcial, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como conductor de camión a tiempo parcial hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente

Como asociado pagado por hora a tiempo completo, es elegible para cobertura médica, dental, de la visión, AD&D, enfermedad grave y seguro por accidentes, y puede cubrir a sus hijos dependientes y a su cónyuge/pareja. No puede inscribirse en la cobertura de asociado solo o de asociado + hijos como consecuencia de la transferencia porque ya tuvo la oportunidad de inscribirse usted y sus hijos. No obstante, puede inscribirse en la cobertura de asociado + cónyuge/pareja o de asociado + familia para agregar a su cónyuge/pareja como consecuencia de su transferencia.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se inscribe en línea, la cobertura entra en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscribe, o 2) el primer día del mes en el que se cumplen 89 días de empleo continuo.
- Si se inscribe llamando a Servicios al Personal, la cobertura entrará en vigencia en la última de las siguientes fechas:
  - del primer día del mes en el cual se cumple su día 89 de empleo continuo; o
  - de su elección entre 1) la fecha de inscripción, o 2) el primer día del periodo de pago en el que se produce la transferencia. Si elige una fecha de entrada en vigencia distinta a la fecha de inscripción, las primas retroactivas hasta esa fecha se deducirán de su pago después de impuestos.

Seguro de vida pagado por la compañía

Como asociado pagado por hora a tiempo completo, se le inscribe automáticamente en la cobertura del seguro de vida pagado por la compañía, que entra en vigencia a partir de la última de las siguientes fechas: 1) el primer día del periodo de pago en el que se produce su transferencia, o 2) el primer día del mes en el que cumple 89 días de empleo continuo.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes

Como asociado pagado por hora a tiempo completo, sigue reuniendo los requisitos para el seguro de vida opcional para asociados y la cobertura del seguro de vida opcional para dependientes para los hijos que sean elegibles. También puede obtener cobertura para su cónyuge/pareja mediante una cobertura de seguro de vida para dependientes. Es posible que se apliquen los requisitos del Certificado de buena salud.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si contrata un seguro de vida dependiente para su cónyuge/pareja, este puede estar sujeto a los requisitos del Certificado de buena salud:
  - Si inscribe a su cónyuge/pareja por el monto garantizado, la cobertura entra en vigencia en la última de las siguientes fechas: 1) se inscribe, o 2) el primer día del mes en el que se cumplen 89 días de empleo continuo.
  - Si se inscribe por un monto superior al garantizado para usted o para su cónyuge/pareja, la cobertura estará sujeta a la aprobación de Prudential. Su cónyuge/pareja deberá proporcionar un Certificado de buena salud y posiblemente deba someterse a un examen médico. Si se aprueba, la cobertura que exceda el monto garantizado entrará en vigencia en la última de las siguientes fechas: 1) la fecha en que Prudential apruebe la cobertura de su cónyuge/pareja, o 2) el primer día del mes calendario en el que cumplen 89 días de empleo continuo. Si no se aprueba la cobertura por encima del monto garantizado, su cónyuge/pareja se inscribirán en el monto garantizado y la cobertura entrará en vigencia como si su cónyuge/pareja se hubieran inscrito solamente por el monto garantizado cuando cumplieron los requisitos por primera vez.

(Continúa en la próxima página)

CONDUCTOR DE CAMIÓN A TIEMPO PARCIAL TRANSFERIDO AL PUESTO DE ASOCIADO PAGADO POR HORA A TIEMPO COMPLETO (CONTINUACIÓN)

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados pagados por hora a tiempo completo*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las reglas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios clasificado como conductor de camión a tiempo parcial, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como conductor de camión a tiempo parcial hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Discapacidad a corto plazo
Como asociado pagado por hora a tiempo completo, es elegible para una cobertura por discapacidad a corto plazo.

Queda automáticamente inscrito en el beneficio básico y de maternidad del **plan básico de discapacidad a corto plazo pagado por hora a tiempo completo**, a menos que trabaje en California, Hawái, Nueva Jersey o Rhode Island. Los asociados de estos estados pueden acogerse a los programas de discapacidad establecidos por ley. Los asociados de Nueva York se inscribirán al **plan básico por discapacidad a corto plazo de Nueva York**. La cobertura entra en vigencia en la última de las siguientes fechas: 1) el primer día del periodo de pago siguiente a la fecha en que se inscriba, o 2) el aniversario de 12 meses de su fecha de contratación.

Puede inscribirse en el **plan mejorado de discapacidad a corto plazo para asociados a tiempo completo pagados por hora** a menos que trabaje en California, Hawái, Nueva Jersey o Rhode Island. Los asociados de estos estados pueden acogerse a los programas de discapacidad establecidos por ley. Los asociados de Nueva York pueden inscribirse en el **plan mejorado por discapacidad a corto plazo de Nueva York**.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se inscribe en línea, la cobertura entra en vigencia en la última de las siguientes fechas: 1) la fecha en la que se inscribe, o 2) el aniversario de 12 meses de su fecha de contratación.
- Si se inscribe llamando a Servicios al Personal, la cobertura entrará en vigencia en la última de las siguientes fechas:
  - el aniversario de 12 meses de su fecha de contratación, o
  - su elección entre 1) la fecha de inscripción, o 2) el primer día del periodo de pago en el que se produce la transferencia.

Discapacidad de largo plazo
Como asociado pagado por hora a tiempo completo, es elegible para la cobertura por discapacidad a largo plazo en virtud del **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si usted se inscribe en línea, la cobertura entra en vigencia en la última de las siguientes fechas: 1) el primer día del periodo de pago siguiente a la fecha en que se inscriba, o 2) el aniversario de 12 meses de su fecha de contratación.
- Si se inscribe llamando a Servicios al Personal, la cobertura entrará en vigencia en la última de las siguientes fechas:
  - el aniversario de 12 meses de su fecha de contratación, o
  - su elección entre 1) la fecha de inscripción, o 2) el primer día del periodo de pago en el que se produce la transferencia. Si la fecha de entrada en vigencia es distinta a la fecha de inscripción, las primas retroactivas hasta esa fecha se deducirán de su pago.

CONDUCTOR DE CAMIÓN A TIEMPO PARCIAL TRANSFERIDO AL PUESTO DE GERENTE DEL CENTRO DE VISIÓN POR HORA A TIEMPO COMPLETO

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Gerentes del Centro de visión por hora a tiempo completo*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios clasificado como conductor de camión a tiempo parcial, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como conductor de camión a tiempo parcial hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente
Como gerente del Centro de visión por hora a tiempo completo, es elegible para la cobertura médica, dental, de la visión, AD&D, enfermedad grave y seguro por accidentes, y puede cubrir a sus hijos dependientes y a su cónyuge/pareja. No puede inscribirse en la cobertura de asociado solo o de asociado + hijos como consecuencia de la transferencia porque ya tuvo la oportunidad de inscribirse usted y sus hijos en la cobertura como conductor de camión a tiempo parcial. No obstante, puede inscribirse a la cobertura de asociado + cónyuge/pareja o de asociado + familia para agregar a su cónyuge/pareja a la cobertura.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:
- Si se inscribe por Internet, la cobertura tiene vigencia a partir de la fecha de inscripción.
- Si se inscribe llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que se inscribe o 2) el primer día del periodo de pago en el que se produce la transferencia. Si elige una fecha de entrada en vigencia distinta a la fecha de inscripción, las primas retroactivas hasta esa fecha se deducirán de su pago después de impuestos.

Seguro de vida pagado por la compañía
Como gerente del centro de visión a tiempo completo y por hora, se le inscribe automáticamente en la cobertura del seguro de vida pagado por la compañía, que entra en vigencia a partir del primer día del periodo de pago en el que se produce su transferencia.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como gerentes del centro de visión por hora a tiempo completo, sigue reuniendo los requisitos para el seguro de vida opcional para asociados y el seguro de vida opcional para dependiente para los hijos dependientes que reúnan los requisitos. También puede obtener cobertura para su cónyuge/pareja mediante una cobertura de seguro de vida para dependientes. Es posible que se apliquen los requisitos del Certificado de buena salud.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:
- Si contrata un seguro de vida dependiente para su cónyuge/pareja, este puede estar sujeto a los requisitos del Certificado de buena salud:
  - Si se inscribe por el monto garantizado para su cónyuge/pareja, o por cualquier monto para su hijo, la cobertura entra en vigencia en la fecha de inscripción.
  - Si se inscribe por un monto superior al garantizado para usted o para su cónyuge/pareja, la cobertura estará sujeta a la aprobación de Prudential. Su cónyuge/pareja deberán proporcionar un Certificado de buena salud y posiblemente deba someterse a un examen médico. Si se aprueba, la cobertura por encima del monto garantizado para su cónyuge/pareja entrará en vigencia cuando Prudential la apruebe. Si no se aprueba la cobertura por encima del monto garantizado, su cónyuge/pareja se inscribirán en el monto garantizado y la cobertura entrará en vigencia como si su cónyuge/pareja se hubieran inscrito solamente por el monto garantizado cuando cumplieron los requisitos por primera vez.

Discapacidad a corto plazo
Como gerente del Centro de visión por hora a tiempo completo, es elegible para una cobertura por discapacidad a corto plazo.

Queda automáticamente inscrito en el beneficio básico y de maternidad del **plan básico de discapacidad a corto plazo pagado por hora a tiempo completo**, a menos que trabaje en California, Hawái, Nueva Jersey o Rhode Island. Los asociados de estos estados pueden acogerse a los programas de discapacidad establecidos por ley. Los asociados de Nueva York se inscribirán al **plan básico por discapacidad a corto plazo de Nueva York**. La cobertura entra en vigencia a partir del primer día del periodo de pago en que tuvo lugar la transferencia.

Puede inscribirse en el **plan mejorado de discapacidad a corto plazo para asociados a tiempo completo pagados por hora** a menos que trabaje en California, Hawái, Nueva Jersey o Rhode Island. Los asociados de estos estados pueden acogerse a los programas de discapacidad establecidos por ley. Los asociados de Nueva York pueden inscribirse en el **plan mejorado por discapacidad a corto plazo de Nueva York**.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:
- Si se inscribe en línea, la cobertura es efectiva a partir del primer día del periodo de pago en que tuvo lugar la transferencia.
- Si se inscribe llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que se inscribe o 2) el primer día del periodo de pago en el que se produce la transferencia.

Discapacidad de largo plazo
Como gerente del Centro de visión por hora a tiempo completo, es elegible para la cobertura por discapacidad a largo plazo en virtud del **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:
- Si se inscribe en línea, la cobertura es efectiva a partir del primer día del periodo de pago en que tuvo lugar la transferencia.
- Si se inscribe llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que se inscribe o 2) el primer día del periodo de pago en el que se produce la transferencia.

CONDUCTOR DE CAMIÓN A TIEMPO PARCIAL TRANSFERIDO AL PUESTO DE ASOCIADO GERENCIAL (INCLUIDO CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO)

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados gerenciales*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios clasificado como conductor de camión a tiempo parcial, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como conductor de camión a tiempo parcial hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente
Como asociado gerencial, sigue siendo elegible para la cobertura de seguro médico, dental, de la visión, AD&D, enfermedad grave y por accidente, y puede obtener cobertura para sus hijos dependientes y para su cónyuge/pareja. Además, el monto máximo de la cobertura del seguro AD&D aumenta a $1,000,000.

Si era elegible para la cobertura en la fecha de su transferencia, no puede inscribirse en la cobertura de asociado solo o de asociado + hijos como consecuencia de su transferencia porque ya tuvo la oportunidad de inscribirse usted y a sus hijos. No obstante, puede inscribirse en la cobertura de asociado + cónyuge/pareja o de asociado + familia para agregar a su cónyuge/pareja.

Si no era elegible para la cobertura en la fecha de su transferencia, puede inscribirse en cualquier nivel de cobertura.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:
- Si se inscribe por Internet, la cobertura entra en vigencia a partir de la fecha de inscripción.
- Si se inscribe llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que se inscribe o 2) el primer día del periodo de pago en el que se produce la transferencia. Si elige una fecha de entrada en vigencia distinta a la fecha de inscripción, las primas retroactivas hasta esa fecha se deducirán de su pago después de impuestos.

Seguro de vida pagado por la compañía
Como asociado gerencial, se le inscribe automáticamente en la cobertura del seguro de vida pagado por la compañía, que entra en vigencia a partir del primer día del periodo de pago en el que se produce su transferencia.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como asociado gerencial, sigue siendo elegible para la cobertura opcional del seguro de vida para asociados, pero el monto máximo de la cobertura aumenta a $1,000,000. Se aplican los requisitos del Certificado de buena salud si aumenta su cobertura. Asimismo, sigue siendo elegible para el seguro de vida opcional para sus hijos dependientes que reúnan los requisitos.

Como asociado gerencial, puede cubrir a su cónyuge/pareja con un seguro de vida opcional para dependientes. Es posible que se apliquen los requisitos del Certificado de buena salud.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:
- Si contrata un seguro de vida dependiente para su cónyuge/pareja, este puede estar sujeto a los requisitos del Certificado de buena salud:
  - Si se inscribe por el valor garantizado para su cónyuge/pareja, la cobertura entra en vigencia a partir de la fecha de inscripción.
  - Si se inscribe por un monto superior al garantizado para usted o para su cónyuge/pareja, la cobertura estará sujeta a la aprobación de Prudential. Su cónyuge/pareja deberán proporcionar un Certificado de buena salud y posiblemente deba someterse a un examen médico. Si se aprueba, la cobertura por encima del monto garantizado para su cónyuge/pareja entrará en vigencia cuando Prudential la apruebe. Si no se aprueba la cobertura por encima del monto garantizado, su cónyuge/pareja se inscribirán en el monto garantizado y la cobertura entrará en vigencia como si su cónyuge/pareja se hubieran inscrito solamente por el monto garantizado cuando cumplieron los requisitos por primera vez.
- Consulte la tabla titulada **Asociados gerenciales** en la sección **Inscripción y fechas efectivas por clasificación laboral** de este capítulo para conocer las reglas que se aplican si cambia de cobertura para usted (incluido el aumento en el monto de la cobertura) después del periodo de inscripción inicial.

Discapacidad a corto plazo
Asociado gerencial (que no sea conductor de camión): Queda automáticamente inscrito a los beneficios básicos y de maternidad del **plan de discapacidad a corto plazo para asociados asalariados**. La cobertura entra en vigencia a partir del primer día del periodo de pago en que tuvo lugar la transferencia.

Asociado gerencial (conductor de camión a tiempo completo): Queda automáticamente inscrito a los beneficios básicos y de maternidad del **plan de discapacidad a corto plazo para conductores de camión**. La cobertura entra en vigencia a partir del primer día del periodo de pago en que tuvo lugar la transferencia.

Discapacidad de largo plazo
Asociado gerencial (que no sea conductor de camión): es elegible para la cobertura por discapacidad a largo plazo en virtud del **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**.

Asociado gerencial (conductor de camión a tiempo completo): tiene derecho a la cobertura por discapacidad a largo plazo del **plan de discapacidad a largo plazo para conductores de camión**.
Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:
- Si se inscribe en línea, la cobertura entra en vigencia a partir del primer día del periodo de pago en que tuvo lugar la transferencia.
- Si se inscribe llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que se inscribe o 2) el primer día del periodo de pago en el que se produce la transferencia.

ASOCIADO PAGADO POR HORA A TIEMPO COMPLETO TRANSFERIDO AL PUESTO DE ASOCIADO PAGADO POR HORA A TIEMPO PARCIAL O TEMPORAL

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados pagados por hora a tiempo parcial y asociados temporales*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado a tiempo completo, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado a tiempo completo hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente
Como asociado pagado por hora a tiempo parcial o asociado temporal que se trasfiere desde una clasificación de asociado pagado por hora a tiempo completo, es elegible para cobertura médica, dental, de la visión, AD&D, por enfermedad grave y accidente, y podrá cubrir a sus hijos dependientes que cumplan los requisitos. No obstante, consulte **Su verificación anual de elegibilidad** en la sección **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** de este capítulo para obtener información importante sobre el periodo de tiempo durante el que será elegible para los beneficios médicos y las verificaciones futuras de elegibilidad para acceder a los beneficios médicos.

Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para la cobertura para cónyuge/pareja. Si estaba inscrito en la fecha de su transferencia y cubría a su cónyuge/pareja, su cobertura se ajustará automáticamente a la cobertura de asociado solo o de asociado + hijos (dependiendo de si cubre a sus hijos dependientes elegibles), que entra en vigencia a partir del primer día del primer periodo de pago después de la fecha en la que se produzca su transferencia. Su cónyuge/pareja puede ser elegible para la continuación de la cobertura. Consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** de este Libro de beneficios para asociados de 2025.

No puede realizar cambios en su cobertura como consecuencia de su transferencia porque ya tuvo la oportunidad de inscribirse usted y sus hijos dependientes elegibles en la cobertura para asociados pagados por hora a tiempo completo.

Seguro de vida pagado por la compañía
Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para un seguro de vida pagado por la compañía. Su cobertura continuará hasta el último día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha. Puede convertir su cobertura de seguro de vida pagado por la compañía en una póliza individual. Consulte el capítulo **Seguro de vida pagado por la compañía** de este *Libro de beneficios para asociados* de 2025 para obtener información sobre cómo solicitar la conversión a una póliza individual.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como asociado pagado por hora a tiempo parcial o asociado temporal, sigue siendo elegible para la cobertura opcional del seguro de vida de asociado y de dependiente opcional para su hijo dependiente que reúna los requisitos.

Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para la cobertura para cónyuge/pareja. Si ha inscrito a su cónyuge/pareja a un seguro de vida para dependientes, seguirá vigente hasta el último día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha. Puede convertir la cobertura de seguro de vida de su cónyuge/pareja dependiente en una póliza individual. Consulte el capítulo **Seguro de vida opcional para dependientes** de este *Libro de beneficios para asociados* de 2025 para obtener información sobre cómo solicitar la conversión a una póliza individual.

Discapacidad a corto plazo
Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para la cobertura de discapacidad a corto plazo. Su cobertura anterior por discapacidad a corto plazo para asociado pagado por hora a tiempo completo permanecerá vigente hasta el último día del periodo de pago en el que se produzca su transferencia y no será efectiva después de esa fecha.

Discapacidad de largo plazo
Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para la cobertura de discapacidad a largo plazo.
Si estaba afiliado al seguro de discapacidad a largo plazo en la fecha de su transferencia, su cobertura continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha.

ASOCIADOS PAGADOS POR HORA A TIEMPO COMPLETO TRANSFERIDOS A UN PUESTO DE CONDUCTOR DE CAMIÓN A TIEMPO PARCIAL

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Conductores de camión a tiempo parcial*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *para conocer las reglas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado a tiempo completo, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado a tiempo completo hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente
Como conductor de camión a tiempo parcial transferido desde la clasificación de asociado pagado por hora a tiempo completo, seguirá siendo elegible para la cobertura de seguro médico, dental, de la visión, AD&D, enfermedad grave y por accidente, y puede obtener cobertura para sus hijos dependientes.

Como conductor de camión a tiempo parcial, no es elegible para la cobertura para cónyuge/pareja. Si estaba inscrito en la fecha de su transferencia y cubría a su cónyuge/pareja, su cobertura se ajustará automáticamente a la cobertura de asociado solo o de asociado + hijos (dependiendo de si cubre a sus hijos dependientes elegibles), que entra en vigencia a partir del primer día del primer periodo de pago siguiente a la fecha en la que se produzca su transferencia. Su cónyuge/pareja puede ser elegible para la continuación de la cobertura. Consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** de este *Libro de beneficios para asociados* de 2025.

No puede realizar cambios en su cobertura como consecuencia de su transferencia porque ya tuvo la oportunidad de inscribirse usted y sus hijos dependientes elegibles en la cobertura para asociados pagados por hora a tiempo completo.

Seguro de vida pagado por la compañía
Como conductor de camión a tiempo parcial, no es elegible para un seguro de vida pagado por la compañía. Su cobertura continuará hasta el último día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha. Puede convertir su seguro de vida pagado por la compañía en una póliza individual. Consulte el capítulo **Seguro de vida pagado por la compañía** de este *Libro de beneficios para asociados* de 2025 para obtener más información.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como conductor de camión a tiempo parcial, sigue reuniendo los requisitos para el seguro de vida opcional para asociados y el seguro de vida para dependientes para los hijos que sean elegibles.

Como conductor de camión a tiempo parcial, no es elegible para la cobertura para cónyuge/pareja. Si ha inscrito a su cónyuge/pareja a un seguro de vida para dependientes, seguirá vigente hasta el último día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha. Puede convertir la cobertura de seguro de vida de su cónyuge/pareja dependiente en una póliza individual. Consulte el capítulo **Seguro de vida opcional para dependientes** de este *Libro de beneficios para asociados* de 2025 para obtener información sobre cómo solicitar la conversión a una póliza individual.

Discapacidad a corto plazo
Como conductor de camión a tiempo parcial, no es elegible para la cobertura por discapacidad a corto plazo. Su cobertura anterior por discapacidad a corto plazo para asociado pagado por hora a tiempo completo permanecerá vigente hasta el último día del periodo de pago en el que se produzca su transferencia y no será efectiva después de esa fecha.

Discapacidad de largo plazo
Como conductor de camión a tiempo parcial, no es elegible para la cobertura por discapacidad a largo plazo. Si estaba afiliado al seguro de discapacidad a largo plazo en la fecha de su transferencia, su cobertura continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha.

ASOCIADOS PAGADOS POR HORA A TIEMPO COMPLETO TRANSFERIDOS A UN PUESTO DE GERENTE DEL CENTRO DE VISIÓN POR HORA A TIEMPO COMPLETO

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Gerentes del Centro de visión por hora a tiempo completo*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado a tiempo completo, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado a tiempo completo hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Sus beneficios no cambiarán como consecuencia de la transferencia. No se permite ningún cambio como consecuencia de la transferencia, a excepción de los cambios en el seguro de vida opcional para asociados y dependientes, que pueden realizarse en cualquier momento.

El monto de su seguro de vida pagado por la compañía se actualizará para reflejar su nuevo salario, hasta un máximo de $50,000. Si el monto de su seguro de vida pagado por la compañía aumenta, el cambio será efectivo a partir del primer día del periodo de pago en el que se produzca su transferencia. Si el monto de su seguro de vida pagado por la compañía disminuye, el cambio será efectivo a partir del primer día del periodo de pago que comience después de la fecha de su transferencia.

ASOCIADO PAGADO POR HORA A TIEMPO COMPLETO TRANSFERIDO AL PUESTO DE ASOCIADO GERENCIAL (INCLUIDO CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO)

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados gerenciales*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado a tiempo completo, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado a tiempo completo hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente, seguro de vida pagado por la compañía
Como asociado gerencial, sigue siendo elegible para cobertura de seguro médico, dental, de la visión, AD&D, por enfermedad grave y accidente, y puede obtener cobertura para sus hijos dependientes y para su cónyuge/pareja. Además, el monto máximo de la cobertura del seguro AD&D aumenta a $1,000,000. No se permite ningún cambio como resultado de la transferencia, salvo los cambios en la cobertura del seguro AD&D para aumentar los montos de cobertura.

El monto de su seguro de vida pagado por la compañía se actualizará para reflejar su nuevo salario, hasta un máximo de $50,000. Si el monto de su seguro de vida pagado por la compañía aumenta, el cambio será efectivo a partir del primer día del periodo de pago en el que se produzca su transferencia. Si el monto de su seguro de vida pagado por la compañía disminuye, el cambio será efectivo a partir del primer día del periodo de pago que comience después de la fecha de su transferencia.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como asociado gerencial, sigue siendo elegible para la cobertura opcional del seguro de vida para asociados, pero el monto máximo de la cobertura aumenta a $1,000,000. Se aplican los requisitos del Certificado de buena salud si aumenta su cobertura. Asimismo, sigue siendo elegible para un seguro de vida opcional para su cónyuge/pareja e hijos dependientes que reúnan los requisitos.

Discapacidad a corto plazo
Asociados administrativos (que no sean conductores de camión): Tiene derecho a una cobertura por discapacidad a corto plazo. Queda automáticamente inscrito a los beneficios básicos y de maternidad del **plan de discapacidad a corto plazo para asociados asalariados**. La cobertura entra en vigencia a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Su cobertura conforme al **plan de discapacidad a corto plazo para asociados a tiempo completo pagados por hora** continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia.

Asociado gerencial (conductores de camión a tiempo completo): es elegible para la cobertura por discapacidad a corto plazo. Queda automáticamente inscrito en los beneficios básicos y de maternidad del **plan de discapacidad a corto plazo para conductores de camión**, con efecto a partir del primer día del periodo de pago en el que se produce su transferencia. Su cobertura conforme al **plan de discapacidad a corto plazo para asociados a tiempo completo pagados por hora** continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia.

(Continúa en la próxima página)

ASOCIADO PAGADO POR HORA A TIEMPO COMPLETO TRANSFERIDO AL PUESTO DE ASOCIADO GERENCIAL (INCLUIDO CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO) (CONTINUACIÓN)

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados gerenciales*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado a tiempo completo, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado a tiempo completo hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Discapacidad de largo plazo

Asociado gerencial (que no sea conductor de camión): sigue siendo elegible para la cobertura del seguro por discapacidad a largo plazo en virtud del **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**. Su cobertura no cambiará como resultado de la transferencia y no se permite ningún cambio como resultado de la transferencia.

Asociado gerencial (conductor de camión a tiempo completo): tiene derecho a la cobertura del seguro por discapacidad a largo plazo del **plan de discapacidad a largo plazo para conductores de camión**.

Si en la fecha de su transferencia estaba inscrito en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**, su cobertura continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia. Se le inscribe automáticamente en el mismo nivel de cobertura (50 % o 60 %) del **plan de discapacidad a largo plazo para conductores de camión** con la opción de cinco años de duración, que entra en vigencia a partir del primer día del periodo de pago en el que se produce su transferencia. ***Esto puede dar lugar a un aumento de las deducciones de primas de su pago.***

Si en la fecha de su transferencia no estaba inscrito en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**, puede inscribirse en el **plan de discapacidad a largo plazo para conductores de camión**. Se aplican los requisitos del Certificado de buena salud.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se le inscribió automáticamente en el plan de **discapacidad a largo plazo para conductores de camión** porque estaba inscrito en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados** a tiempo completo en la fecha de su transferencia:
  - Si cancela su inscripción en el **plan de discapacidad a largo plazo para conductores de camión** o su cobertura disminuye, el cambio entrará en vigencia al día siguiente de la sesión de inscripción en línea. Si realiza el cambio llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que llama, o 2) el primer día del periodo de pago en el que se produce la transferencia.
  - Si no realiza cambios en el nivel de cobertura (50 % o 60 %) en el que estaba automáticamente inscrito, pero cambia a la opción de duración completa, no estará sujeto a los requisitos del Certificado de buena salud. La cobertura entrará en vigencia a partir del primer día del periodo de pago en que tuvo lugar la transferencia.
  - Si aumenta el nivel de cobertura al 60 % después de haber estado inscrito automáticamente al nivel de cobertura del 50 % pero permanece en la opción de duración de cinco años, estará sujeto a los requisitos de Certificado de buena salud y es posible que deba someterse a un examen médico a su cargo. Si se aprueba, la cobertura entrará en vigencia el primer día del periodo de pago siguiente a la fecha en que se reciba la notificación de la aprobación de Lincoln. Si no se aprueba el aumento de cobertura, seguirá estando inscrito al 50 % y la cobertura entrará en vigencia el primer día del periodo de pago en el que se produzca su transferencia.
  - Si aumenta el nivel de cobertura al 60 % después de haber estado inscrito automáticamente al nivel de cobertura del 50 % y cambia a la opción de duración de completa, estará sujeto a los requisitos del Certificado de buena salud y es posible que deba someterse a un examen médico a su cargo. Si se aprueba, el aumento en cobertura entrará en vigencia el primer día del periodo de pago siguiente a la fecha en que se reciba la notificación de la aprobación de Lincoln. Si no se aprueba el aumento de cobertura, seguirá estando inscrito al 50 % y la cobertura entrará en vigencia el primer día del periodo de pago en el que se produzca su transferencia. No obstante, el cambio a la opción de duración completa no está sujeto a los requisitos del Certificado de buena salud y tendrá vigencia el primer día del periodo de pago en el que se produzca la transferencia.
- Si en la fecha de su transferencia no estaba inscrito en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**, se le aplicarán los requisitos del Certificado de buena salud y es posible que deba someterse a un examen médico a su cargo. Si se aprueba, la cobertura entrará en vigencia el primer día del periodo de pago siguiente a la fecha en que se reciba la notificación de la aprobación de Lincoln.

GERENTE DEL CENTRO DE VISIÓN POR HORA A TIEMPO COMPLETO TRANSFERIDO AL PUESTO DE ASOCIADO PAGADO POR HORA TEMPORAL O A TIEMPO PARCIAL

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados pagados por hora a tiempo parcial y asociados temporales*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como gerente del Centro de visión por hora a tiempo completo, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como gerente del Centro de visión por hora a tiempo completo hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente
Como asociado pagado por hora a tiempo parcial o asociado temporal que se transfiere desde una clasificación de gerente del Centro de visión por hora a tiempo completo, será elegible para cobertura médica, dental, de la visión, AD&D, por enfermedad grave y accidente, y podrá cubrir a sus hijos dependientes que cumplan los requisitos. No obstante, consulte **Su verificación anual de elegibilidad** en la sección **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** de este capítulo para obtener información importante sobre el periodo de tiempo durante el que será elegible para los beneficios médicos y las verificaciones futuras de elegibilidad para acceder a los beneficios médicos.

Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para la cobertura para cónyuge/pareja. Si estaba inscrito en la fecha de su transferencia y cubría a su cónyuge/pareja, su cobertura se ajustará automáticamente a la cobertura de asociado solo o de asociado + hijos (dependiendo de si cubre a sus hijos dependientes elegibles), que entra en vigencia a partir del primer día del periodo de pago que comience después de que se produzca su transferencia. Su cónyuge/pareja puede ser elegible para la continuación de la cobertura. Consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** de este *Libro de beneficios para asociados* de 2025.

No puede realizar cambios en su cobertura como consecuencia de su transferencia porque ya tuvo la oportunidad de inscribirse usted y sus hijos dependientes elegibles para la cobertura como asociado pagado por hora a tiempo completo.

Seguro de vida pagado por la compañía
Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para un seguro de vida pagado por la compañía. Su cobertura continuará hasta el último día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha. Puede convertir su cobertura de seguro de vida pagado por la compañía en una póliza individual. Consulte el capítulo **Seguro de vida pagado por la compañía** de este *Libro de beneficios para asociados* de 2025 para obtener información sobre cómo solicitar la conversión a una póliza individual.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como asociado pagado por hora a tiempo parcial o asociado temporal, sigue siendo elegible para la cobertura opcional del seguro de vida de asociado y de dependiente opcional para su hijo dependiente que reúna los requisitos.

Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para la cobertura para cónyuge/pareja. Si ha inscrito a su cónyuge/pareja a un seguro de vida para dependientes, seguirá vigente hasta el último día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha. Puede convertir la cobertura de seguro de vida de su cónyuge/pareja dependiente en una póliza individual. Consulte el capítulo **Seguro de vida opcional para dependientes** de este *Libro de beneficios para asociados* de 2025 para obtener información sobre cómo solicitar la conversión a una póliza individual.

Discapacidad a corto plazo
Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para la cobertura de discapacidad a corto plazo. Sucobertura anterior por discapacidad a corto plazo para asociado pagado por hora a tiempo completo para gerentes del centro de visión permanecerá vigente hasta el último día del periodo de pago en el que se produzca su transferencia y no será efectiva después de esa fecha.

Discapacidad de largo plazo
Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para la cobertura de discapacidad a largo plazo. Su cobertura continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha.

GERENTE DEL CENTRO DE VISIÓN POR HORA A TIEMPO COMPLETO TRANSFERIDO AL PUESTO DE CONDUCTOR DE CAMIÓN A TIEMPO PARCIAL

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Conductores de camión a tiempo parcial*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como gerente del Centro de visión por hora a tiempo completo, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado del Centro de visión por hora a tiempo completo hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado el periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente
Como conductor de camión a tiempo parcial transferido desde la clasificación de asociado gerente del Centro de visión por hora a tiempo completo, seguirá siendo elegible para cobertura de seguro médico, dental, de visión, AD&D, enfermedad grave y por accidente, y puede obtener cobertura para sus hijos dependientes.

Como conductor de camión a tiempo parcial, no es elegible para la cobertura para cónyuge/pareja. Si estaba inscrito en la fecha de su transferencia y cubría a su cónyuge/pareja, su cobertura se ajustará automáticamente a la cobertura de asociado solo o de asociado + hijos (dependiendo de si cubre a sus hijos dependientes elegibles), que entra en vigencia a partir del primer día del primer periodo de pago que comience tras que se produzca su transferencia. Su cónyuge/pareja puede ser elegible para la continuación de la cobertura. Consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** de este *Libro de beneficios para asociados* de 2025.

No puede realizar cambios en su cobertura como consecuencia de su transferencia porque ya tuvo la oportunidad de inscribirse usted y sus hijos dependientes elegibles para la cobertura como asociado pagado por hora a tiempo completo.

Seguro de vida pagado por la compañía
Como conductor de camión a tiempo parcial, no es elegible para un seguro de vida pagado por la compañía. Su cobertura continuará hasta el último día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha. Puede convertir su seguro de vida pagado por la compañía en una póliza individual. Consulte el capítulo **Seguro de vida pagado por la compañía** de este *Libro de beneficios para asociados* de 2025 para obtener información sobre cómo solicitar la conversión a una póliza individual.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como conductor de camión a tiempo parcial, sigue reuniendo los requisitos para el seguro de vida opcional para asociados y el seguro de vida opcional para dependientes para los hijos dependientes que sean elegibles.

Como conductor de camión a tiempo parcial, no es elegible para la cobertura para cónyuge/pareja. Si ha inscrito a su cónyuge/pareja a un seguro de vida para dependientes, seguirá vigente hasta el último día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha. Puede convertir la cobertura de seguro de vida de su cónyuge/pareja dependiente en una póliza individual. Consulte el capítulo **Seguro de vida opcional para dependientes** de este *Libro de beneficios para asociados* de 2025 para obtener información sobre cómo solicitar la conversión a una póliza individual.

Discapacidad a corto plazo
Como conductor de camión a tiempo parcial, no es elegible para la cobertura por discapacidad a corto plazo. Su cobertura anterior por discapacidad a corto plazo para asociado pagado por hora a tiempo completo para gerentes del centro de visión permanecerá vigente hasta el último día del periodo de pago en el que se produzca su transferencia y no será efectiva después de esa fecha.

Discapacidad de largo plazo
Como conductor de camión a tiempo parcial, no es elegible para la cobertura por discapacidad a largo plazo. Si estaba afiliado al seguro de discapacidad a largo plazo en la fecha de su transferencia, su cobertura continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha.

GERENTE DEL CENTRO DE VISIÓN POR HORA A TIEMPO COMPLETO TRANSFERIDO AL PUESTO DE ASOCIADO PAGADO POR HORA A TIEMPO COMPLETO

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados pagados por hora a tiempo completo*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las reglas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como gerente del Centro de visión por hora a tiempo completo, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como gerente del Centro de visión por hora a tiempo completo hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Sus beneficios no cambiarán como consecuencia de la transferencia. No se permite ningún cambio como consecuencia de la transferencia, a excepción de los cambios en el seguro de vida opcional para asociados y dependientes, que pueden realizarse en cualquier momento.

El monto de su seguro de vida pagado por la compañía se actualizará para reflejar su nuevo salario, hasta un máximo de $50,000. Si el monto de su seguro de vida pagado por la compañía aumenta, el cambio será efectivo a partir del primer día del periodo de pago en el que se produzca su transferencia. Si el monto de su seguro de vida pagado por la compañía disminuye, el cambio será efectivo a partir del primer día del periodo de pago que comience después de la fecha de su transferencia.

GERENTE DEL CENTRO DE VISIÓN POR HORA A TIEMPO COMPLETO TRANSFERIDO AL PUESTO DE ASOCIADO GERENCIAL (INCLUIDO CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO)

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados gerenciales*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como gerente del Centro de visión por hora a tiempo completo, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como gerente del Centro de visión por hora a tiempo completo hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente, seguro de vida pagado por la compañía
Como asociado gerencial, sigue siendo elegible para cobertura de seguro médico, dental, de la visión, AD&D, por enfermedad grave y accidente, y puede obtener cobertura para sus hijos dependientes y para su cónyuge/pareja. Además, el monto máximo de la cobertura del seguro AD&D aumenta a $1,000,000. No se permite ningún cambio como resultado de la transferencia, salvo los cambios en la cobertura del seguro AD&D para aumentar los montos de cobertura.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como asociado gerencial, sigue siendo elegible para la cobertura opcional del seguro de vida para asociados, pero el monto máximo de la cobertura aumenta a $1,000,000. Se aplican los requisitos del Certificado de buena salud si aumenta su cobertura. Asimismo, sigue siendo elegible para un seguro de vida opcional para dependientes para su cónyuge/pareja e hijos dependientes que reúnan los requisitos.

Discapacidad a corto plazo
Asociados administrativos (que no sean conductores de camión): Tiene derecho a una cobertura por discapacidad a corto plazo. Queda automáticamente inscrito a los beneficios básicos y de maternidad del **plan de discapacidad a corto plazo para asociados asalariados**. La cobertura entra en vigencia a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Su cobertura conforme al **plan de discapacidad a corto plazo para asociados a tiempo completo pagados por hora** continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia.

Asociado gerencial (conductores de camión a tiempo completo): es elegible para la cobertura por discapacidad a corto plazo. Queda automáticamente inscrito en los beneficios básicos y de maternidad del **plan de discapacidad a corto plazo para conductores de camión**, con efecto a partir del primer día del periodo de pago en el que se produce su transferencia. Su cobertura conforme al **plan de discapacidad a corto plazo para asociados a tiempo completo pagados por hora** continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia.

(Continúa en la próxima página)

GERENTE DEL CENTRO DE VISIÓN POR HORA A TIEMPO COMPLETO TRANSFERIDO AL PUESTO DE ASOCIADO GERENCIAL (INCLUIDO CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO) (CONTINUACIÓN)

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados gerenciales*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como gerente del Centro de visión por hora a tiempo completo, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como gerente del Centro de visión por hora a tiempo completo hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Discapacidad de largo plazo

Asociado gerencial (que no sea conductor de camión): sigue siendo elegible para la cobertura del seguro por discapacidad a largo plazo en virtud del **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**. Su cobertura no cambiará como resultado de la transferencia y no se permite ningún cambio como resultado de la transferencia.

Asociado gerencial (conductor de camión a tiempo completo): tiene derecho a la cobertura del seguro por discapacidad a largo plazo del **plan de discapacidad a largo plazo para conductores de camión**.

Si en la fecha de su transferencia estaba inscrito en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**, su cobertura continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia. Se le inscribe automáticamente en el mismo nivel de cobertura (50 % o 60 %) del **plan de discapacidad a largo plazo para conductores de camión** con la opción de cinco años de duración, que entra en vigencia a partir del primer día del periodo de pago en el que se produce su transferencia. ***Esto puede dar lugar a un aumento de las deducciones de primas de su pago.***

Si en la fecha de su transferencia no estaba inscrito en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**, puede inscribirse en el **plan de discapacidad a largo plazo para conductores de camión**. Se aplican los requisitos del Certificado de buena salud.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se le inscribió automáticamente en el plan de **discapacidad a largo plazo para conductores de camión** porque estaba inscrito en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados** a tiempo completo en la fecha de su transferencia:
  - Si cancela su inscripción en el **plan de discapacidad a largo plazo para conductores de camión** o su cobertura disminuye, el cambio entrará en vigencia al día siguiente de la sesión de inscripción en línea. Si realiza el cambio llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que llama, o 2) el primer día del periodo de pago en el que se produce la transferencia.
  - Si no realiza cambios en el nivel de cobertura (50 % o 60 %) en el que estaba automáticamente inscrito, pero cambia a la opción de duración completa, no estará sujeto a los requisitos del Certificado de buena salud. La cobertura entrará en vigencia a partir del primer día del periodo de nómina en que tuvo lugar su transferencia.
  - Si aumenta el nivel de cobertura al 60 % después de haber estado inscrito automáticamente al nivel de cobertura del 50 % pero permanece en la opción de duración de cinco años, estará sujeto a los requisitos de Certificado de buena salud y es posible que deba someterse a un examen médico a su cargo. Si se aprueba, la cobertura entrará en vigencia el primer día del periodo de pago siguiente a la fecha en que se reciba la notificación de la aprobación de Lincoln. Si no se aprueba el aumento de cobertura, seguirá estando inscrito al 50 % y la cobertura entrará en vigencia el primer día del periodo de pago en el que se produzca su transferencia.
  - Si aumenta el nivel de cobertura al 60 % después de haber estado inscrito automáticamente al nivel de cobertura del 50 % y cambia a la opción de duración de completa, estará sujeto a los requisitos del Certificado de buena salud y es posible que deba someterse a un examen médico a su cargo. Si se aprueba, el aumento en cobertura entrará en vigencia el primer día del periodo de pago siguiente a la fecha en que se reciba la notificación de la aprobación de Lincoln. Si no se aprueba el aumento de cobertura, seguirá estando inscrito al 50 % y la cobertura entrará en vigencia el primer día del periodo de pago en el que se produzca su transferencia. No obstante, el cambio a la opción de duración completa no está sujeto a los requisitos del Certificado de buena salud y tendrá vigencia el primer día del periodo de pago en el que se produzca la transferencia.
- Si en la fecha de su transferencia no estaba inscrito en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**, se le aplicarán los requisitos del Certificado de buena salud y es posible que deba someterse a un examen médico a su cargo. Si se aprueba, la cobertura entrará en vigencia el primer día del periodo de pago siguiente a la fecha en que se reciba la notificación de la aprobación de Lincoln.

ASOCIADO GERENCIAL (INCLUIDO CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO) TRANSFERIDO AL PUESTO DE ASOCIADO PAGADO POR HORA TEMPORAL O A TIEMPO PARCIAL

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados pagados por hora a tiempo parcial y asociados temporales*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado gerencial, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado gerencial hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente
Como asociado pagado por hora a tiempo parcial o asociado temporal que se trasfiere desde una clasificación de asociado gerencial, tendrá derecho a cobertura médica, dental, de la visión, AD&D, por enfermedad grave y accidente, y podrá cubrir a sus hijos dependientes que cumplan los requisitos. No obstante, consulte **Su verificación anual de elegibilidad** en la sección **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** de este capítulo para obtener información importante sobre el periodo de tiempo durante el que será elegible para los beneficios médicos y las verificaciones futuras de elegibilidad para acceder a los beneficios médicos.

Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para la cobertura para cónyuge/pareja. Si estaba inscrito en la fecha de su transferencia y cubría a su cónyuge/pareja, su cobertura se ajustará automáticamente a la cobertura de asociado solo o de asociado + hijos (dependiendo de si cubre a sus hijos dependientes elegibles), que entra en vigencia a partir del primer día del primer periodo de pago en el que se produzca su transferencia. Su cónyuge/pareja puede ser elegible para la continuación de la cobertura. Consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** de este *Libro de beneficios para asociados* de 2025.

No puede realizar cambios en su cobertura como consecuencia de su transferencia porque ya tuvo la oportunidad de inscribirse usted y sus hijos dependientes elegibles en la cobertura como asociado gerencial.

Si estaba inscrito en un seguro AD&D por un monto superior a $200,000, su cobertura se reducirá a $200,000.

Seguro de vida pagado por la compañía
Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para un seguro de vida pagado por la compañía. Su cobertura continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha. Puede convertir su cobertura de seguro de vida pagado por la compañía en una póliza individual. Consulte el capítulo **Seguro de vida pagado por la compañía** de este *Libro de beneficios para asociados* de 2025 para obtener información sobre cómo solicitar la conversión a una póliza individual.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como asociado pagado por hora a tiempo parcial o asociado temporal, sigue siendo elegible para la cobertura opcional del seguro de vida para asociados, pero el monto máximo de la cobertura disponible se reduce a $200,000. Si está inscrito en una cobertura superior a $200,000 el día *anterior* al primer día del periodo de pago en el que se produce la transferencia, la cobertura se reducirá a $200,000 a partir del primer día del periodo de pago en el que se produce la transferencia.

Como asociado pagado por hora a tiempo parcial o asociado temporal, sigue siendo elegible para el seguro de vida opcional para sus hijos dependientes que reúnan los requisitos, pero no es elegible para la cobertura para cónyuges/parejas. Si ha inscrito a su cónyuge/pareja a un seguro de vida para dependientes, seguirá vigente hasta el último día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha. Puede convertir la cobertura de seguro de vida de su cónyuge/pareja dependiente en una póliza individual. Consulte el capítulo **Seguro de vida opcional para dependientes** de este *Libro de beneficios para asociados* de 2025 para obtener información sobre cómo solicitar la conversión a una póliza individual.

Discapacidad a corto plazo
Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para la cobertura de discapacidad a corto plazo. Su cobertura continuará hasta el último día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha.

Discapacidad de largo plazo
Como asociado pagado por hora a tiempo parcial o asociado temporal, no es elegible para la cobertura de discapacidad a largo plazo. Si estaba afiliado al seguro de discapacidad a largo plazo en la fecha de su transferencia, su cobertura continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha.

ASOCIADO GERENCIAL (INCLUIDO CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO) TRANSFERIDO AL PUESTO DE CONDUCTOR DE CAMIÓN A TIEMPO PARCIAL

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Conductores de camión a tiempo parcial*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado gerencial, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado gerencial hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente
Como conductor de camión a tiempo parcial transferido desde la clasificación de asociado gerencial, seguirá siendo elegible para cobertura de seguro médico, dental, de visión, AD&D, enfermedad grave y por accidente, y puede obtener cobertura para sus hijos dependientes.

Como conductor de camión a tiempo parcial, no es elegible para la cobertura para cónyuge/pareja. Si estaba inscrito en la fecha de su transferencia y cubría a su cónyuge/pareja, su cobertura se ajustará automáticamente a la cobertura de asociado solo o de asociado + hijos (dependiendo de si cubre a sus hijos dependientes elegibles), que entra en vigencia a partir del primer día del primer periodo de pago en el que se produzca su transferencia. Su cónyuge/pareja puede ser elegible para la continuación de la cobertura. Consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** de este *Libro de beneficios para asociados* de 2025.

No puede realizar cambios en su cobertura como consecuencia de su transferencia porque ya tuvo la oportunidad de inscribirse usted y sus hijos dependientes elegibles como asociado gerencial (incluidos los conductores de camión).

Si estaba inscrito en un seguro AD&D por un monto superior a $200,000, su cobertura se reducirá a $200,000.

Seguro de vida pagado por la compañía
Como conductor de camión a tiempo parcial, no es elegible para un seguro de vida pagado por la compañía. Su cobertura continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha. Puede convertir su seguro de vida pagado por la compañía en una póliza individual. Consulte el capítulo **Seguro de vida pagado por la compañía** de este *Libro de beneficios para asociados* de 2025 para obtener información sobre cómo solicitar la conversión a una póliza individual.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como conductor de camión a tiempo parcial, sigue siendo elegible para la cobertura opcional del seguro de vida para asociados, pero el monto máximo de la cobertura disponible se reduce a $200,000. Si está inscrito en una cobertura superior a $200,000 el día anterior al primer día del periodo de pago en el que se produce la transferencia, la cobertura se reducirá a $200,000 a partir del primer día del periodo de pago en el que se produce la transferencia.

Como conductor de camión a tiempo parcial, sigue siendo elegible para el seguro de vida opcional para sus hijos dependientes que reúnan los requisitos, pero no es elegible para la cobertura para cónyuges/parejas. Si ha inscrito a su cónyuge/pareja en cobertura para dependientes, seguirá vigente hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha. Puede convertir la cobertura de seguro de vida de su cónyuge/pareja dependiente en una póliza individual. Consulte el capítulo **Seguro de vida opcional para dependientes** de este *Libro de beneficios para asociados* de 2025 para obtener información sobre cómo solicitar la conversión a una póliza individual.

Discapacidad a corto plazo
Como conductor de camión a tiempo parcial, no es elegible para la cobertura por discapacidad a corto plazo. Su cobertura anterior por incapacidad a corto plazo remunerada permanecerá vigente hasta el último día del periodo de pago en el que se produzca su transferencia y no será efectiva después de esa fecha.

Discapacidad de largo plazo
Como conductor de camión a tiempo parcial, no es elegible para la cobertura por discapacidad a largo plazo. Si estaba afiliado al seguro de discapacidad a largo plazo en la fecha de su transferencia, su cobertura continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia y no tendrá vigencia después de esa fecha.

ASOCIADO GERENCIAL (INCLUIDO CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO) TRANSFERIDO AL PUESTO DE ASOCIADO PAGADO POR HORA A TIEMPO COMPLETO

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados pagados por hora a tiempo completo*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las reglas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado gerencial, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado gerencial hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente, seguro de vida pagado por la compañía
Sus beneficios no cambiarán como consecuencia de su transferencia, salvo que si estaba inscrito en un seguro AD&D por un monto superior a $200,000, su cobertura se reducirá a $200,000. De lo contrario, no se permiten cambios como consecuencia de su transferencia.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como asociado pagado por hora a tiempo completo, sigue siendo elegible para la cobertura opcional del seguro de vida para asociados, pero el monto máximo de la cobertura disponible se reduce a $200,000. Si está inscrito en una cobertura superior a $200,000 el día *anterior* al primer día del periodo de pago en el que se produce la transferencia, la cobertura se reducirá a $200,000 a partir del primer día del periodo de pago en el que se produce la transferencia. Asimismo, sigue siendo elegible para un seguro de vida opcional para dependientes para su cónyuge/pareja e hijos dependientes que reúnan los requisitos.

Discapacidad a corto plazo
Como asociado pagado por hora a tiempo completo, es elegible para una cobertura por discapacidad a corto plazo. Su inscripción en el **plan de discapacidad a corto plazo para asociados asalariados o conductores de camión** continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia. Queda automáticamente inscrito en el **plan mejorado de discapacidad a corto plazo pagado por hora a tiempo completo** a menos que trabaje en California, Hawái, Nueva Jersey o Rhode Island. Los asociados de estos estados pueden acogerse a los programas de discapacidad establecidos por ley. Los asociados de Nueva York se inscribirán al **plan mejorado por discapacidad a corto plazo de Nueva York**. ***Esto dará lugar a deducciones de primas de su pago.***

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Puede cancelar su inscripción al **plan mejorado de discapacidad a corto plazo para asociados a tiempo completo pagados por hora** o, para los asociados de Nueva York, al **plan mejorado de discapacidad a corto plazo de Nueva York**. Si cancela su inscripción en el **plan mejorado de discapacidad a corto plazo para asociados a tiempo completo pagados por hora** o, para los asociados de Nueva York, en el **plan mejorado de discapacidad a corto plazo de Nueva York**, se lo inscribirá automáticamente en el plan básico de discapacidad a corto plazo para asociados a tiempo completo pagados por hora o, para los asociados de Nueva York, en el **plan básico de discapacidad a corto plazo de Nueva York** y su cobertura entrará en vigencia al día siguiente de la sesión de inscripción en línea. Si cancela su inscripción llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que llama o 2) el primer día del periodo de pago en el que se produce la transferencia.
- Si no cancela su inscripción en el **plan mejorado de discapacidad a corto plazo para asociados a tiempo completo pagados por hora** o, para los asociados de Nueva York, en el **plan mejorado de discapacidad a corto plazo** de Nueva York, su cobertura entrará en vigencia el primer día del periodo de pago en el que se produzca su transferencia.

Discapacidad de largo plazo
Transferencia de asociado gerencial (que no sea conductor de camión): No se permiten cambios como consecuencia de su transferencia.

Transferencia de asociado gerencial (conductor de camión a tiempo completo): Como asociado pagado por hora a tiempo completo, es elegible para el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**. Si en la fecha de su transferencia estaba inscrito en el **plan de discapacidad a largo plazo para conductores de camión**, su cobertura continuará hasta el último día del periodo de pago en el que se produzca su transferencia. Se le inscribe automáticamente en el mismo nivel de cobertura (50 % o 60 %) en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo** a partir del primer día del periodo de pago en el que se produce su transferencia.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se le inscribió automáticamente en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo** porque estaba inscrito en el **plan de discapacidad a largo plazo para conductores de camión** en la fecha de su transferencia:
  - Si se cancela o disminuye su inscripción automática en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**, el cambio entrará en vigencia al día siguiente de la sesión de inscripción en línea. Si cancela su inscripción llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que llama o 2) el primer día del periodo de pago en el que se produce la transferencia.
  - Si aumenta el nivel de cobertura al 60 % después de haber estado inscrito automáticamente al nivel de cobertura del 50 %, la cobertura entrará en vigencia el primer día del periodo de pago siguiente a la fecha de inscripción.
- Si no estaba inscrito en el **plan de discapacidad a largo plazo para conductores de camión** antes de la fecha de su transferencia y opta por inscribirse en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**:
  - Si usted se inscribe en línea, la cobertura entra en vigencia en la última de las siguientes fechas: 1) el primer día del periodo de pago siguiente a la fecha en que se inscriba, o 2) el aniversario de 12 meses de su fecha de contratación.
  - Si se inscribe llamando a Servicios al Personal, la cobertura entrará en vigencia el día del aniversario de 12 meses de su fecha de contratación o, a su elección, 1) la fecha en que se inscriba o 2) el primer día del periodo de pago en el que se produzca su transferencia, la fecha que ocurra en último término.

ASOCIADO GERENCIAL (INCLUIDO CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO) TRANSFERIDO AL PUESTO DE ASOCIADO GERENCIAL DEL CENTRO DE VISIÓN POR HORA A TIEMPO COMPLETO

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados pagados por hora a tiempo completo*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las reglas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado gerencial, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado gerencial hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, por enfermedad grave, por accidente, seguro de vida pagado por la compañía
Sus beneficios no cambiarán como consecuencia de su transferencia. No se permiten cambios como consecuencia de su transferencia.

Seguro de vida opcional para asociados, seguro de vida opcional para dependientes
Como gerente del Centro de visión por hora a tiempo completo, sigue siendo elegible para la cobertura opcional del seguro de vida para asociados, pero el monto máximo de la cobertura disponible se reduce a $200,000. Si está inscrito en una cobertura superior a $200,000 el día *anterior* al primer día del periodo de pago en el que se produce la transferencia, la cobertura se reducirá a $200,000 a partir del primer día del periodo de pago en el que se produce la transferencia. Asimismo, sigue siendo elegible para un seguro de vida opcional para dependientes para su cónyuge/pareja e hijos dependientes que reúnan los requisitos.

Seguro por muerte accidental o desmembramiento (AD&D)
Como gerente del centro de visión por hora a tiempo completo, sigue siendo elegible para la cobertura AD&D, pero el monto máximo de la cobertura disponible se reduce a $200,000. Si está inscrito en una cobertura superior a $200,000 el día anterior al primer día del periodo de pago en el que se produce la transferencia, la cobertura se reducirá a $200,000 a partir del primer día del periodo de pago en el que se produce la transferencia.

Discapacidad a corto plazo
Como gerente del Centro de visión a tiempo completo, es elegible para una cobertura por discapacidad a corto plazo. Su inscripción en el **plan de discapacidad a corto plazo para asociados asalariados o conductores de camión** continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia. Queda automáticamente inscrito en el **plan mejorado de discapacidad a corto plazo pagado por hora a tiempo completo** a menos que trabaje en California, Hawái, Nueva Jersey o Rhode Island. Los asociados de estos estados pueden acogerse a los programas de discapacidad establecidos por ley. Los asociados de Nueva York se inscribirán al **plan mejorado por discapacidad a corto plazo de Nueva York**. ***Esto dará lugar a deducciones de primas de su pago.***

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Puede cancelar su inscripción al **plan mejorado de discapacidad a corto plazo para asociados a tiempo completo pagados por hora** o, para los asociados de Nueva York, al **plan mejorado de discapacidad a corto plazo de Nueva York**. Si cancela su inscripción en el plan mejorado de discapacidad a corto plazo para asociados a tiempo completo pagados por hora o, para los asociados de Nueva York, en el plan mejorado de discapacidad a corto plazo de Nueva York, se lo inscribirá automáticamente en el plan básico de discapacidad a corto plazo para asociados a tiempo completo pagados por hora o, para los asociados de Nueva York, en el plan básico de discapacidad a corto plazo de Nueva York y su cobertura entrará en vigencia al día siguiente de la sesión de inscripción en línea. Si cancela su inscripción llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que llama o 2) el primer día del periodo de pago en el que se produce la transferencia.
- Si no cancela su inscripción en el **plan mejorado de discapacidad a corto plazo para asociados a tiempo completo pagados por hora** o, para los asociados de Nueva York, en el **plan mejorado de discapacidad a corto plazo de Nueva York**, su cobertura entrará en vigencia el primer día del periodo de pago en el que se produzca su transferencia.

(Continúa en la próxima página)

ASOCIADO GERENCIAL (INCLUIDO CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO) TRANSFERIDO AL PUESTO DE ASOCIADO GERENCIAL DEL CENTRO DE VISIÓN POR HORA A TIEMPO COMPLETO (CONTINUACIÓN)

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados pagados por hora a tiempo completo*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las reglas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente la elegibilidad para los beneficios al estar clasificado como asociado gerencial, y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado gerencial hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Discapacidad de largo plazo

Transferencia de asociado gerencial (que no sea conductor de camión): No se permiten cambios como consecuencia de su transferencia.

Transferencia de asociado gerencial (conductor de camión a tiempo completo): Como gerente del Centro de visión a tiempo completo, es elegible para el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**. Si en la fecha de su transferencia estaba inscrito en el **plan de discapacidad a largo plazo para conductores de camión**, su cobertura continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia. Se le inscribe automáticamente en el mismo nivel de cobertura (50 % o 60 %) en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo** a partir del primer día del periodo de pago en el que se produce su transferencia.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se le inscribió automáticamente en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo** porque estaba inscrito en el **plan de discapacidad a largo plazo para conductores de camión** en la fecha de su transferencia:
  - Si cancela su inscripción en el plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo o disminuye su cobertura, el cambio entrará en vigencia al día siguiente de la sesión de inscripción en línea. Si realiza el cambio llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que llama, o 2) el primer día del periodo de pago en el que se produce la transferencia.
  - Si aumenta el nivel de cobertura al 60 % después de haber estado inscrito automáticamente al nivel de cobertura del 50 %, la cobertura entrará en vigencia el primer día del periodo de pago siguiente a la fecha de inscripción.
- Si no estaba inscrito en el **plan de discapacidad a largo plazo para conductores de camión** antes de la fecha de su transferencia y opta por inscribirse en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**:
  - Si se inscribe en línea, la cobertura es efectiva a partir del primer día del periodo de pago en que tuvo lugar la transferencia.
  - Si se inscribe llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que se inscribe o 2) el primer día del periodo de pago en el que se produce la transferencia.

ASOCIADO GERENCIAL (CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO) TRANSFERIDO AL PUESTO DE ASOCIADO GERENCIAL (QUE NO SEA CONDUCTOR DE CAMIÓN)

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados gerenciales*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente elegibilidad para los beneficios al estar clasificado como asociado gerencial (conductor de camión a tiempo completo), y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado gerencial (conductor de camión a tiempo completo) hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, enfermedad grave, por accidentes, seguro de vida pagado por la compañía, seguro de vida opcional para asociados y dependientes
Sus beneficios no cambiarán como consecuencia de su transferencia. No se permite ningún cambio como consecuencia de su transferencia, salvo en la cobertura opcional del seguro de vida para asociados y dependiente, que puede modificarse en cualquier momento.

Discapacidad a corto plazo
Como asociado gerencial (que no sea conductor de camión), queda automáticamente inscrito en los beneficios básicos y de maternidad del **plan de discapacidad a corto plazo para asociados asalariados**, con efecto a partir del primer día del periodo de pago en el que se produce su transferencia. Su inscripción en el **plan de discapacidad a corto plazo para conductores de camión** continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia.

Discapacidad de largo plazo
Como asociado gerencial (que no sea no conductor de camión), es elegible para el **plan de discapacidad a largo plazo a tiempo completo y asalariado pagado por hora**. Si en la fecha de su transferencia estaba inscrito en el **plan de discapacidad a largo plazo para conductores de camión**, su cobertura continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia. Se le inscribe automáticamente en el mismo nivel de cobertura (50 % o 60 %) en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo** a partir del primer día del periodo de pago en el que se produce su transferencia.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se le inscribió automáticamente en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo** porque estaba inscrito en el **plan de discapacidad a largo plazo para conductores de camión** en la fecha de su transferencia:
- Si cancela su inscripción en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo** o disminuye su cobertura, el cambio entrará en vigencia al día siguiente de la sesión de inscripción en línea. Si realiza el cambio llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que llama, o 2) el primer día del periodo de pago en el que se produce la transferencia.
  - Si aumenta el nivel de cobertura al 60 % después de haber estado inscrito automáticamente al nivel de cobertura del 50 %, la cobertura entrará en vigencia el primer día del periodo de pago siguiente a la fecha de inscripción.
- Si no estaba inscrito en el **plan de discapacidad a largo plazo para conductores de camión** antes de la fecha de su transferencia y opta por inscribirse en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**:
  - Si se inscribe en línea, la cobertura es efectiva a partir del primer día del periodo de pago en que tuvo lugar la transferencia.
  - Si se inscribe llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que se inscribe o 2) el primer día del periodo de pago en el que se produce la transferencia.

ASOCIADO GERENCIAL (QUE NO SEA CONDUCTOR DE CAMIÓN) TRANSFERIDO AL PUESTO DE ASOCIADO GERENCIAL (CONDUCTOR DE CAMIÓN A TIEMPO COMPLETO)

Usted debe realizar los cambios permitidos que se describen a continuación dentro de los 60 días a partir del primer día del periodo de pago en que tuvo lugar la transferencia. Si no realiza cambios, en la mayoría de los casos tendrá la oportunidad de hacerlo en la próxima Inscripción anual o cuando se produzca un evento de cambio de elección válido. Consulte la tabla titulada ***Asociados gerenciales*** *en la sección* ***Inscripción y fechas efectivas por clasificación laboral*** *de este capítulo para conocer las normas que se aplican cuando se inscribe o realiza cambios después de su periodo de inscripción inicial. La inscripción después del periodo de inscripción inicial puede estar sujeta a los requisitos del Certificado de buena salud.*

Si ha adquirido recientemente elegibilidad para los beneficios al estar clasificado como asociado gerencial (que no sea conductor de camión), y el periodo de inscripción inicial que se le comunicó no ha finalizado antes de la fecha de su transferencia, su periodo de inscripción inicial no cambiará. Puede realizar cualquier elección permitida como consecuencia de su clasificación como asociado gerencial (que no sea conductor de camión) hasta el final de su periodo de inscripción inicial.

Las reglas que se detallan a continuación se aplicarán una vez finalizado su periodo de inscripción inicial, hasta la fecha en que transcurran 60 días desde el primer día del periodo de pago en el que se produzca su transferencia.

Todos los beneficios quedan sujetos a los términos y condiciones que se describen en el presente *Libro de beneficios para asociados* de 2025.

Seguro médico, dental, de la visión, AD&D, enfermedad grave, por accidentes, seguro de vida pagado por la compañía, seguro de vida opcional para asociados y dependientes
Sus beneficios no cambiarán como consecuencia de su transferencia. No se permite ningún cambio como consecuencia de su transferencia, salvo en la cobertura opcional del seguro de vida para asociados y dependiente, que puede modificarse en cualquier momento.

Discapacidad a corto plazo
Como asociado gerencial (conductor de camión a tiempo completo), queda automáticamente inscrito en los beneficios básicos y de maternidad del **plan de discapacidad a corto plazo para conductores de camión**, con efecto a partir del último día del periodo de pago en el que se produce su transferencia. Su cobertura en virtud del **plan de discapacidad a corto plazo para asociados asalariados** continuará hasta el día inmediatamente anterior al primer día del periodo de pago en el que se produzca su transferencia.

Discapacidad de largo plazo
Como asociado gerencial (conductor de camión a tiempo completo), tiene derecho a la cobertura por discapacidad a largo plazo del **plan de discapacidad a largo plazo para conductores de camión**.

Si en la fecha de su transferencia estaba inscrito en el **plan de discapacidad a largo plazo y asalariado a tiempo completo pagado por hora**, su cobertura continuará hasta el día del periodo de pago en el que se produzca su transferencia. Se le inscribe automáticamente en el mismo nivel de cobertura (50 % o 60 %) del **plan de discapacidad a largo plazo para conductores de camión** con la opción de cinco años de duración, que entra en vigencia a partir del primer día del periodo de pago en el que se produce su transferencia. ***Esto puede dar lugar a un aumento de las deducciones de primas de su pago.***

Si en la fecha de su transferencia no estaba inscrito en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**, puede inscribirse en el **plan de discapacidad a largo plazo para conductores de camión**. Se aplican los requisitos del Certificado de buena salud.

Si realiza un cambio dentro de los 60 días desde el primer día del periodo de pago en el cual ocurre la transferencia, su cobertura entra en vigencia tal como se indica a continuación:

- Si se le inscribió automáticamente en el plan de **discapacidad a largo plazo para conductores de camión** porque estaba inscrito en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados** a tiempo completo en la fecha de su transferencia:
  - Si cancela su inscripción en el **plan de discapacidad a largo plazo para conductores de camión** o su cobertura disminuye, el cambio entrará en vigencia al día siguiente de la sesión de inscripción en línea. Si realiza el cambio llamando a Servicios al Personal, puede elegir una fecha de entrada en vigencia que sea 1) la fecha en que llama, o 2) el primer día del periodo de pago en el que se produce la transferencia.
  - Si no realiza cambios en el nivel de cobertura (50 % o 60 %) en el que estaba automáticamente inscrito, pero cambia a la opción de duración completa, no estará sujeto a los requisitos del Certificado de buena salud. La cobertura entrará en vigencia a partir del primer día del periodo de nómina en que tuvo lugar su transferencia.
  - Si aumenta el nivel de cobertura al 60 % después de haber estado inscrito automáticamente al nivel de cobertura del 50 % pero permanece en la opción de duración de cinco años, estará sujeto a los requisitos de Certificado de buena salud y es posible que deba someterse a un examen médico a su cargo. Si se aprueba, la cobertura entrará en vigencia el primer día del periodo de pago siguiente a la fecha en que se reciba la notificación de la aprobación de Lincoln. Si no se aprueba el aumento de cobertura, seguirá estando inscrito al 50 % y la cobertura entrará en vigencia el primer día del periodo de pago en el que se produzca su transferencia.
  - Si aumenta el nivel de cobertura al 60 % después de haber estado inscrito automáticamente al nivel de cobertura del 50 % y cambia a la opción de duración de completa, estará sujeto a los requisitos del Certificado de buena salud y es posible que deba someterse a un examen médico a su cargo. Si se aprueba, el aumento en cobertura entrará en vigencia el primer día del periodo de pago siguiente a la fecha en que se reciba la notificación de la aprobación de Lincoln. Si no se aprueba el aumento de cobertura, seguirá estando inscrito al 50 % y la cobertura entrará en vigencia el primer día del periodo de pago en el que se produzca su transferencia. No obstante, el cambio a la opción de duración completa no está sujeto a los requisitos del Certificado de buena salud y tendrá vigencia el primer día del periodo de pago en el que se produzca la transferencia.
- Si en la fecha de su transferencia no estaba inscrito en el **plan de discapacidad a largo plazo para asociados pagados por hora y asalariados a tiempo completo**, se le aplicarán los requisitos del Certificado de buena salud y es posible que deba someterse a un examen médico a su cargo. Si se aprueba, la cobertura entrará en vigencia el primer día del periodo de pago siguiente a la fecha en que se reciba la notificación de la aprobación de Lincoln.

Órdenes de manutención de los hijos por razones médicas

Si es elegible para la cobertura del Plan, es posible que se le exija que proporcione cobertura a su hijo en virtud de un Aviso nacional de manutención médica (NMSN) debidamente diligenciada o de una Orden de cobertura médica para menores (QMCSO). La QMCSO es una orden emitida por un organismo administrativo o un tribunal que exige que un asociado, padre/madre o tutor brinde cobertura de atención médica para sus dependientes elegibles después de un divorcio o proceso legal de colocación de niños en custodia. La ley federal exige que el Plan otorgue beneficios médicos, dentales y/o de la visión a todo dependiente elegible de un participante del Plan exigidos a través de una orden del tribunal o un aviso de una agencia de las autoridades que reúne los requisitos de una QMCSO. El NMSN es un aviso de manutención médica estandarizado que utilizan las agencias estatales de manutención de menores para exigir que los niños se inscriban en el plan de grupo de un empleador. Un NMSN debidamente diligenciado se considera una QMCSO y debe ser respetado por todos los planes de salud de grupo de las compañías. El término QMCSO, tal como se utiliza en esta sección, también se refiere a un NMSN aprobado.

Puede obtener los procedimientos escritos para determinar si una orden cumple con los requisitos federales, sin cargo, llamando al Servicio de apoyo médico al **877-930-5607**.

Una vez que el Plan determina que una orden es una QMCSO, la cobertura comienza el primer día del periodo de pago en que el Plan recibe la orden, a menos que en la orden se especifique otra fecha. Si usted es elegible para el plan médico, dental y/o de la visión y no optó por cobertura antes de la recepción de la orden, usted y su(s) hijo(s) identificados en la QMCSO se le inscribirá en el Plan Premier predeterminado con la cobertura para asociado + hijos, a menos que la QMCSO especifique lo contrario.

Si está en el estado de Hawái, el plan predeterminado es el Plan de Salud Hawái (Health Plan Hawaii, HMSA). Si se encuentra en un lugar donde se ofrece el Plan PPO, el plan predeterminado es el Plan Saver.

Cuando esté inscrito en el plan por defecto, se lo inscribirá a la tarifa relacionada con el consumo de tabaco. Si no consume tabaco, debe llamar al Servicios al Personal al **800-421-1362** en un plazo de 60 días a partir de la fecha de la carta de los Servicios médicos de apoyo para solicitar un cambio de situación de consumo de tabaco y pasar a la tarifa más baja de no consumidor. Para obtener información adicional sobre cómo obtener una tarifa relacionada con el consumo de tabaco, incluida la disponibilidad de una norma alternativa razonable para obtener dichas tarifas, consulte la información relativa a las tarifas de consumidor de tabaco en la sección **Pago de los beneficios** de este capítulo.

Si se inscribió en la cobertura antes de que se recibiera la orden, se agregará a su hijo a la cobertura actual, con las siguientes excepciones:

- Si está inscrito en un plan HMO o uno de los planes locales, su cobertura cambiará al Plan Premier, conforme al cual el hijo hubiese tenido cobertura independientemente de donde viva.
- Si está inscrito en el Plan PPO, su cobertura cambiará al Plan Saver, conforme al cual el hijo hubiese tenido cobertura independientemente de donde viva.
- Si usted está en el estado de Hawái, su cobertura cambiará a HMSA.

Tiene 60 días para llamar al Servicios al personal al **800-421-1362** para elegir un plan médico alternativo.

Cuando el Plan reciba una QMCSO, se aplicarán las siguientes reglas:

- Si el Plan recibe una QMCSO cuando usted es elegible, pero antes de que usted complete el periodo de espera inicial para la cobertura médica, la orden entrará en vigencia cuando se cumpla dicho periodo de espera inicial, sujeto a los términos del Plan aplicables.
- Si usted no es elegible para la cobertura cuando el Plan recibe una QMCSO, se rechazará la orden.
- Si usted no es elegible para la cobertura cuando el plan recibe una QMCSO, pero luego adquiere la elegibilidad, el Plan requiere una nueva QMCSO para que la cobertura de su dependiente entre en vigencia.
- Si usted es elegible para la cobertura cuando el Plan recibe una QMCSO, pero pierde la elegibilidad y la recupera, el Plan requiere una nueva QMCSO para que la cobertura de su dependiente entre en vigencia. Este requisito se aplicará en los siguientes casos:
  - Si no es elegible por falta de pago de las primas
  - Si no es elegible como consecuencia de un cambio en su situación laboral
- Si es elegible para la cobertura y tiene una QMCSO en vigencia, luego cesa en el empleo, pero es contratado nuevamente y vuelve a ser elegible, el Plan requiere una nueva QMCSO para que la cobertura entre en vigencia.

Cuando el administrador de la red subcontratado implementa la cobertura para un dependiente que ordena un tribunal, la información relacionada con el dependiente solo se compartirá con el custodio legal. Si tiene preguntas, comuníquese con el Servicio de apoyo médico al **877-930-5607**.

BAJA O CAMBIO DE LA COBERTURA DE LA QMCSO

Puede cancelar la cobertura QMCSO ordenada por el tribunal para el (los) hijo(s) identificado(s) en la QMCSO si se aplica lo siguiente:

- La QMCSO se cancela por orden de un tribunal o de una agencia administrativa: debe solicitar su cambio en un plazo de 60 días (como cuando la QMCSO ya no sea apropiada).

  EJEMPLOS:

  – No tiene cobertura médica antes de que un tribunal emitiera una QMCSO, que le obliga tener cobertura para usted y un hijo. De acuerdo con la QMCSO, usted está inscrito en la cobertura médica del Plan para usted mismo y su hijo. Debido a un cambio de circunstancias, la QMCSO se cancela de forma prospectiva. Al día siguiente de la cancelación de la QMCSO, usted solicita darse de baja de la cobertura para usted mismo y su hijo. El Plan le permite abandonar la cobertura de su hijo que fue objeto de la QMCSO a partir de la fecha cuando esta se cancele. No obstante, solamente podrá darse de baja de la cobertura de asociado durante la Inscripción anual, a menos que se produzca otro evento de cambio de elección.

  – Está inscrito en la cobertura médica en el momento en que se emite una QMCSO para su hijo. De acuerdo con los términos de la QMCSO, usted y su hijo están inscritos en la cobertura médica. Debido a un cambio de circunstancias, la QMCSO se cancela de forma prospectiva. Al día siguiente de la cancelación de la QMCSO, usted solicita darse de baja de la cobertura para usted mismo y su hijo. El Plan le permite abandonar la cobertura de su hijo que fue objeto de la QMCSO a partir de la fecha cuando esta se cancele. No obstante, solamente podrá darse de baja de la cobertura de asociado durante la Inscripción anual, a menos que se produzca otro evento de cambio de elección.

- La QMCSO se anula por orden de un tribunal o de una agencia administrativa (por ejemplo, si una agencia determina que la orden no es válida).

  EJEMPLO:

  – No tiene cobertura médica antes de que un tribunal emitiera una QMCSO, que le obliga tener cobertura para usted y un hijo. De acuerdo con la QMCSO, usted está inscrito en la cobertura médica del Plan para usted mismo y su hijo. Seis meses después, el tribunal determina que había emitido la QMCSO por error y emite una "orden de rescisión" que retira con efecto retroactivo la QMCSO. El Plan le permite volver al estado "sin cobertura" a partir de la primera fecha de su inscripción y la de su hijo y le devuelve las primas asociadas. Deberá pagar el costo de los beneficios que el Plan pagó en nombre de usted y su hijo durante el periodo en el que se rescindió la cobertura y se reembolsaron las primas. Para obtener más información sobre este proceso, llame al administrador externo que figura en su tarjeta de identificación del Plan.

- Un hijo que es objeto de la orden del tribunal alcanza la edad de emancipación en el estado que emite la orden del tribunal. Comuníquese con el organismo para el cumplimiento del sustento de menores de su estado para obtener más detalles.

Si la QMCSO se cancela mediante una orden judicial o de una agencia administrativa, la aplicación de la orden finalizará en la fecha que se especifica en la orden o el primer día del periodo de pago en la que el Plan recibe la orden, lo que ocurra después. Aunque la orden finaliza automáticamente, la cobertura para el niño no lo hará. Recibirá una carta de aviso de cancelación de los Servicios de asistencia médica en la que se le informa de que su orden ha sido cancelada, y tendrá 60 días a partir de la fecha de aviso para llamar a Servicios al Personal para cancelar la cobertura del niño.

La cobertura del hijo no se dará por terminada a menos que los Servicios de asistencia médica hayan recibido evidencia satisfactoria por escrito de que:

- LA QMCSO ya no está en vigencia, o
- El hijo está o estará inscrito en una cobertura comparable que entrará en vigencia a más tardar en la fecha de entrada en vigencia de la pérdida de cobertura del hijo en virtud del Plan.

Cuando una QMCSO se cancela, no puede darse de baja de su propia cobertura ni de la de ningún otro dependiente, a menos que se produzca un cambio de estado para usted o sus otros dependientes, o durante la Inscripción anual. Sin embargo, puede cambiar su opción de plan de seguro médico llamando a Servicios al Personal, siempre que solicite el cambio dentro de los 60 días siguientes a la carta de aviso de cancelación. No puede dar de baja la cobertura dental de asociado durante el periodo de Inscripción anual ni debido a un evento de cambio de elección, a menos que haya tenido cobertura durante dos años calendario consecutivos.

Si se recibe la orden para rescindir la cobertura, esta se cancelará de manera retroactiva y usted volverá a tener la cobertura que tenía antes de que se implementara la QMCSO en la medida permitida por la ley.

En qué momento finaliza su cobertura del Plan

La cobertura del Plan de salud y bienestar para asociados para usted y para sus dependientes finaliza cuando se presente la primera de las siguientes situaciones:

- El momento del cese de su relación laboral.
- El último día de la cobertura para la que se pagaron las primas, si no pagó las primas dentro de los 30 días de la fecha de vencimiento de estas.
- En la fecha de su fallecimiento (del asociado) para usted y sus dependientes.
- En la fecha de fallecimiento para un dependiente fallecido.
- En la fecha en que usted, su cónyuge/pareja o hijo a cargo pierdan la elegibilidad.
- Cuando Walmart deje de ofrecer el beneficio.
- Cuando hay una tergiversación o presentación fraudulenta de una reclamación de beneficios o elegibilidad.
- Cuando hay un acto de fraude o una declaración errónea de un hecho material.
- Cuando usted abandone voluntariamente la cobertura.

Si su clasificación de empleo cambia, consulte la tabla correspondiente en la sección **Cambio de una clasificación laboral a otra** de este capítulo para obtener información sobre cualquier repercusión en su cobertura.

Si cancela voluntariamente la cobertura después de un evento de cambio de elección o en la Inscripción anual:

- **Tras un eventos de cambio de elección:**
  - Si cancela la cobertura a través de la inscripción en línea, la cobertura de todos los beneficios, excepto los de discapacidad a largo plazo y discapacidad a corto plazo, continuará hasta la fecha del evento. La cobertura por discapacidad a largo plazo y discapacidad a corto plazo continuará hasta la fecha de la sesión de inscripción en línea.
  - Si cancela la cobertura llamando al Servicio al Personal, la cobertura de todos los beneficios continúa hasta el día del evento.
- Para más información, consulte **Cambios de elección permitidos fuera del periodo de Inscripción anual** en este capítulo.
- **Durante la Inscripción anual:** la cobertura continúa hasta el 31 de diciembre del año en curso que contiene el periodo de Inscripción anual.

Elegibilidad, inscripción y fechas de vigencia para los asociados en Hawái

Elegibilidad, inscripción y fechas de vigencia para los asociados en Hawái

Si es usted un asociado que trabaja en Hawái, se le aplicarán los beneficios descritos a lo largo de este *Libro de beneficios para asociados* de 2025, con la excepción de algunas diferencias en los términos de elegibilidad aplicables a los beneficios médicos y de discapacidad a corto plazo. En la medida en que la información tratada en este capítulo entre en conflicto con la información del capítulo **Elegibilidad, inscripción y fechas de vigencia**, la información de este capítulo prevalecerá.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Plan de salud Hawái (HMSA)	Visite **hmsa.com**	**808-948-6372**
Plan de Salud de la Fundación Kaiser	Vaya al sitio **kaiserpermanente.org**	**800-966-5955**
Inscripción en los beneficios de Walmart	Visite **One.Walmart.com/Enroll**	Llame a Servicios al Personal al **800-421-1362**
Preguntas de elegibilidad sobre el programa de seguro de discapacidad temporal de Hawái, establecido por la ley	Visite **One.Walmart.com/LOA > mySedgwick**	Llame a Sedgwick al **800-492-5678**
Notificación a los Servicios al Personal dentro de un plazo de 60 días de un evento de cambio de elección	Visite **One.Walmart.com**	Llame a Servicios al Personal al **800-421-1362**

Lo que debe saber como asociado de Hawái

- Los asociados de Hawái tienen dos opciones de cobertura médica: Health Plan Hawaii (HMSA) y Kaiser Foundation Health Plan. Para obtener más información sobre estas opciones médicas, visite **One.Walmart.com**, o consulte la información de contacto para cada opción en la tabla anterior.
- Debido a que Hawái tiene un programa de discapacidad por mandato legal, los asociados a tiempo completo por hora generalmente no reúnen los requisitos para participar en un plan de discapacidad a corto plazo de Walmart. No obstante, es posible que siga reuniendo los requisitos para el beneficio por maternidad bajo el plan básico de discapacidad a corto plazo de Walmart. Para obtener información, consulte el capítulo **Discapacidad a corto plazo para asociados a tiempo completo pagados por hora**.
- Los periodos de elegibilidad inicial para la cobertura varían para los asociados de Hawái en función de su estado de empleo, según se describe en este capítulo.

Periodos de espera de elegibilidad para la cobertura médica

ASOCIADOS GERENCIALES

Si es asociado gerencial en Hawái, los términos de elegibilidad que se describen en el capítulo **Elegibilidad, inscripción y fechas de vigencia** son aplicables para usted. Los asociados gerenciales y los asociados en formación para puestos gerenciales en Hawái son elegibles para cobertura médica en la fecha de su contratación. Para obtener información detallada sobre la elegibilidad y la inscripción en todos los beneficios disponibles conforme al Plan de salud y bienestar para asociados, consulte la tabla para asociados gerenciales en la sección **Inscripción y fechas efectivas por clasificación laboral** del capítulo **Elegibilidad, inscripción y fechas de vigencia**.

ASOCIADOS A TIEMPO COMPLETO PAGADOS POR HORA, A TIEMPO PARCIAL PAGADOS POR HORA Y TEMPORALES

Si usted es asociado pagado por hora a tiempo completo (incluidos los farmacéuticos pagados por hora a tiempo completo y los supervisores de campo en tiendas y clubes), un asociado pagado por hora a tiempo parcial o un asociado temporal en Hawái, la elegibilidad para la cobertura médica está sujeta a las reglas especiales dispuestas para los asociados en Hawái. Los términos de elegibilidad para los beneficios que no sean médicos o de discapacidad se describen en el capítulo **Elegibilidad, inscripción y fechas de vigencia**. La elegibilidad para otros beneficios también se describe en las tablas bajo **Inscripción y fechas efectivas por clasificación laboral** que figuran más adelante en este capítulo. Para obtener información detallada, consulte la tabla correspondiente.

Opciones de cobertura médica para los asociados de Hawái

Los asociados en Hawái tienen dos opciones de cobertura:

- Plan de salud Hawái (HMSA); y
- Plan de Salud de la Fundación Kaiser.

Viste los sitios web en la tabla al comienzo de este capítulo para obtener información sobre las opciones médicas.

Pago de primas durante una licencia de ausencia para los asociados de Hawái

Debido a que la parte de la prima del seguro médico que debe pagar el asociado se basa en el sueldo, no adeuda ninguna prima si no percibe el sueldo durante una licencia de ausencia aprobado. La única prima para la cobertura médica que deberá pagar en el caso de una licencia de ausencia aprobado sin goce de sueldo es la parte de la prima que corresponde a los dependientes. Todas las demás opciones de beneficios requieren el pago durante un permiso de ausencia aprobado como se describe en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Según las leyes de Hawái, Walmart debe contribuir por lo menos con el 50 % de la prima de su cobertura médica (asociado solo), pero no de la cobertura de los dependientes. Los asociados deben pagar el resto del costo de la prima, pero solo hasta el 1.5 % de su sueldo o el 50 % del costo de la prima por periodo de pago, lo que sea menor. Por ejemplo, si su sueldo por periodo de pago es de $1,000 y usted califica para las tarifas para no fumadores, no debe pagar más de $15 para la cobertura por periodo de pago (suponiendo que la prima entera es al menos de $30).

Inscripción y fechas efectivas para los asociados de Hawái

ASOCIADOS A TIEMPO COMPLETO PAGADOS POR HORA
Incluye a los farmacéuticos pagados por hora California, los asociados de la cadena de suministro de campo por hora a tiempo completo y los supervisores de campo por hora a tiempo completo en tiendas y clubes; excluye a los gerentes de centros de visión por hora a tiempo completo.

NOTA: *No confunda el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura antes de la fecha de vigencia de la cobertura.*

<table>
<tr><th>Plan</th><th colspan="2">Periodos de inscripción y fechas de entrada en vigencia</th></tr>
<tr><td rowspan="2">Médico</td><td colspan="2">Periodo de inscripción inicial:
Debe inscribirse en la cobertura entre la fecha del primer día de pago y el día anterior a la fecha de entrada en vigencia de la cobertura.</td></tr>
<tr><td>Cuándo entra en vigencia la cobertura:
Su cobertura entra en vigencia en la primera de las siguientes fechas:
• El primer día del periodo de pago después de un periodo de trabajo de al menos 20 horas por semana durante cuatro semanas consecutivas, o
• El primer día del mes calendario durante el cual se cumple su 89° día de empleo a tiempo completo continuo.</td><td rowspan="2">Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la Cambios de elección permitidos fuera del periodo de Inscripción anualsección de este capítulo Elegibilidad, inscripción y fechas de vigencia.</td></tr>
<tr><td>Dental (la inscripción es por dos años calendario consecutivos)
De la vista
Seguro por enfermedades graves
Seguro contra accidentes
AD&D</td><td>Periodo de inscripción inicial:
Debe inscribirse en la cobertura entre la fecha del primer día de pago y el día anterior a la fecha de entrada en vigencia de la cobertura.</td></tr>
<tr><td colspan="2">Cuándo entra en vigencia la cobertura:
Su cobertura entra en vigencia el primer día del mes calendario durante el cual se cumplen 89 días de empleo a tiempo completo continuos.</td></tr>
</table>

(Continúa en la próxima página)

ASOCIADOS A TIEMPO COMPLETO PAGADOS POR HORA (CONTINUACIÓN)
Incluye a los farmacéuticos pagados por hora California, los asociados de la cadena de suministro de campo por hora a tiempo completo y los supervisores de campo por hora a tiempo completo en tiendas y clubes; excluye a los gerentes de centros de visión por hora a tiempo completo.

NOTA: *No confunda el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura antes de la fecha de vigencia de la cobertura.*

Plan	Periodos de inscripción y fechas de entrada en vigencia
Seguro de vida pagado por la compañía	Se inscribe automáticamente el primer día del mes calendario en el que cumple día 89 de trabajo continuo a tiempo completo y su cobertura entra en vigencia en esa fecha.
Recursos de asistencia para los asociados Seguro contra accidentes durante viajes de negocios	Su inscripción es automática en la fecha de contratación y su cobertura entra en vigencia en esa fecha.
Seguro de discapacidad temporal de Hawái* (programa obligatorio por ley) Plan básico de discapacidad a corto plazo de Walmart • Cobertura básica (no disponible para los asociados que trabajan en Hawái) • Beneficios por maternidad (disponibles para las asociadas que trabajan en Hawái) *Para obtener información general sobre los beneficios estatales, consulte el capítulo **Discapacidad a corto plazo para asociados a tiempo completo pagados por hora**.	Para el seguro de discapacidad temporal de Hawái, consulte la tabla **Recursos** al principio de este capítulo para obtener información de contacto sobre los requisitos y las fechas de entrada en vigencia. En el caso de los beneficios por maternidad del plan básico de discapacidad a corto plazo, su inscripción es automática al aniversario de 12 meses de la fecha de contratación y su cobertura entra vigente en esa fecha, siempre que se satisfagan los requisitos de actividad laboral descritos en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.
Seguro de vida opcional para asociados Seguro de vida opcional para dependientes	**Periodo de inscripción inicial:** Debe inscribirse en la cobertura entre la fecha de su primer día de pago y el día *anterior* al primer día del mes calendario en el que caiga su 89.º día de trabajo continuo a tiempo completo. **Cuándo entra en vigencia la cobertura:*** **Si se inscribe durante el periodo de inscripción inicial:** • Si se inscribe por el monto garantizado, la cobertura entra en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscribe, o 2) el primer día del mes calendario en el que se cumplen 89 días de empleo a tiempo completo continuo. • Si se inscribe por un monto superior al monto garantizado, la cobertura para usted y/o su cónyuge/pareja estará sujeta a la aprobación de Prudential. Deberá presentar un Certificado de buena salud para usted y/o su cónyuge/pareja y posiblemente deba someterse a un examen médico. Si se aprueba, su cobertura entrará en vigencia en la última de las siguientes fechas: 1) la fecha en que Prudential apruebe su cobertura, o 2) el primer día del mes calendario en el que se cumplen 89 días de empleo a tiempo completo continuo. Si no se aprueba ninguna cobertura por encima del monto garantizado, usted (o su cónyuge) quedará inscrito en una cobertura por el monto garantizado y la cobertura entrará en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscriba, o 2) el primer día del mes calendario en el que cumpla 89 días de trabajo a tiempo completo continuo. **Si se inscribe en la cobertura o aumenta la cobertura después del periodo de inscripción inicial:** • La cobertura para usted y/o su cónyuge/pareja (incluido un aumento de la cobertura elegida anteriormente) está sujeta a la aprobación de Prudential. Deberá presentar un Certificado de buena salud para usted y/o su cónyuge/pareja y posiblemente deba someterse a un examen médico. Si se aprueba, su cobertura entrará en vigencia en la fecha en que Prudential la apruebe. • No es necesario presentar un Certificado de buena salud para los hijos que inscriba en la cobertura opcional para dependientes. Si debe facilitar un Certificado de buena salud, las retenciones en nómina de sus primas no comenzarán hasta que su cobertura entre en vigencia, como se ha descrito anteriormente.

*Si su cónyuge/pareja o hijo dependiente está limitado porque debe recibir tratamiento médico (en su hogar o en otro lugar), la cobertura se retrasa hasta que su cónyuge/pareja o hijo tenga el alta médica (no se aplica a un recién nacido).

(Continúa en la próxima página)

ASOCIADOS A TIEMPO COMPLETO PAGADOS POR HORA (CONTINUACIÓN)

Incluye a los farmacéuticos pagados por hora California, los asociados de la cadena de suministro de campo por hora a tiempo completo y los supervisores de campo por hora a tiempo completo en tiendas y clubes; excluye a los gerentes de centros de visión por hora a tiempo completo.

NOTA: *No confunda el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura antes de la fecha de vigencia de la cobertura.*

Plan	Periodos de inscripción y fechas de entrada en vigencia
• Plan por discapacidad a largo plazo (incluidos los beneficios mejorados)	**Periodo de inscripción inicial:** Debe inscribirse en la cobertura entre la fecha de su primer día de pago y el día *anterior* al primer día del mes calendario en el que se cumplen 89 días de empleo a tiempo completo continuo. **Cuándo entra en vigencia la cobertura:** • **Si se inscribe en la cobertura durante el periodo de inscripción inicial:** La cobertura entra en vigencia en el aniversario de 12 meses de su fecha de contratación. • **Si se inscribe en la cobertura o aumenta la cobertura después del periodo de inscripción inicial:** – Si usted se inscribe en la cobertura o la aumenta después de un evento de cambio de elección, su cobertura entra en vigencia en la última de las siguientes fechas: 1) el primer día del periodo de pago siguiente a la fecha en que se inscriba, o 2) en el aniversario de 12meses de su fecha de contratación. – Si se inscribe en la cobertura o la aumenta durante la Inscripción anual para el próximo año del Plan, su cobertura entrará en vigencia en la última de las siguientes fechas: 1) el 1.º de enero de ese año o 2) el aniversario de 12 meses de su fecha de contratación. Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** del capítulo **Elegibilidad, inscripción y fechas de vigencia**.

NOTA: Algunos beneficios requieren que se cumpla la definición de trabajo activo. Para más información, consulte la sección **"Trabajo activo" o "activamente en el trabajo"** del capítulo **Elegibilidad, inscripción y fechas de vigencia**.

ASOCIADOS A TIEMPO PARCIAL PAGADOS POR HORA Y ASOCIADOS TEMPORALES

NOTA: *No confunda el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura antes de la fecha de vigencia de la cobertura.*

<table>
<tr><th>Plan</th><th colspan="2">Periodos de inscripción y fechas de entrada en vigencia</th></tr>
<tr><td>Médico*</td><td colspan="2">Periodo de inscripción inicial:
Debe inscribirse en la cobertura entre la fecha del primer día de pago y el día anterior a la fecha de entrada en vigencia de la cobertura.</td></tr>
<tr><td rowspan="4">*Los asociados a tiempo parcial por hora y los asociados temporales en Hawái no están sujetos a los requisitos descritos en la sección Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos en el capítulo Elegibilidad, inscripción y fechas de vigencia.</td><td>Cuándo entra en vigencia la cobertura:
Su cobertura entra en vigencia en la primera de las siguientes fechas:
• El primer día del periodo de pago después de un periodo de trabajo de al menos 20 horas por semana durante cuatro semanas consecutivas, o
• El primer día del mes calendario en el cual se cumple su día 89 de empleo continuo.</td><td rowspan="3">Si escoge la cobertura, su elección debe permanecer vigente hasta el final del año calendario que contenga la fecha de vigencia de la cobertura y no podrá modificarse hasta el periodo de Inscripción anual del siguiente año calendario, a menos que surja un evento de cambio de elección, como se describe en la sección Cambios de elección permitidos fuera del periodo de Inscripción anual del capítulo Elegibilidad, inscripción y fechas de vigencia.</td></tr>
<tr><td>Dental (la inscripción es por dos años calendario consecutivos)
De la vista
Seguro por enfermedades graves</td><td>Periodo de inscripción inicial:
Debe inscribirse en la cobertura entre la fecha del primer día de pago y el día anterior a la fecha de entrada en vigencia de la cobertura.</td></tr>
<tr><td>Seguro contra accidentes
AD&D</td><td colspan="2">Cuándo entra en vigencia la cobertura:
Su cobertura entra en vigencia el primer día del mes calendario durante el cual se cumplen 89 días de empleo continuo.</td></tr>
<tr><td>Recursos de asistencia para los asociados
Seguro contra accidentes durante viajes de negocios</td><td colspan="2">Queda inscrito automáticamente en la fecha de contratación.</td></tr>
</table>

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ASOCIADOS A TIEMPO PARCIAL PAGADOS POR HORA Y ASOCIADOS TEMPORALES (CONTINUACIÓN)
NOTA: *No confunda el periodo de inscripción inicial con la fecha de vigencia de la cobertura. Para la mayoría de los beneficios, debe inscribirse en la cobertura antes de la fecha de vigencia de la cobertura.*

Plan	Periodos de inscripción y fechas de entrada en vigencia
Seguro de discapacidad temporal de Hawái* (programa obligatorio por ley)	Para el seguro de discapacidad temporal de Hawái, consulte la tabla **Recursos** al principio de este capítulo para obtener información de contacto sobre los requisitos y las fechas de entrada en vigencia.
Seguro de vida opcional para asociados Seguro de vida opcional para dependientes	**Periodo de inscripción inicial:** Debe inscribirse en la cobertura entre la fecha del primer día de pago y el día *anterior* a la fecha de entrada en vigencia de la cobertura. **Cuándo entra en vigencia la cobertura:*** **Si se inscribe durante el periodo de inscripción inicial:** • Si se inscribe por el monto garantizado, la cobertura entra en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscribe, o 2) el primer día del mes calendario en el que se cumplen 89 días de empleo continuo. • Si se inscribe por un monto superior al monto garantizado, la cobertura para usted y/o su cónyuge/pareja estará sujeta a la aprobación de Prudential. Deberá presentar un Certificado de buena salud para usted y/o su cónyuge/pareja y posiblemente deba someterse a un examen médico. Si se aprueba, la cobertura entrará en vigencia en la última de las siguientes fechas: 1) la fecha en que Prudential apruebe su cobertura, o 2) el primer día del mes calendario en el que se cumplen 89 días de empleo continuo. Si no se aprueba ninguna cobertura por encima del monto garantizado, usted quedará inscrito en una cobertura por el monto garantizado y la cobertura entrará en vigencia en la última de las siguientes fechas: 1) la fecha en que se inscriba, o 2) el primer día del mes calendario en el que cumpla 89 días de trabajo a tiempo completo continuo. **Si se inscribe en la cobertura o aumenta la cobertura después del periodo de inscripción inicial:** • La cobertura para usted y/o su cónyuge/pareja (incluido un aumento de la cobertura elegida anteriormente) está sujeta a la aprobación de Prudential. Deberá presentar un Certificado de buena salud para usted y/o su cónyuge/pareja y posiblemente deba someterse a un examen médico. Si se aprueba, su cobertura entrará en vigencia en la fecha en que Prudential la apruebe. • No es necesario presentar un Certificado de buena salud para los hijos que inscriba en la cobertura opcional para dependientes. Si debe facilitar un Certificado de buena salud, las retenciones en nómina de sus primas no comenzarán hasta que su cobertura entre en vigencia, como se ha descrito anteriormente.

*Si su hijo dependiente está limitado porque debe recibir tratamiento médico (en su hogar o en otro lugar), la cobertura se retrasa hasta que su hijo tenga el alta médica (no se aplica a un recién nacido).

Los asociados pagados por hora a tiempo parcial y temporales solo pueden agregar a la cobertura a sus hijos dependientes elegibles, pero no a sus cónyuges/parejas. El seguro de vida pagado por la compañía no está disponible para los asociados pagados por hora a tiempo parcial y temporales.

NOTA: Algunos beneficios requieren que se cumpla la definición de trabajo activo. Para más información, consulte la sección **"Trabajo activo" o "activamente en el trabajo"** del capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Asociados gerenciales: Consulte la tabla de asociados gerenciales en la sección **Inscripción y fechas efectivas por clasificación laboral** del capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Plan médico

La información de este capítulo describe los beneficios médicos a los que puede acceder si:

- Usted es conductor de camión por hora, temporal, a tiempo parcial, o asociado asalariado (de la gerencia) elegible
- Ha cumplido todos los requisitos para que la cobertura tenga vigencia, incluidos los requisitos de trabajo activo, y
- Se ha inscrito debida y oportunamente.

Si tiene preguntas sobre la elegibilidad, la inscripción y los requisitos para que la cobertura sea efectiva, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Plan médico

RECURSOS			
Encuentre lo que necesita	**En línea**	**Por teléfono: Health Care Advisor**	**Otros recursos**
Información importante para ayudarle a gestionar sus gastos de salud y encontrar proveedores de la red TPA	**Herramientas de comparación de precios:** IncludedHealth.com/Walmart		
	Directorio de proveedores: IncludedHealth.com/Walmart		
Aetna Plan Premier, Plan Contribution, Plan Saver y Plan local de Banner	Visite One.Walmart.com/Health o aetna.com	**855-548-2387**	**Aetna** **151 Farmington Avenue** **Hartford, Connecticut 06156**
BlueAdvantage Administrators of Arkansas, Plan Premier, Plan Contribution y Plan Saver	Visite One.Walmart.com/Health o blueadvantagearkansas.com	**866-823-3790**	**BlueAdvantage Administrators of Arkansas** **P.O. Box 1460** **Little Rock, Arkansas 72203-1460**
UMR Plan Premier, Contribution y Saver Plan local Mercy Arkansas	Visite One.Walmart.com/Health o UMR.com	**855-870-9177** **800-804-1272**	**UMR** **P.O. Box 30541** **Salt Lake City, Utah 84130-0541**
HealthSCOPE Benefits Revisión del historial clínico por cáncer, cirugía cardiaca, revisión del historial clínico por diálisis renal o enfermedad renal terminal, trasplante y beneficios de viaje relacionados (incluida la formación de familias).		**800-804-1289** Transplante: **479-621-2830**	
Contigo Health Prótesis de cadera y rodilla, cirugía de columna, programas de cirugía de pérdida de peso y beneficios de viajes relacionados		**877-230-7037**	
Kindbody Beneficios de la formación de familias	**Visite Kindbody.com/Walmart**	**855-454-7663**	Correo electrónico: Walmart@kindbody.com
Solicite una copia impresa del *Libro de beneficios para asociados* de 2025		Llame a Servicios al Personal al **800-421-1362.**	Escanee el código QR de abajo:

- En este capítulo se describen los beneficios médicos ofrecidos conforme a las opciones del AMP autoaseguradas del Plan médico de los asociados. Consulte la sección **Plan Médico para Asociados (AMP)** para obtener información sobre lo que significa que una opción esté autoasegurada.
- En algunos lugares, el AMP también ofrece opciones de plan PPO y de Organizaciones de Mantenimiento de la Salud (HMO). Si bien se ofrecen en el AMP, las opciones de planes PPO y HMO están totalmente aseguradas y son administradas por separado por la compañía de seguro. Si en su lugar de trabajo existe una opción de seguro totalmente asegurada, los detalles de la cobertura se describen en materiales en línea en **One.Walmart.com/Health** o que provee por separado la compañía de seguro del plan PPO o HMO. Los términos de cobertura de estas opciones no se describen en este capítulo. No obstante, los términos de elegibilidad del capítulo **Elegibilidad, inscripción y fechas de vigencia** anulan cualquier término incoherente de los documentos de la HMO y la PPO. Consulte la sección **Asistencia en el control de su salud** de este capítulo para conocer algunos recursos a su disposición, incluso si está inscrito a una opción HMO o PPO.
- Antes de que la cobertura que ofrece la HMO pueda entrar en vigencia, algunas HMO requieren que los participantes acepten un acuerdo de arbitraje. Si la HMO no recibe el acuerdo de arbitraje dentro de los 60 días siguientes a su inscripción, su cobertura de la HMO no entrará en vigencia y no tendrá cobertura médica bajo el AMP a menos que experimente un evento de cambio de elección válido, tal como se describe en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Plan Médico para Asociados (AMP)

La información de este capítulo se aplica a su caso si se inscribe en la opción de Plan Premier, Plan Contribution o Plan Saver, o en la opción de planes locales de Mercy Arkansas o Banner. A los fines de este capítulo, estas opciones se denominan "opciones del AMP".

El Plan médico para asociados (AMP) ofrece beneficios médicos para usted y los dependientes cubiertos a través de varias opciones del AMP. Las opciones del AMP que se describen en este capítulo son autoaseguradas, esto significa que los beneficios ofrecidos dentro de las opciones no están asegurados por una compañía de seguros. En otras palabras, la compañía de seguros no paga los beneficios con sus propios activos. En su lugar, usted y otros asociados inscritos en la opción autoasegurada del AMP hacen aportes (denominados "primas") a través de deducciones de su sueldo para cubrir una parte del costo de sus beneficios, y el resto del costo lo paga Walmart, ya sea con los activos de la compañía o a través de un fideicomiso financiado por Walmart.

Si bien todas las opciones del AMP generalmente brindan beneficios para los mismos servicios cubiertos, una opción específica puede tener un diseño alternativo. La información de este capítulo explicará cada opción del AMP autoasegurada, incluidos los diseños alternativos, y las herramientas y funciones para ayudarle a encontrar atención para usted y sus dependientes cubiertos.

Para informarse sobre recursos útiles que le ayuden a gestionar el cuidado de la salud:

- Puede consultar los directorios de proveedores en **IncludedHealth.com/Walmart**
- Puede encontrar una herramienta de comparación de precios en **IncludedHealth.com/Walmart**
- Encontrará información sobre los servicios cubiertos y las reclamaciones en el sitio web de su administrador externo:
  - **aetna.com**
  - **blueadvantagearkansas.com**
  - **UMR.com**
- Puede encontrar más información sobre las opciones del AMP visitando **One.Walmart.com/Health**

Asociados que se inscriben en la cobertura médica a través de una opción de plan HMO o PPO: Hay opciones del plan HMO y PPO disponibles para algunos lugares de trabajo. Las pólizas y los materiales de inscripción para las opciones de los planes HMO y PPO pueden describir diferentes requisitos de elegibilidad y periodos de espera en comparación con los que se describen en el capítulo **Elegibilidad, inscripción y fechas de vigencia**. Si hay alguna diferencia entre los términos de elegibilidad de las opciones de los planes HMO o PPO y los términos de elegibilidad del AMP, tal como se describe en el capítulo **Elegibilidad, inscripción y fechas de vigencia**, se aplicarán los términos de elegibilidad del capítulo **Elegibilidad, inscripción y fechas de vigencia**. No obstante, los términos relacionados con los beneficios cubiertos conforme a una opción de HMO o PPO, además de algunos beneficios discutidos en la sección **Asistencia en el control de su salud**, se describen en los materiales proporcionados por separado por la aseguradora HMO o PPO o puede encontrarlos en **One.Walmart.com/Health**.

Inscripción

Asegúrese de **inscribirse antes de la fecha límite** descrita en sus materiales de inscripción. **Debe inscribirse antes de la fecha de vigencia.**

Será elegible para inscribirse en el AMP si cumple con las condiciones de elegibilidad que se describen en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

CUÁNDO Y CÓMO INSCRIBIRSE

No confunda el periodo de inscripción con la fecha de entrada en vigencia de su cobertura. El periodo de inscripción es el periodo de tiempo durante el cual debe realizar las elecciones de sus beneficios. La fecha de entrada en vigencia de su cobertura es cuando esas elecciones entran en vigencia. Su periodo de inscripción específico y la fecha de entrada en vigencia de la cobertura varían en función de una serie de factores, incluida la clasificación de su empleo. Consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener más información. **Asegúrese de inscribirse antes de la fecha límite de inscripción que se indica en los materiales de inscripción que reciba. El AMP no puede hacer excepciones** para permitir que los asociados individuales se inscriban después de que finalice el periodo de inscripción, por lo que debe inscribirse antes de la fecha límite o tendrá que esperar hasta la próxima Inscripción anual o a menos que surja un evento de cambio de elección. Para obtener información, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Se puede acceder a la herramienta de inscripción a los beneficios en línea a través de **One.Walmart.com/Enroll**.

SELECCIÓN DE UN NIVEL DE COBERTURA

Cuando se inscriba en el AMP, seleccionará su nivel de cobertura, incluidos los dependientes elegibles que desee cubrir. Los niveles de cobertura son:

- Asociado solo
- Asociado + cónyuge/pareja que reúna los requisitos (no disponible para asociados pagados por hora a tiempo parcial o temporales, ni para conductores de camión a tiempo parcial)
- Asociado + hijos o
- Asociado + familia (no disponible para asociados pagados por hora a tiempo parcial o temporales, ni para conductores de camión a tiempo parcial).

Para obtener información sobre la elegibilidad de los dependientes, incluido qué miembros de la familia pueden inscribirse para la cobertura y cuándo, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

COSTO DE LA COBERTURA

Los aportes o "primas" que pague por la cobertura médica variarán en función de la opción del AMP que elija, del nivel de cobertura que elija, de si puede acogerse a las tarifas para no fumador y de si está inscrito en el AMP a través de la continuación de la cobertura de la ley COBRA. Para más información sobre las primas, consulte la sección **Pago de los beneficios** del capítulo **Elegibilidad, inscripción y fechas de vigencia**. Asimismo, consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** para obtener más información sobre la continuación de la cobertura de COBRA.

Función del administrador de la red subcontratado (TPA)

El AMP brinda beneficios médicos solo para ciertos servicios, en los términos y condiciones descritos en este capítulo, que se denominan "servicios cubiertos". Consulte la sección **Qué está cubierto por el AMP** en este capítulo para obtener una definición de los servicios cubiertos. Los gastos de los "servicios cubiertos" son "gastos médicos elegibles". El administrador del AMP ha delegado la autoridad fiduciaria para tomar decisiones sobre reclamaciones y apelaciones, incluidas las determinaciones de autorización previa cuando corresponda, en varios administradores de terceros (TPA). Su TPA específico dependerá de la opción del AMP que elija y su lugar de trabajo y, en algunos casos, del tipo de servicios que usted reciba. Si su lugar de trabajo cambia durante el año, las opciones del AMP disponibles para usted y el TPA que administra sus beneficios pueden cambiar. El TPA primario que administra la opción del AMP que usted elige se identifica en su tarjeta de identificación del plan. El Plan se reserva el derecho a cambiar el TPA que administra sus beneficios en cualquier momento.

Para ciertos servicios cubiertos, como aquellos disponibles a través del programa de los Centros de Excelencia o el beneficio de viaje para atención, un TPA que no sea su TPA administrará los beneficios. Consulte la siguiente tabla.

Su TPA también puede ser una compañía de seguros que emite pólizas de seguro médico en otros sectores de su negocio. Esto no significa que sus beneficios médicos del AMP estén asegurados. Muchas compañías de seguros también prestan servicios de TPA a planes autoasegurados, que son planes financiados con activos de los empleadores que los patrocinan. El administrador del AMP ha delegado la responsabilidad para determinar las reclamaciones de beneficios del AMP en el TPA aplicable, quien, a su vez, puede consultar a profesionales de la salud para que lo ayuden a tomar determinaciones relacionadas con las reclamaciones. Cada TPA utilizará sus políticas y procedimientos internos para tomar decisiones sobre reclamaciones y apelaciones en nombre del AMP.

ADMINISTRADORES DE TERCEROS (TPA) DELEGADOS POR EL ADMINISTRADOR DEL PLAN	
• Opción del Plan Premier • Opción del Plan Contribution • Opción del Plan Saver • Servicios de formación de familias cubiertos por el programa de los Centros de Excelencia	Aetna Life Insurance Company (Aetna)* BlueAdvantage Administrators of Arkansas (BlueAdvantage)* UMR
Opción de Plan local de Banner	Aetna
Opción del Plan local Mercy Arkansas	UMR
Programa de Centros de Excelencia para: • Revisión del historial clínico de cáncer, evaluación en el lugar y tratamiento • Programa de Centros de Excelencia • Revisión de historiales clínicos de diálisis renal (ambulatoria) o enfermedad renal terminal, evaluación y tratamiento en el lugar • Servicios de trasplante, y • Beneficios de viaje relacionados con estos programas de los Centros de Excelencia (incluso para la formación de familias)	HealthSCOPE Benefits
Programa de Centros de Excelencia • Cirugía cardíaca • Reemplazo de cadera y rodilla • Cirugía de columna • Cirugía para la pérdida de peso, y • Beneficios de viaje relacionados con estos programas de los Centros de Excelencia	Contigo Health
Programa de doula	Beneficios de HealthSCOPE (doula en persona) Kindbody (doula virtual)

*Para los participantes del AMP en Alabama, Alaska, Arizona, Colorado, Illinois, Indiana, Iowa, Kentucky, Minnesota, Missouri, Carolina del Norte, Carolina del Sur, Tennessee, Texas, Virginia, Virginia Occidental o Wisconsin, las decisiones de las reclamaciones de autorización previa ("reclamaciones previas al servicio") las toma American Health Holding, Inc. en nombre de Included Health.

Además de administrar sus beneficios, el TPA identificado en su tarjeta de identificación del plan también brinda acceso a su red de proveedores para la mayoría de los servicios cubiertos. Esta es su "red de TPA". Para obtener más información sobre los proveedores dentro de la red, consulte la sección **Proveedores dentro de la red y proveedores fuera de la red** a continuación.

Opciones del AMP disponibles para usted

Por lo general, las opciones específicas del AMP disponibles para usted dependerán de su trabajo o de la ubicación del centro asignado ("lugar de trabajo"). Si trabaja de forma remota o recibe la continuación de la cobertura de COBRA, se lo asignará a un centro específico. Si trabaja como conductor de camión, las opciones de AMP disponibles para usted pueden estar determinadas por su domicilio registrado en vez del lugar donde trabaja. En las próximas páginas, encontrará tablas de las diversas opciones de AMP que pueden estar disponibles para usted. Cada tabla proporciona un resumen de la cobertura para cada opción del AMP. A continuación de las tablas encontrará información que le ayudará a evaluar la mejor opción para usted. Recuerde que en algunos lugares, también puede tener acceso a una opción asegurada mediante el AMP, pero se describirá en los materiales proporcionados por la aseguradora, que también están disponibles en **One.Walmart.com/Health**.

OPCIONES DE PLAN PREMIER, PLAN CONTRIBUTION, PLAN SAVER

Las tres opciones principales disponibles en todo el país son las opciones de Plan Premier, Plan Contribution y Plan Saver. La tabla titulada **Opciones de Plan Premier, Plan Contribution y Plan Saver** compara estas opciones y facilita detalles sobre la cobertura de cada una de ellas. No obstante, si hay una opción de plan local disponible en su lugar de trabajo (consulte a continuación), tal opción generalmente sustituirá a la opción Plan Contribution como opción de cobertura.

En algunas ubicaciones, puede haber acuerdos entre el AMP (o un TPA) y los proveedores que incluyen incentivos financieros para que los proveedores gestionen la atención.

OPCIONES DE PLANES LOCALES

Si están disponibles en su lugar de trabajo, las opciones del AMP disponibles para usted también pueden incluir un "plan local", que brinda acceso a grupos de proveedores en un área específica. Si existe una opción de un plan local que incluye su lugar de trabajo, las opciones del AMP disponibles para usted serán probablemente el Plan Premier, el Plan Saver o la opción de plan local disponible, pero no la opción del Plan Contribution. En otras palabras, si se encuentra disponible una opción de plan local, por lo general, esta reemplazará la opción de Plan Contribution como una opción de cobertura si su lugar de trabajo se encuentra en esa área.

Los acuerdos que se establezcan entre el AMP y estos grupos de proveedores pueden incluir incentivos financieros para gestionar la atención.

Las opciones de planes locales están disponibles en las áreas designadas que se indican a continuación:

Plan local Banner

- Phoenix, área metropolitana de Arizona

Plan local Mercy Arkansas

- Partes del noroeste de Arkansas y del condado de McDonald, Missouri

Para obtener los detalles de la cobertura de las opciones del plan local, consulte el cuadro titulado **Opciones de plan local: Banner y Mercy Arkansas** .

PROVEEDORES DENTRO DE LA RED Y PROVEEDORES FUERA DE LA RED

Su "red de TPA" está formada por proveedores que han acordado contractualmente con el TPA aceptar un monto negociado por los servicios cubiertos que prestan. Eso significa que el monto total de los gastos médicos elegibles pagados por usted y el AMP de los servicios cubiertos no será mayor que el monto negociado. **Los proveedores dentro de su red de TPA no pueden facturarle ningún monto superior al monto negociado por los servicios cubiertos por el AMP.**

Para algunos servicios, como aquellos cubiertos a través del programa de Centros de Excelencia o los servicios avanzados de diagnóstico por imagen, la red de proveedores es diferente de la red de su TPA o un subconjunto reducido de esta. Estas redes más restringidas se denominan "redes AMP" para indicar que son redes creadas por el AMP para servicios cubiertos específicos. Para esos servicios cubiertos, el AMP puede pagar solo un beneficio limitado, o ningún beneficio, si no utiliza uno de los proveedores de la red del AMP, aunque utilice un proveedor que esté en la red del AMP para otros servicios cubiertos.

Los "proveedores que no son parte de la red" son proveedores que no pertenecen a la red de su TPA o AMP. Esto también puede referirse a los proveedores de su red del AMP que se tratan como proveedores fuera de la red cuando usted recibe servicios que solo son servicios cubiertos cuando se reciben a través de la red del AMP, como en el caso del programa de los Centros de Excelencia.

Para información adicional, consulte la sección **Redes de proveedores** de este capítulo.

OPCIONES DE PLAN PREMIER, PLAN CONTRIBUTION Y PLAN SAVER			
	Plan Premier	**Plan Contribution**	**Plan Saver**
Deducible anual (individual/familiar) • Dentro de la red • Fuera de la red	 $2,750/$5,500 $5,500/$11,000	 $1,750/$3,500 $3,500/$7,000	 $3,000/$6,000 $6,000/$12,000
Fondos proporcionados por Walmart (individual/familiar)	N/D	$250/$500 *Aporte máximo anual de la compañía a la HRA*	$350/$700 *Aporte paralelo máximo anual de la compañía a la HSA*
Desembolso máximo anual (individual/familiar) • Dentro de la red • Fuera de la red	 $6,850/$13,700 Ninguno	 $6,850/$13,700 Ninguno	 $6,650/$13,300 Ninguno
Atención preventiva elegible • Dentro de la red • No parte de la red	 100 % (sin deducible) 50 % (sin deducible)	 100 % (sin deducible) 50 % (sin deducible)	 100 % (sin deducible) 50 % (sin deducible)
Visitas al consultorio del médico (en persona o telesalud) *Incluye pruebas de diagnóstico de rutina realizadas el mismo día en el consultorio del médico* **Atención médica primaria** • Dentro de la red • No parte de la red **Especialista** • Dentro de la red • No parte de la red	 100 % después de un copago de $35 50 % después del deducible 100 % después de un copago de $75 50 % después del deducible	 75 % después del deducible 50 % después del deducible 75 % después del deducible 50 % después del deducible	 75 % después del deducible 50 % después del deducible 75 % después del deducible 50 % después del deducible
Visitas de telesalud por video a través de Doctor On Demand por Included Health	Copago de $0	Copago de $0	Copago de $0 después del deducible[1]
Cuidado de urgencias[2] • Dentro de la red • No parte de la red	 100 % después de un copago de $75 50 % después del deducible	 75 % después del deducible 50 % después del deducible	 75 % después del deducible 50 % después del deducible
Pruebas de diagnóstico *Pruebas no preventivas solicitadas o realizadas fuera del consultorio del médico* • Dentro de la red • No parte de la red	 75 % después del deducible 50 % después del deducible	 75 % después del deducible 50 % después del deducible	 75 % después del deducible 50 % después del deducible
Servicios avanzados de diagnóstico por imágenes Resonancias magnéticas y tomografías computarizadas • *Red alternativa*[3] • Red[4] • No parte de la red	 75 % después del deducible 50 % después del deducible 50 % después del deducible	 75 % después del deducible 50 % después del deducible 50 % después del deducible	 75 % después del deducible 50 % después del deducible 50 % después del deducible
Hospitalización[2] **y otros servicios cubiertos** Atención hospitalaria o ambulatoria *Incluidos los servicios de médicos, cirujanos, ambulancias aéreas y de otros proveedores/instalaciones que no figuren en la lista* • Dentro de la red • No parte de la red	 75 % después del deducible 50 % después del deducible	 75 % después del deducible 50 % después del deducible	 75 % después del deducible 50 % después del deducible
Salud mental **Cargos de hospitalización y centros ambulatorios** • Dentro de la red • No parte de la red **Visitas ambulatorias al consultorio (en persona o telesalud)** • Dentro de la red • No parte de la red	 75 % después del deducible 50 % después del deducible 100 % después de un copago de $35 50 % después del deducible	 75 % después del deducible 50 % después del deducible 75 % después del deducible 50 % después del deducible	 75 % después del deducible 50 % después del deducible 75 % después del deducible 50 % después del deducible
Servicios de emergencia[2] **Transporte terrestre de ambulancia**[5]	100 % después del deducible y copago de $300	100 % después del deducible y copago de $300	100 % después del deducible y copago de $300
Farmacia	Consulte el capítulo **Beneficio de farmacia**.		
Centros de Excelencia[3]	Consulte la sección **Centros de Excelencia** de este capítulo.		

[1] *La información que indica que se aplica el deducible está actualizada al 15 de diciembre de 2024. Si esto cambia, se actualizarán los materiales del AMP.*

[2] *Consulte la sección* **Servicios de emergencia, ambulancia de transporte terrestre, prevención y telesalud** *más adelante en este capítulo para conocer todos los detalles sobre la facturación sorpresa y el reparto de costos de los servicios de atención de urgencia, hospitalización y emergencia. Es posible que no se aplique a los centros de atención de urgencia de su estado.*

[3] *Es una red del AMP*

[4] *Se refiere a un proveedor de la red del TPA.*

[5] *Cubierto solo como se describe en la sección* **Servicios de emergencia, ambulancia de transporte terrestre, prevención y telesalud** *y* **Cuándo se aplican beneficios limitados al AMP** *a la sección AMP más adelante en este capítulo.*

OPCIONES DE PLAN LOCAL: BANNER Y MERCY ARKANSAS		
	Banner	**Mercy Arkansas**
	Beneficios dentro de la red únicamente *Ningún beneficio para los servicios brindados fuera de la red excepto los servicios de emergencia*	
Deducible anual (individual/familiar)	$3,000/$6,000	$1,750/$3,500
Fondos proporcionados por Walmart (individual/familiar)	N/D	N/D
Desembolso máximo anual (individual/familiar)	$6,850/$13,700	$6,850/$13,700
Atención preventiva elegible	100 % (sin deducible)	100 % (sin deducible)
Visitas al consultorio del médico (en persona o telesalud) *Incluye pruebas de diagnóstico de rutina realizadas el mismo día en el consultorio del médico* **Atención médica primaria** **Especialista**	100 % después de un copago de $35 100 % después de un copago de $75	100 % después de un copago de $35 100 % después de un copago de $75
Visitas de telesalud por video a través de Doctor On Demand por Included Health	Copago de $0	Copago de $0
Cuidado de urgencias[1]	100 % después de un copago de $75	100 % después de un copago de $75
Pruebas de diagnóstico *Pruebas no preventivas solicitadas o realizadas fuera del consultorio del médico*	75 % después del deducible	75 % después del deducible
Hospitalización[1] **y otros servicios cubiertos** Atención hospitalaria o ambulatoria *Incluidos los servicios de médicos, cirujanos, ambulancias aéreas y de otros proveedores/instalaciones que no figuren en la lista*	75 % después del deducible	75 % después del deducible
Salud mental **Gastos de hospitalización y ambulatorios (en persona o telesalud)** **Visitas ambulatorias al consultorio (en persona o telesalud)**	75 % después del deducible 100 % después de un copago de $35	75 % después del deducible 100 % después de un copago de $35
Servicios de emergencia[1] **Transporte terrestre de ambulancia**[2]	100 % después del deducible y copago de $300	100 % después del deducible y copago de $300
Farmacia	Consulte el capítulo **Beneficio de farmacia**.	
Centros de Excelencia[3]	Consulte la sección **Centros de Excelencia** de este capítulo.	

NOTA: El plan local de Mercy Arkansas brinda una cobertura limitada para consultas a quiroprácticos en consultorio. Se ofrece un máximo de 10 visitas por año calendario.

[1] *Consulte la sección* **Servicios de emergencia, ambulancia de transporte terrestre, prevención y telesalud** *más adelante en este capítulo para conocer todos los detalles sobre la facturación sorpresa y el reparto de costos de los servicios de atención de urgencia, hospitalización y emergencia. Es posible que no se aplique a los centros de atención de urgencia de su estado.*

[2] *Cubierto solo como se describe en la sección* **Servicios de emergencia, ambulancia de transporte terrestre, prevención y telesalud** *y* **Cuándo se aplican beneficios limitados al AMP** *más adelante en este capítulo.*

[3] *Es una red del AMP*

Evalúe sus opciones

Para informarse sobre recursos útiles que le ayuden a gestionar el cuidado de la salud:

- Puede consultar los directorios de proveedores en **IncludedHealth.com/Walmart**
- Puede encontrar una herramienta de comparación de precios en **IncludedHealth.com/Walmart**
- Encontrará información sobre los servicios cubiertos y las reclamaciones en el sitio web de su administrador externo:
  - **aetna.com**
  - **blueadvantagearkansas.com**
  - **UMR.com**
- Puede encontrar más información sobre las opciones del AMP visitando **One.Walmart.com/Health**

FONDOS PROPORCIONADOS POR WALMART

Opción de Plan Contribution: cuenta de reembolso para la salud

La opción de Plan Contribution incluye una cuenta de reembolso para la salud (HRA). Cada año, Walmart asigna dinero a la HRA para que usted y cualquier dependiente cubierto lo utilicen para cubrir su parte del costo de los gastos médicos elegibles, incluidos los que se aplican a su deducible anual y al desembolso máximo en efectivo. No puede aportar su propio dinero a la HRA. Los montos que aporta Walmart están disponibles únicamente para los fines que se indican a continuación y se perderán si deja de estar inscrito en la opción de Plan Contribution. El monto anual asignado a la HRA dentro de la opción de Plan Contribution depende de si está inscrito en una cobertura para asociados solos (en cuyo caso se le asignará el monto "individual") o en un nivel de cobertura que incluya a los dependientes elegibles (en cuyo caso se le asignará el monto "familiar").

Al comienzo de cada año nuevo, Walmart asignará los fondos de la HRA de ese año a su HRA. El AMP cubre de manera automática la parte que le corresponde de los gastos médicos elegibles (excepto los gastos por medicamentos recetados) con los fondos de la HRA hasta que estos fondos se agoten. La asignación de fondos de la HRA de cada año puede usarse en principio solo para gastos médicos elegibles por servicios cubiertos que reciba dentro de ese año, con la excepción de cualquier saldo restante en su HRA que al final del año se transferirá directamente para su uso durante el próximo año, siempre que permanezca inscrito en la opción de Plan Contribution. Los fondos de la HRA que se transfieren de forma directa al próximo año se denominan "fondos de transferencia directa". El saldo de su HRA (incluidos los fondos de la HRA asignados para el año en curso y cualquier cantidad transferida de forma directa del año anterior) no puede superar su deducible anual dentro de la red conforme a la opción del Plan Contribution para el año actual.

Solo los montos designados como "fondos de transferencia directa" se pueden utilizar para pagar los servicios cubiertos prestados en un año anterior.

Por ejemplo, si estaba inscrito en la opción de Plan Contribution en 2024 y 2025, los fondos de la HRA asignados en 2025 podrían usarse solo para cubrir los gastos médicos elegibles de los servicios recibidos en 2025, pero no para los servicios recibidos antes de 2025 (como por ejemplo un gasto realizado en 2024 pero que no se procesa hasta 2025). Sin embargo, cualquier "fondo de transferencia directa", fondos de la HRA que se transfieren directamente del 2024 al 2025, se puede usar para cubrir cualquier gasto médico elegible por servicios recibidos mientras está inscrito en el Plan Contribution.

Si se le contrata a mitad de año y se inscribe en la opción del Plan Contribution, Walmart prorrateará mensualmente su asignación inicial de la HRA. No obstante, su deducible anual y el desembolso máximo en efectivo no se prorrateen. Si tiene un evento de cambio de elección, como se describe en el capítulo **Elegibilidad, inscripción y fechas de vigencia**, y cambia su nivel de cobertura a mitad de año de "asociado solo" a "asociado + familia", Walmart ajustará la asignación a la HRA, el deducible anual y el desembolso máximo anual en efectivo según corresponda. Sin embargo, si cambia de la cobertura para "asociado + familia" a la de "asociado solo", los montos asignados previamente a su HRA no se reducirán.

Si cancela su cobertura médica, pierde la elegibilidad o cambia de la opción del Plan Contribution a una opción diferente, los fondos de la HRA no utilizados se perderán, pero aún estarán disponibles para pagar los gastos médicos elegibles en los que haya incurrido antes de que su cobertura conforme al Plan Contribution haya terminado. Si pierde la cobertura debido a un evento calificador y continúa inscrito en la opción de Plan Contribution a través de la cobertura de continuación de COBRA, los fondos de la HRA permanecen disponibles para usted según los términos descritos anteriormente y Walmart continuará asignando fondos a su HRA cada año mientras continúe la cobertura, sujeto a las restricciones de COBRA sobre la duración de la continuación de la cobertura. Consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** para obtener más información sobre la continuación de la cobertura de COBRA.

Opción de Plan Saver: cuenta de ahorro de salud

La opción de Plan Saver le brinda la oportunidad de contribuir a una cuenta de ahorro de salud (HSA) a través de deducciones de su sueldo antes de impuestos. Walmart aporta contribuciones paralelas a las deducciones de su sueldo a esta cuenta, dólar por dólar, hasta el límite de $350 si cuenta con cobertura para asociado solo o $700 si ha elegido otra cobertura que no sea para el asociado solo. Los aportes combinados a su HSA (la suya y la de Walmart) no pueden exceder el límite anual del IRS para 2025 de $4,300 si cuenta con cobertura para asociado solo o de $8,550 para todos los demás niveles de cobertura, más $1,000 si cumple 55 años al final del año 2025.

Puede optar por usar su dinero en la HSA para pagar los gastos médicos elegibles que están sujetos al deducible anual, o bien puede pagarlos usted mismo en efectivo y guardar el dinero de la HSA para gastos futuros. Consulte el capítulo **Cuenta de ahorro de salud (HSA)** para obtener información adicional.

COSTO COMPARTIDO

Los cuadros recopilatorios de las páginas anteriores muestran el porcentaje o parte del costo de los servicios cubiertos que pagará el AMP. Consulte la sección **Coseguro** de la siguiente página para obtener información sobre el "cargo máximo permitido", o el costo del servicio cubierto que el AMP utilizará para determinar los beneficios. El costo de los servicios cubiertos se reparte entre usted y el AMP. Usted es responsable de pagar el "coseguro", que es la diferencia entre el 100 % de los costos de los servicios cubiertos y el porcentaje o parte que paga el AMP, además del deducible y el copago aplicables. La parte de los gastos médicos elegibles que usted es responsable de pagar se denomina "costo compartido", que incluye los montos de deducible, copago y coseguro. El costo compartido no incluye ningún otro gasto, como montos por servicios que no están cubiertos o montos que paga a un proveedor fuera de la red que superan el cargo máximo permitido del AMP.

Deducible anual

Su deducible es la cantidad de gastos médicos elegibles que paga cada año por la mayoría de los servicios cubiertos, incluidos los medicamentos recetados, antes de que el AMP comience a compartir el costo de los servicios cubiertos. Por ejemplo, si usted está inscrito en el plan Contribution, tiene un deducible anual de proveedores dentro de la red de $1,750, generalmente deberá pagar los primeros $1,750 de sus gastos médicos elegibles totales por los servicios cubiertos dentro de la red antes de que el AMP pague cualquier beneficio. El AMP pagará los servicios de atención preventiva elegibles y algunos servicios cubiertos en las opciones de Plan Premier y de planes locales que están sujetos a un copago (por ejemplo, visitas al consultorio del médico) antes de que alcance los deducibles anuales correspondientes.

Las opciones de Plan Premier, Plan Contribution y Plan Saver tienen un deducible anual de la red por separado (para los gastos médicos elegibles pagados a proveedores de la red) y un deducible anual fuera de la red (para los gastos médicos elegibles pagados a proveedores fuera de la red). En ese caso, su parte de los gastos médicos elegibles que se aplican al deducible anual dentro de la red también se aplica al deducible anual fuera de la red y viceversa. Si la opción del AMP en la que se inscribe tiene un deducible dentro de la red y uno fuera de la red, el AMP comenzará a pagar una parte del costo de los servicios cubiertos de un proveedor dentro de la red después de que haya alcanzado el deducible anual dentro de la red, pero el AMP generalmente no pagará ninguna parte del costo de los servicios cubiertos de un proveedor fuera de la red hasta que se haya alcanzado el deducible fuera de la red.

Si se inscribe en una opción de los planes locales que no cubre los servicios fuera de la red, solo tendrá un deducible anual dentro de la red. En este caso, los montos pagados por los servicios fuera de la red no son gastos médicos elegibles y no contarán para el deducible anual de la red, excepto cuando los servicios fuera de la red sean servicios cubiertos para una afección médica de emergencia en un departamento de emergencias, ciertos servicios cubiertos proporcionados por un proveedor fuera de la red, en un centro de atención de la red sujeto a requisitos de notificación y consentimiento, que no ha obtenido su consentimiento para facturarle cantidades que excedan el cargo máximo permitido del AMP, o servicios proporcionados por un proveedor de ambulancia aérea fuera de la red que estarían cubiertos por el AMP si los proporcionara un proveedor de servicios de ambulancia aérea dentro de la red.

Todas las opciones del AMP tienen un monto deducible "individual" y un monto deducible "familiar". El monto "individual" es su deducible anual correspondiente si ha elegido la cobertura para el asociado solo. El monto "familiar" es su deducible anual correspondiente si ha elegido cualquiera de los otros niveles de cobertura que incluyen dependientes elegibles. Si elige la cobertura para dependientes elegibles, los deducibles se pueden alcanzar a través de cualquier combinación de servicios que utilicen usted y los dependientes cubiertos, pero no se pagará ningún beneficio del AMP ni para usted ni para los familiares cubiertos, excepto por los servicios que no estén sujetos a un deducible, hasta que se alcance la totalidad del deducible anual correspondiente (dentro o fuera de la red).

Si está inscrito en la opción de Plan Contribution: Puede alcanzar todo o parte del deducible anual con los fondos de la cuenta HRA provistos por su compañía durante el año en curso y cualquier dinero transferido de la HRA que pueda tener del año anterior. Cuando haya usado todos los fondos de la HRA, debe utilizar los fondos propios para alcanzar el resto del deducible anual.

Si está inscrito en la opción de Plan Saver: Si se inscribe en el Plan de Ahorro, por lo general debe pagar el costo total de los medicamentos recetados hasta que alcance el deducible anual de proveedores dentro de la red. Existen ciertas excepciones (incluyendo algunos medicamentos preventivos y de venta libre y servicios preventivos), que se analizan a continuación en **Programa de atención preventiva** en este capítulo y en el capítulo **Beneficio de farmacia**.

Los siguientes gastos, si corresponden a una opción específica, **no cuentan** para el deducible anual de los proveedores dentro de la red ni fuera de la red.

- Copagos, incluyendo, sin limitarse a, los de farmacia, visitas al médico en persona o por telesalud, atención de urgencia, servicios cubiertos para una afección médica no urgente en el departamento de emergencia o servicios cubiertos para ambulancia terrestre.
- Coseguro por servicios de farmacia y por servicios de reemplazo de cadera o rodilla fuera del programa de Centros de Excelencia sin excepción
- Descuentos, cupones, programas de descuento en farmacias o arreglos similares provistos por fabricantes de medicamentos o farmacias para asistirlo en la compra de medicamentos con receta médica (incluidos los cargos por medicamento con receta médica pagados directamente a las farmacias en su nombre mediante programas con descuentos/cupones)
- Montos que superen el cargo máximo permitido del AMP que paga a proveedores fuera de la red, incluidos, entre otros, montos pagados por servicios para el tratamiento de una afección médica que no sea de emergencia en un departamento de emergencias, montos pagados a un proveedor, sujeto a requisitos de notificación y

consentimiento, que ha obtenido su consentimiento para facturarle los montos que exceden el cargo máximo permitido y los montos que paga a un proveedor fuera de la red de servicios de ambulancia aérea por servicios que no estarían cubiertos por el AMP si los proporcionara un proveedor dentro de la red de servicios de ambulancia aérea

- Cargos por servicios no cubiertos por el AMP, incluyendo, sin limitarse a, los montos pagados por servicios fuera de la red si es parte de una opción de plan local y los servicios no cubiertos por el programa de Centros de Excelencia para servicios de formación familiar, como aquellos incurridos después de haber alcanzado el monto máximo de su beneficio vitalicio.
- Cargos pagados al 100 % por el AMP, tales como los cargos por servicios preventivos (incluidos los medicamentos preventivos) y determinados servicios de los Centros de Excelencia
- Cargos por servicios preventivos fuera de la red, y
- Primas

Copagos

Un "copago" es un monto fijo que paga por un servicio cubierto o un medicamento recetado y generalmente se paga cuando recibe el servicio o surte una receta. En el caso de los servicios cubiertos que estén sujetos a un copago, debe continuar pagando el copago incluso después de que se haya alcanzado el deducible anual dentro de la red, hasta que alcance el desembolso máximo en efectivo.

Coseguro

En el caso de la mayoría de los servicios cubiertos que no estén sujetos a un copago, deberá compartir el costo de los gastos médicos elegibles con el AMP después de que alcance su deducible anual correspondiente. La parte que usted paga se denomina "coseguro".

Las tablas que contienen los resúmenes de cobertura muestran el beneficio (expresado como un porcentaje de los gastos médicos elegibles) que pagará el AMP por los servicios cubiertos, que varía según el estado del proveedor. Usted será responsable de pagar la parte restante de los gastos médicos elegibles, que también se expresan en forma de porcentaje. Por ejemplo, si el AMP paga un beneficio del 75 % de los gastos médicos elegibles (una vez satisfecho el deducible), el monto del coseguro será del 25 % de los gastos médicos elegibles.

La parte que pagan usted y el AMP por el costo de los servicios cubiertos no se calcula en función de los cargos facturados por el proveedor. Se calcula como un porcentaje del monto máximo que el AMP permitirá por un servicio cubierto, también denominado "cargo máximo permitido" (MAC). Consulte **Cargo máximo permitido** en la sección **Qué está cubierto por el AMP** más adelante en este capítulo para obtener información importante sobre cómo se calcula el cargo máximo permitido. El cargo máximo permitido es el cargo máximo por los servicios cubiertos que se utilizará para determinar cualquier beneficio de AMP, sujeto a cualquier copago, deducible o coseguro del que usted sea responsable.

- **Opciones de Plan Premier, Plan Contribution y Plan Saver:** estas opciones del AMP generalmente pagarán una parte mayor del costo de los servicios cubiertos brindados por un proveedor dentro de la red que de los recibidos de un proveedor fuera de la red. Eso quiere decir que su coseguro será una parte menor del costo de los servicios cubiertos si esos servicios se reciben de un proveedor dentro de la red y no de un proveedor fuera de la red. Y, si recibe servicios de un proveedor fuera de la red, generalmente usted será responsable del costo de los servicios que superen el cargo máximo permitido del AMP, excepto en el caso de los servicios cubiertos para el tratamiento de una afección médica de emergencia en un departamento de emergencias, ciertos servicios cubiertos proporcionados por un proveedor fuera de la red, en un centro de atención de la red sujeto a requisitos de notificación y consentimiento, que no ha obtenido su consentimiento para facturarle cantidades que excedan el cargo máximo permitido, o servicios proporcionados por un proveedor de ambulancia aérea fuera de la red que estarían cubiertos por el AMP si los proporcionara un proveedor de servicios de ambulancia aérea dentro de la red. Si sus servicios cubiertos incluyen una resonancia magnética o una tomografía computarizada, el AMP generalmente pagará una mayor parte del costo de los servicios cubiertos que reciba de un proveedor dentro de la red del TPA que sea un *Proveedor de la red alternativa* de la red del AMP que aquellos recibidos de un proveedor de la red del TPA que no sea un *Proveedor de la red alternativa*. Si no se encuentra ningún *Proveedor de la red alternativa* en un radio de 30 millas del proveedor que solicita los servicios de diagnóstico por imágenes avanzadas, el AMP pagará el monto del beneficio de la red alterna por los servicios cubiertos si utiliza un proveedor dentro la red del TPA. Para obtener más información, consulte **Red de servicios avanzados de diagnóstico por imágenes** en la sección **Redes de proveedores**. Para más información, consulte **Cargo máximo permitido** en la sección **Qué está cubierto por el AMP** de este capítulo. Busque proveedores de TPA dentro de la red en el directorio de proveedores: **IncludedHealth.com/Walmart**
- **Opciones de planes locales:** El AMP no ofrece cobertura para los servicios que se reciban de parte de un proveedor que no pertenezca a la red en virtud de estas opciones, aunque usted o sus dependientes vivan fuera del área de servicio normal del plan local. Usted será responsable del pago del costo total de los servicios que haya recibido de un proveedor fuera de la red, excepto en el caso de los servicios cubiertos para el tratamiento de una afección médica de emergencia en un departamento de emergencias, ciertos servicios cubiertos proporcionados por un proveedor fuera de la red, en un centro de atención de la red sujeto a requisitos de notificación y consentimiento, que no ha obtenido su consentimiento para facturarle cantidades que excedan el cargo máximo permitido, o servicios proporcionados por un proveedor de ambulancia aérea fuera de la red que estarían cubiertos por el AMP si los proporcionara un proveedor de servicios de ambulancia aérea dentro de la red. Para más información, consulte **Cargo máximo permitido** en la sección **Qué está cubierto por el AMP** de este capítulo. Busque proveedores dentro de la red en el directorio de proveedores: **IncludedHealth.com/Walmart**

Tenga en cuenta que, para algunos servicios, como aquellos cubiertos a través del programa de Centros de Excelencia o los servicios avanzados de diagnóstico por imagen, la red de proveedores es diferente de la red de su TPA o un subconjunto reducido de esta. Estas redes más restringidas se denominan "redes AMP" para indicar que son redes creadas por el AMP para servicios cubiertos específicos. Para esos servicios cubiertos, el AMP puede pagar solo un beneficio limitado, o ningún beneficio, si no utiliza uno de los proveedores de la red del AMP, aunque utilice un proveedor que esté en la red del AMP para otros servicios cubiertos.

Los "proveedores que no son parte de la red" incluyen a los proveedores que no pertenecen a la red de su TPA o AMP. Esto también puede referirse a los proveedores de su red del AMP que se tratan como proveedores fuera de la red cuando usted recibe servicios que solo son servicios cubiertos cuando se reciben a través de la red del AMP, como en el caso del programa de los Centros de Excelencia.

Para información adicional, consulte la sección **Redes de proveedores** de este capítulo.

> **!** Los proveedores dentro de la red no le facturarán por los servicios cubiertos que excedan el cargo máximo permitido. Consulte la sección **Qué está cubierto por el AMP** más adelante en este capítulo para obtener más información sobre cómo se calcula el cargo máximo permitido.

Desembolso máximo anual

El monto de desembolso máximo anual en efectivo es lo máximo que podría pagar durante el año calendario por su parte de los costos de los servicios cubiertos recibidos de parte de un proveedor dentro de la red. Por lo general, solo los montos que paga por los servicios cubiertos que reciba de proveedores dentro de la red cuentan para el desembolso máximo. Existen algunas excepciones, como el coseguro por servicios de reemplazo de cadera o rodilla fuera del programa de los Centros de Excelencia sin excepción de la red; el coseguro por servicios de diagnóstico por imágenes avanzadas recibidos de un proveedor de la red del TPA cuando un *Proveedor de la red alternativa* de la red del AMP se encuentra dentro de las 30 millas del proveedor que solicita los servicios de diagnóstico por imágenes avanzadas, o el coseguro por servicios recibidos de un proveedor de la red del TPA cuando hay un proveedor de la red Blue Select disponible dentro de las 30 millas de su domicilio (en las ubicaciones aplicables). Consulte las secciones **Red de servicios avanzados de diagnóstico por imágenes** en la sección **Redes de proveedores** en este capítulo para obtener información detallada. Por lo general, los montos que pague por los servicios cubiertos recibidos de un proveedor que no pertenezca a la red no cuentan para el desembolso máximo. En las listas a continuación se indican los gastos que cuentan y los que no cuentan para calcular el desembolso máximo.

Una vez que se haya satisfecho el desembolso máximo anual, el AMP paga el 100 % del cargo máximo permitido por los servicios cubiertos recibidos de un proveedor dentro de la red, excluidos los que no se aplican al desembolso máximo anual. Será responsable del pago del costo de los servicios cubiertos recibidos de un proveedor que no es parte de la red, excluyendo los que sí cuentan para el desembolso máximo anual.

La opción del AMP que elija tiene un desembolso máximo en efectivo individual y un desembolso máximo en efectivo familiar. Independientemente del nivel de cobertura que elija, usted y cada uno de los dependientes que cuenten con cobertura están sujetos al desembolso máximo en efectivo individual. Si usted o cualquiera de sus dependientes con cobertura pagaron por servicios cubiertos hasta el monto individual, los gastos médicos elegibles de esa persona para los servicios cubiertos se pagarán al 100 % por el resto del año calendario. El gasto máximo en efectivo familiar es una combinación de los gastos médicos elegibles de todas las personas cubiertas por servicios brindados. Cualquier combinación de dos o más personas cubiertas puede contribuir a alcanzar el desembolso máximo en efectivo familiar. Una vez que satisfaga el desembolso máximo familiar total, los gastos médicos elegibles por servicios cubiertos de un proveedor de la red se pagan al 100 % durante el resto del año calendario para cada persona cubierta, incluso si cada persona no ha alcanzado el desembolso máximo individual, excepto según se establezca en esta sección.

Los siguientes gastos, si corresponden a una opción específica del AMP, **cuentan** para el desembolso máximo anual en efectivo:

- Montos que se pagan para cubrir el deducible anual dentro y fuera de la red
- Copagos, incluyendo, sin limitarse a, los de visitas al médico en persona o por telesalud, atención de urgencia o servicios cubiertos que sean servicios de emergencia para una afección médica de emergencia en el departamento de emergencia o servicios cubiertos para ambulancia terrestre.
- Coseguro por servicios prestados por un proveedor dentro de la red o por un proveedor fuera de la red que el AMP paga como haber sido dentro de la red o por ciertos servicios cubiertos prestados por un proveedor fuera de la red, en un centro de atención dentro de la red sujeto a los requisitos de notificación y consentimiento, que no haya obtenido su consentimiento para facturarle montos superiores al cargo máximo permitido, o por servicios prestados por un proveedor fuera de la red de servicios de ambulancia aérea que estarían cubiertos por el AMP si fueran prestados por un proveedor dentro de la red de servicios de ambulancia aérea
- Coseguro/copago por servicios de farmacia

Los siguientes gastos, si corresponden a una opción específica del AMP, **no cuentan** para el desembolso máximo anual en efectivo:

- Los cargos pagados al 100 % por el AMP, tales como los cargos por los servicios preventivos dentro de la red y determinados servicios de los Centros de Excelencia
- Coseguro por servicios de reemplazo de cadera o rodilla fuera del programa de los Centros de Excelencia sin excepción de un proveedor de la red del TPA; servicios de diagnóstico por imágenes avanzadas de un proveedor de la red del TPA cuando un *Proveedor de la red alternativa* esté disponible dentro de las 30 millas del proveedor que solicita los servicios de diagnóstico por imágenes avanzadas; o servicios de un proveedor de la red del TPA cuando un proveedor de la red Blue Select esté disponible dentro de las 30 millas de su domicilio (en ubicaciones aplicables). Para más información, consulte la sección **Redes de proveedores** y la sección **Centros de Excelencia**.
- Cargos por servicios preventivos fuera de la red
- Coseguro para servicios de atención provistos por un proveedor que no es parte de la red
- Montos que superen el cargo máximo permitido del AMP que paga a proveedores fuera de la red, incluidos, entre otros, montos pagados por servicios para el tratamiento de una afección médica que no sea de emergencia en un departamento de emergencias, montos pagados a un proveedor, sujeto a requisitos de notificación y consentimiento, que ha obtenido su consentimiento para facturarle los montos que exceden el cargo máximo permitido y los montos que paga a un proveedor fuera de la red de servicios de ambulancia aérea por servicios que no estarían cubiertos por el AMP si los proporcionara un proveedor dentro de la red de servicios de ambulancia aérea
- Descuentos, cupones, programas de descuento en farmacias o arreglos similares provistos por fabricantes de medicamentos o farmacias para asistirlo en la compra de medicamentos con receta médica (incluidos los descuentos/cupones para medicamentos con receta médica que entrega en las farmacias cuando presenta una receta).
- Cargos por servicios no cubiertos por el AMP, incluidos los montos pagados por servicios fuera de la red si está inscrito en uno de los planes locales que no cubre servicios fuera de la red.
- Los gastos por servicios no cubiertos por el programa de los Centros de Excelencia para la formación de familias, como los incurridos después de haber alcanzado el monto máximo del beneficio de por vida, y
- Primas.

Redes de proveedores

Para informarse sobre recursos útiles que le ayuden a gestionar el cuidado de la salud:

- Puede consultar los directorios de proveedores en **IncludedHealth.com/Walmart**
- Puede encontrar una herramienta de comparación de precios en **IncludedHealth.com/Walmart**
- Encontrará información sobre los servicios cubiertos y las reclamaciones en el sitio web de su administrador externo:
  - **aetna.com**
  - **blueadvantagearkansas.com**
  - **UMR.com**
- Puede encontrar más información sobre las opciones del AMP visitando **One.Walmart.com/Health**

Como ya se ha explicado, ni la parte de los gastos médicos elegibles que corresponde al AMP ni la que le corresponde a usted (su coseguro) se basan en el monto facturado por el proveedor, sino en el "cargo máximo permitido". La forma en que se determina el cargo máximo permitido depende de si el proveedor es parte de la red o no.

Un proveedor de la red suele ser un proveedor que ha acordado aceptar un monto contratado como pago íntegro de los servicios cubiertos a precios reducidos y ha acordado no facturarle montos superiores al cargo máximo permitido, que es el monto contratado.

Hay distintos tipos de proveedores de la red y, en ciertos casos, si un proveedor se considera ser parte de la red dependerá de los servicios que reciba específicamente. Es posible que un proveedor de la red para un servicio cubierto no se considere un proveedor de la red para todos los servicios cubiertos.

Red TPA. Cada opción del AMP proporciona acceso a una red que consiste de un grupo de proveedores que han acordado con el TPA aceptar un monto contratado por los servicios cubiertos. Estos proveedores de la red forman parte de su "red del TPA" y el TPA ha aceptado poner su red del TPA a disposición del AMP. El monto contratado es el cargo máximo permitido por el AMP. La mayoría de los servicios cubiertos por el AMP están disponibles a través de un proveedor de la red del TPA. No obstante, los proveedores de la red del TPA no son proveedores de la red para todos los servicios cubiertos. **Consulte la sección Redes AMP a continuación para obtener información importante sobre los servicios que serán servicios cubiertos únicamente si son facilitados por un proveedor de una red del AMP inferior, incluso si recibe los servicios de un proveedor que, de otra manera, pertenece a la red del TPA para otros servicios cubiertos.**

Red AMP. Cada opción del AMP también aporta acceso a una red de proveedores y centros con los que el AMP ha celebrado un contrato, ya sea directamente o a través de un tercero, que han acordado aceptar un monto contratado para servicios cubiertos específicos. Estos proveedores de la red pertenecen a una "red del AMP", que es diferente de la red del TPA. El monto contratado es el cargo máximo permitido por el AMP. Por lo general, el AMP pagará el mayor beneficio solo cuando reciba servicios cubiertos específicos de un proveedor de una red del AMP. **No todos los proveedores de la red del TPA son proveedores de una red del AMP. Consulte la sección Redes AMP a continuación para obtener información importante sobre los servicios que serán servicios cubiertos únicamente si son facilitados por un proveedor de una red del AMP, incluso si recibe los servicios de un proveedor que, de otra manera, pertenece a la red del TPA para otros servicios cubiertos.**

Un proveedor fuera de la red es un proveedor que no ha acordado aceptar un monto contratado como pago total por los servicios cubiertos. Esto puede incluir a un proveedor que, de lo contrario, forma parte de la red del TPA para ciertos servicios cubiertos, pero no para otros servicios cubiertos, que solo están disponibles a través de una red del AMP. El cargo máximo permitido para los proveedores fuera de la red lo determina cada TPA. Para obtener información importante acerca de cuándo el AMP puede pagar un beneficio reducido, o ningún beneficio para ciertos servicios cubiertos, incluso si los servicios son prestados por un proveedor de la red del TPA y su opción del AMP proporciona de otro modo cobertura fuera de la red, consulte el análisis de los servicios cubiertos disponibles a través del programa de los Centros de Excelencia y los servicios de diagnóstico por imágenes avanzadas en la sección **Redes AMP**. Con algunas excepciones, los proveedores fuera de la red pueden facturarle montos que excedan el cargo máximo permitido determinado por el TPA. Por eso, generalmente, tendrá que pagar una mayor parte del costo de los servicios que reciba de un proveedor que esté fuera de la red. Consulte **Cargo máximo permitido** en la sección **Qué está cubierto por el AMP** más adelante en este capítulo para obtener información detallada sobre cómo cada TPA determina el cargo máximo permitido para los servicios cubiertos recibidos de proveedores fuera de la red.

Redes TPA

Dependiendo de su lugar de trabajo y de la opción del AMP que elija, uno de los siguientes administradores de la red subcontratados administrará sus beneficios conforme al AMP:

- Aetna
- BlueAdvantage Administrators of Arkansas
  - Si su lugar de trabajo se encuentra en el Distrito de Columbia, Florida, Georgia, Maryland, Nuevo Hampshire, Oklahoma, Pensilvania occidental, Tennessee, el norte de Virginia o Wisconsin, consulte la información importante que aparece en la siguiente página en la sección titulada **Redes Blue Select a través de BlueAdvantage Administrators of Arkansas**.
- UMR

Cada TPA celebra contratos con varios proveedores y un proveedor puede estar en todas las redes del TPA o solo en una o dos redes del TPA.

Si su proveedor deja de ser parte de la red de su TPA antes de que usted reciba los servicios, y luego decide recibir los servicios de ese proveedor, los servicios prestados por ese proveedor se suelen tratar como servicios fuera de la red. En ciertos casos, es posible que reúna los requisitos para una cobertura continuada, denominada "continuidad asistencial", en la que su proveedor puede seguir siendo tratado como proveedor de la red del TPA durante un periodo de tiempo. Consulte la información importante sobre los servicios de continuidad de la atención que se describen en la sección titulada **Cuándo se pagan beneficios de la red para servicios fuera de la red** más adelante en este capítulo.

Si está inscrito en la opción del plan Premier, Contribution o Saver, que brinda cobertura fuera de la red y recibe servicios de un proveedor fuera de la red, generalmente usted será responsable del deducible restante, del coseguro y del costo de los servicios que superen el cargo máximo permitido del AMP. Si está inscrito en una de las opciones del plan local que no brinda cobertura fuera de la red, usted será responsable del monto total cobrado por el proveedor fuera de la red.

Con algunas excepciones, los proveedores fuera de la red pueden facturarle montos que excedan el cargo máximo permitido determinado por el TPA. Por eso, generalmente, tendrá que pagar una mayor parte del costo de los servicios que reciba de un proveedor que esté fuera de la red. Consulte **Cargo máximo permitido** en la sección **Qué está cubierto por el AMP** más adelante en este capítulo para obtener información detallada sobre cómo cada TPA determina el cargo máximo permitido para proveedores fuera de la red.

Para informarse sobre recursos útiles que le ayuden a gestionar el cuidado de la salud:

- Puede consultar los directorios de proveedores en **IncludedHealth.com/Walmart**
- Puede encontrar una herramienta de comparación de precios en **IncludedHealth.com/Walmart**
- Encontrará información sobre los servicios cubiertos y las reclamaciones en el sitio web de su administrador externo:
  - **aetna.com**
  - **blueadvantagearkansas.com**
  - **UMR.com**
- Puede encontrar más información sobre las opciones del AMP visitando **One.Walmart.com/Health**

REDES BLUE SELECT A TRAVÉS DE BLUEADVANTAGE ADMINISTRATORS OF ARKANSAS

Si está inscrito en una opción del Plan Premier, Plan Contribution o Plan Saver y BlueAdvantage Administrators of Arkansas es su TPA, es posible que tenga redes TPA más reducidas, llamadas redes Blue Select, si su lugar de trabajo se encuentra en un área de servicio en particular. En estos lugares, debe utilizar un proveedor de la red Blue Select para que se apliquen los términos

de la red, es decir, los deducibles anuales y el coseguro de la red. Si su lugar de trabajo se encuentra en una de las áreas indicadas en esta sección **Redes TPA**, los proveedores que no son parte de la red de Blue Select se considerarán proveedor que no son parte de la red y los servicios recibidos de los proveedores se tratarán como servicios que no son parte de la red, excepto cuando los servicios que no son parte de la red sean servicios cubiertos para una afección médica de emergencia en una sala de emergencia, ciertos servicios cubiertos prestados por un proveedor que no es parte de la red, en un centro de atención dentro de la red sujeto a los requisitos de notificación y consentimiento, que no haya obtenido su consentimiento para facturarle montos superiores al cargo máximo permitido, o por servicios prestados por un proveedor que no es parte de la red de servicios de ambulancia aérea que estarían cubiertos por el AMP si fueran prestados por un proveedor dentro de la red de servicios de ambulancia aérea. El coseguro pagado por los servicios cubiertos de un proveedor de TPA dentro de la red cuando esté disponible un proveedor dentro de la red Blue Select dentro de 30 millas de su casa no se aplicará a su desembolso máximo, excepto cuando los servicios fuera de la red sean servicios cubiertos para una afección médica de emergencia en una sala de emergencia, ciertos servicios cubiertos prestados por un proveedor fuera de la red, en un centro de atención dentro de la red sujeto a los requisitos de notificación y consentimiento, que no haya obtenido su consentimiento para facturarle montos superiores al cargo máximo permitido, o por servicios prestados por un proveedor fuera de la red de servicios de ambulancia aérea que estarían cubiertos por el AMP si fueran prestados por un proveedor dentro de la red de servicios de ambulancia aérea. Puede buscar los proveedores que están en su Red Blue Select, que se enumeran a continuación, en el directorio de proveedores en **IncludedHealth.com/Walmart**. La tarjeta de identificación del plan también identificará su red específica.

Si su lugar de trabajo no se encuentra en una de las áreas que se enumeran a continuación, pero recibe servicios en una de estas áreas (por ejemplo, si está de viaje en una de estas áreas), puede utilizar cualquier proveedor dentro de la red del TPA para los servicios cubiertos, incluidos los que no están en las redes Blue Select, sujeto a todos los términos y condiciones de cobertura del AMP que sean aplicables.

Si su TPA es BlueAdvantage Administrators of Arkansas, debe acceder a la red Blue Select para que los servicios se consideren dentro de la red si su ubicación de trabajo se encuentra en una de las siguientes áreas:

- Florida: NetworkBlue
- Georgia: Blue Open Access POS
- Maryland, Northern Virginia, Distrito de Columbia: BlueChoice Advantage Open Access
- New Hampshire: BlueChoice Open Access POS
- Oklahoma: BluePreferred
- Pensilvania occidental: Community Blue Network
- Tennessee: Network S
- Wisconsin: Blue Preferred POS

Para obtener información sobre las redes Blue Select, llame a su asesor de atención de la salud al número que aparece en la tarjeta de identificación del Plan.

Redes AMP

En el caso de algunos servicios, por lo general, el AMP pagará el beneficio más alto, o el único beneficio, cuando reciba ciertos servicios cubiertos de un proveedor de la red del AMP. Si recibe esos servicios de un proveedor que no pertenece a una red del AMP, tal red puede pagarle un beneficio reducido o no pagarle ningún beneficio por esos servicios, aunque los reciba de un proveedor que, de lo contrario, pertenece a una red del TPA para otros servicios cubiertos. Cada red del AMP se describe a continuación.

RED DE LOS CENTROS DE EXCELENCIA

Los servicios cubiertos que se enumeran a continuación están disponibles a través del programa de los Centros de Excelencia, y se describen detalladamente en la sección **Centros de Excelencia**. En ciertos casos, si recibe los servicios descritos a continuación de un proveedor que no pertenece a la red del AMP, tal red puede pagarle un beneficio reducido, o no pagarle ningún beneficio, aunque reciba los servicios de un proveedor que, de lo contrario, pertenece a una red del TPA para otros servicios cubiertos, a menos que solicite y reciba una excepción.

- Revisión del historial clínico por parte de Mayo Clinic para determinados tipos de cáncer, incluida la evaluación o el tratamiento en el lugar, cuando lo recomiende la Mayo Clinic.
- Servicios para la formación de la familia (a partir de los 18 años) en las Clínicas Kindbody Signature, que incluye, pero no se limita a, la fertilización in vitro (FIV) y la inseminación intrauterina (IIU)
- Revisión electrónica del historial clínico por parte de Cleveland Clinic para determinadas afecciones cardiacas (a partir de 18 años), incluida la cirugía cardiaca en el lugar, cuando Cleveland Clinic lo recomiende.
- Cirugía por reemplazo de cadera o rodilla
- Revisión del historial clínico a cargo de Mayo Clinic por diálisis renal ambulatoria o enfermedad renal terminal (ESRD) (todas las edades), incluyendo la evaluación o tratamiento en el lugar, si así lo recomienda Mayo Clinic
- Cirugías para ciertas afecciones de la columna vertebral (a partir de los 18 años, excepto para ciertas afecciones de la columna vertebral, como la escoliosis)
- Trasplantes de hígado, riñón, corazón (incluidos los Dispositivos de asistencia ventricular [Ventricular Assist Devices, VAD] duraderos y los corazones totalmente artificiales), pulmón (incluida la cirugía de reducción de volumen pulmonar [Lung Volume Reduction Surgery, LVRS]), páncreas, riñón y páncreas de forma simultánea, órganos múltiples y de médula ósea o células madre (incluido el tratamiento con células T CAR), y
- Cirugía para la pérdida de peso (desde los 14 años en adelante), que incluye derivación gástrica, manga gástrica y cruce duodenal.

Consulte la sección **Centros de Excelencia** para obtener información completa sobre estos servicios y las condiciones y requisitos de elegibilidad de los Centros de Excelencia.

RED DE SERVICIOS AVANZADOS DE DIAGNÓSTICO POR IMÁGENES

Si está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver (pero no una opción de un plan local), es posible que pueda acceder a una red alternativa de proveedores de servicios avanzados de diagnóstico por imágenes (resonancias magnéticas y tomografías computarizadas). Esta red alternativa de proveedores es una red del AMP. Todos los Proveedores de la red alternativa están también en su red del TPA pero no todos los proveedores de su red del TPA son Proveedores de la red alternativa. El beneficio del AMP para los servicios de imágenes avanzadas dependerá de si el proveedor es un proveedor de la red del TPA que es un *Proveedor de la red alternativa* en la red del AMP, un proveedor de la red del TPA que no es un *Proveedor de la red alternativa* en la red del AMP, o un proveedor que no pertenece a la red. Por lo general, el AMP pagará una porción mayor del costo de los servicios cubiertos recibidos de un *Proveedor de la red alternativa* que los recibidos de un proveedor de la red del TPA que no sea un *Proveedor de la red alternativa*, cuando un *Proveedor de la red alternativa* esté disponible dentro de un radio de 30 millas del proveedor que solicita los servicios de imágenes avanzadas. El AMP también pagará una parte del costo de los servicios cubiertos recibidos de un proveedor que no es parte de la red si está inscrito en la opción del Plan Premier, Contribution o Saver, de acuerdo con los términos regulares del AMP aplicables a los servicios cubiertos recibidos de un proveedor que no sea parte de la red. **Se requiere autorización previa para los servicios avanzados de diagnóstico por imagen;** consulte la sección **Autorización previa** que aparece más adelante en este capítulo. Si tiene alguna pregunta, puede comunicarse con su asesor de atención de la salud al número que figura en su tarjeta de identificación del plan.

Consulte la sección **Desembolso máximo anual** sobre el desembolso máximo anual para obtener información importante sobre la aplicación del límite de desembolso máximo a su parte del costo cubierto por los servicios de diagnóstico por imágenes avanzadas.

VISITAS DE TELESALUD

El costo de los servicios cubiertos para las visitas de telesalud se abonará de acuerdo con los términos del AMP que serían aplicables de otro modo (por ejemplo, las mismas que las visitas al médico de forma ambulatoria), a menos que los servicios sean prestados por Doctor On Demand de Included Health. Para obtener más detalles, consulte la sección **Visitas de telesalud por video a través de Doctor On Demand por Included Health**.

Cuándo se pagan beneficios de la red para servicios fuera de la red

En algunas ocasiones, los servicios cubiertos que recibe de un proveedor fuera de la red pueden considerarse servicios cubiertos recibidos de un proveedor dentro de la red. En estos casos, el AMP pagará la tasa de beneficio dentro de la red, que se basa en el cargo máximo permitido utilizado para los proveedores fuera de la red (en lugar del cantidad contratada utilizada para los proveedores de la red) o el monto determinado por la ley aplicable, el cual está sujeto a otros términos aplicables del AMP. Usted seguirá siendo responsable de cualquier monto que exceda el cargo máximo permitido del AMP pago del costo total de los servicios que haya recibido de un proveedor que no es parte de la red, excepto en el caso de los servicios cubiertos para el tratamiento de una afección médica de emergencia en un departamento de emergencias, servicios cubiertos proporcionados por un proveedor que no es parte de la red, en un centro de atención de la red sujeto a requisitos de notificación y consentimiento, que no ha obtenido su consentimiento para facturarle cantidades que excedan el cargo máximo permitido, y servicios cubiertos por un proveedor de ambulancia aérea que no es parte de la red que estarían cubiertos por el AMP si los proporcionara un proveedor de servicios de ambulancia aérea dentro de la red. En algunos casos, es posible que deba pagar el tratamiento cuando lo reciba y presentar una reclamación de reembolso.

Los gastos médicos elegibles por servicios cubiertos recibidos de un proveedor fuera de la red se pagarán como si fueran servicios cubiertos recibidos de un proveedor dentro de la red en los siguientes casos:

- Si sus hijos dependientes menores de 19 años necesitan un tratamiento en un hospital de Children's Miracle Network.
- Si no hay proveedores dentro de la red con la especialidad correspondiente en un radio de 30 millas de su domicilio (no se aplica a las opciones del plan local, a los servicios de los Centros de Excelencia ni a los servicios relacionados con el beneficio de desplazamiento para atención). Si cree que le corresponde esta excepción, deberá ponerse en contacto con su TPA.
- Servicios por el tratamiento recibido durante un viaje de vacaciones o de negocios en los EE. UU., cuando es posible que dicho tratamiento no se hubiese previsto de forma razonable antes del viaje o el ciclo del tratamiento se iniciara antes del viaje y, por motivos médicos, se debiese continuar durante el viaje.
- Si se aplican las protecciones de continuidad de la atención, como se describe aquí:
  - Está sometido a un tratamiento por una enfermedad grave y compleja, a un tratamiento institucional o de hospitalización, a una intervención quirúrgica no electiva o a una enfermedad terminal. En tales casos, los servicios cubiertos de un proveedor fuera de la red se tratan como servicios cubiertos de un proveedor dentro de la red hasta la fecha de entrada en vigencia de la siguiente Inscripción anual, o 90 días después de que se le notifique que el proveedor ya no es un proveedor dentro de la red, lo que ocurra más tarde; siempre y cuando el curso del tratamiento haya comenzado cuando el proveedor era un proveedor dentro de la red y no haya interrupción de la relación médico/paciente (tal como, si cambia de TPA durante el año debido a un cambio de lugar de trabajo y está en medio de un curso de tratamiento). Su proveedor fuera de la red no podrá facturarle la diferencia entre el cargo máximo permitido y el monto facturado por los servicios cubiertos recibidos durante el periodo de 90 días posterior al aviso de que el proveedor ya no pertenece a la red, o cuando usted ya no esté recibiendo tratamiento como paciente de atención continua, si sucede antes.
  - Está embarazada y se somete a un tratamiento relacionado con el embarazo. En ese caso, los servicios cubiertos de un proveedor fuera de la red se tratan como servicios cubiertos de un proveedor de la red durante 90 días

después de que se le notifique que el proveedor ya no pertenece a la red o seis semanas después del parto, lo que ocurra más tarde; siempre que los servicios hayan comenzado cuando el proveedor pertenecía a la red y que no se interrumpa la relación médico/paciente. Su proveedor fuera de la red no podrá facturarle la diferencia entre el cargo máximo permitido y el monto facturado por los servicios cubiertos recibidos durante el periodo de 90 días posterior al aviso de que el proveedor ya no pertenece a la red, o cuando usted ya no esté recibiendo tratamiento como paciente de atención continua, si sucede antes.

- Usted añade la cobertura del AMP y estaba utilizando a un proveedor fuera de la red del AMP en un curso de tratamiento iniciado antes de la fecha de entrada en vigencia de la cobertura, en el que no hay interrupción de la relación médico/paciente. En ese caso, los servicios de un proveedor fuera de la red se considerarán como servicios de un proveedor dentro de la red hasta la siguiente Inscripción anual.

En los siguientes casos adicionales, la ley aplicable exige que el proveedor fuera de la red no pueda facturarle la diferencia entre los montos que excedan el cargo máximo permitido, que se determina de conformidad con la legislación aplicable:

- Si recibe servicios cubiertos para una afección médica de emergencia de un proveedor fuera de la red o de un departamento de emergencias fuera de la red
- Si recibe servicios cubiertos de un proveedor que no es parte de la red en una instalación del cuidado de la salud de la red que está sujeta al requisito de notificación y consentimiento y que no ha obtenido su consentimiento para facturarle montos superiores al cargo máximo permitido.
- Si recibe servicios de un proveedor fuera de la red de servicios de ambulancia aérea, que serían servicios cubiertos por el AMP si los proporciona un proveedor dentro de la red de servicios de ambulancia aérea.

En la medida en que el AMP cubra los servicios de ambulancia aérea provistos por un proveedor dentro de la red, los servicios de ambulancia aérea fuera de la red se tratarán como gastos cubiertos por la red. Su costo compartido será el mismo que para los servicios de ambulancia aérea dentro de la red cubiertos y el monto sobre el cual se calcula su porcentaje de costo compartido se basará en el monto facturado o en el monto calculado según la Ley de Garantía de los Ingresos de Jubilación para los Empleados de 1974 (ERISA), el que sea menor. El cargo máximo permitido por los servicios de ambulancia aérea fuera de la red serán el monto negociado por el AMP o el monto determinado por el proceso de resolución de disputas independiente requerido por ERISA. Según la ley aplicable, el proveedor fuera de la red del servicio de ambulancia aérea no podrá facturarle la diferencia entre los cargos facturados y el monto máximo pagado por el AMP.

Una "afección médica de emergencia" es una afección médica, incluidas las afecciones de la salud mental o los trastornos por abuso de sustancias, que se manifiesta por síntomas agudos de gravedad suficiente como para que una persona común y prudente con un conocimiento medio de salud y medicina considere de forma razonable que la ausencia de atención médica inmediata (i) pone en grave peligro la salud de la persona (o, con respecto a una mujer embarazada, la salud de la mujer o del niño por nacer); (ii) provoca un deterioro grave del funcionamiento del cuerpo; o (iii) provoca una disfunción grave de cualquier órgano o parte del cuerpo.

Consulte la sección titulada **Transporte terrestre de ambulancia** en la sección **Servicios de emergencia, ambulancia de transporte terrestre, prevención y telesalud** para obtener más detalles.

COBERTURA PARA VIAJES AL EXTRANJERO

Si viaja al exterior, siga estos pasos:

- Antes de comenzar el viaje, comuníquese con TPA para obtener más información acerca de la cobertura médica y los servicios médicos de emergencia para viajar al exterior. La cobertura fuera de los Estados Unidos puede variar.
- Siempre lleve la tarjeta de identificación del plan cuando viaje, y preséntela cuando reciba servicios médicos.

Servicios de emergencia, ambulancia de transporte terrestre, prevención y telesalud

SERVICIOS DE EMERGENCIA

Cuando busca tratamiento en un departamento de emergencias para servicios que no son "servicios de emergencia" por una "afección médica de emergencia", sus costos de gastos en efectivo pueden ser significativos, especialmente si el centro de atención o el proveedor no está en su red de TPA. **Repase esta sección con atención.**

El AMP pagará el beneficio que se describe a continuación por los servicios de emergencia. Por lo general, la ley define a los "servicios de emergencia" como una revisión médica adecuada en el departamento de emergencias de un hospital o en un departamento de emergencias independiente para evaluar una "afección médica de emergencia". **Una "afección médica de emergencia" es una afección médica, incluidas las afecciones de la salud mental o los trastornos por abuso de sustancias, que se manifiesta por síntomas agudos de gravedad suficiente como para que una persona común y prudente con un conocimiento medio de salud y medicina considere de forma razonable que la ausencia de atención médica inmediata (i) pone en grave peligro la salud de la persona (o, con respecto a una mujer embarazada, la salud de la mujer o del niño por nacer); (ii) provoca un deterioro grave del funcionamiento del cuerpo; o (iii) provoca una disfunción grave de cualquier órgano o parte del cuerpo.**

El copago del departamento de emergencias es de $300 por visita, ya sea que visite un centro dentro de la red o no (a menos que sea admitido en el hospital como paciente hospitalizado desde el departamento de emergencias o fallezca antes de la admisión, en cuyos casos se omite el copago). Este copago es adicional al deducible anual y se debe pagar incluso después de que se haya alcanzado el deducible anual.

Si los servicios que recibe en un departamento de emergencias son "servicios de emergencia", el AMP pagará el costo de los servicios cubiertos como beneficios dentro de la red, que es el 100 % después de que haya alcanzado el deducible dentro de la red y haya pagado el copago de $300, incluso si el departamento de emergencias o proveedor es un proveedor o centro de atención que no pertenece a la red. El pago del AMP a un

proveedor o centro de atención fuera de la red se basará en el monto negociado por el AMP o en el monto determinado por el proceso de resolución de disputas independiente requerido por la Ley de Garantía de los Ingresos de Jubilación para los Empleados de 1974. El proveedor o centro de atención fuera de la red no podrá facturarle la diferencia entre el monto facturado y el monto pagado por el AMP.

Sí, después de una revisión retrospectiva, al decidir sobre su reclamación posterior al servicio de un proveedor o centro de atención que no es parte de la red, si el TPA determina que una persona razonable y prudente no consideraría la afección médica como una emergencia, los servicios estarán sujetos a todos los términos aplicables del AMP. Si está inscrito en la opción del plan Premier, Contribution o Saver, el AMP pagará el 50 % del cargo máximo permitido por los servicios cubiertos después de que haya alcanzado su deducible fuera de la red y usted será responsable de pagar el deducible, el copago de $300, el coseguro y los montos que excedan el cargo máximo permitido del AMP por los servicios médicos brindados en el departamento de emergencias de un centro de atención fuera de la red. Si está inscrito en una opción de plan local, el AMP no pagará los servicios recibidos de un proveedor o centro de atención fuera de la red y usted será responsable del monto total. Podrá apelar la determinación del TPA según los procedimientos para reclamaciones posteriores al servicio (incluyendo la revisión externa) que se describen en el capítulo **Reclamaciones y apelaciones**.

Si el proveedor o el centro de atención pertenece a la red, el AMP pagará el 100 % de los servicios cubiertos después de que usted haya alcanzado el deducible anual, independientemente de si el administrador de terceros determina que la visita es por una "afección médica de emergencia", sujeta al copago de $300.

TRANSPORTE TERRESTRE DE AMBULANCIA

Si recibe servicios de transporte terrestre de ambulancia por una afección que no sea una "afección médica de emergencia", según se describe anteriormente, tales servicios no estarán cubiertos, incluso si son facilitados por un proveedor de la red o un proveedor que no es parte de la red, si se encuentra en una opción del AMP que facilite cobertura que no sea parte de la red, excepto en los casos descritos en la sección **Cuándo se aplican beneficios limitados al AMP**.

Si usted recibe servicios de transporte terrestre de ambulancia que no son para una "afección médica de emergencia", pero están cubiertos por el AMP como se describe en la sección **Cuándo se aplican beneficios limitados al AMP**, el AMP pagará el 100 % de los servicios cubiertos después de que usted haya satisfecho su deducible de la red y pagado el copago de $300. El copago de $300 se aplica a cada servicio de transporte terrestre de ambulancia que reciba, pero no se aplicará si termina como paciente hospitalizado en el hospital al que es transportado o si fallece antes de ser hospitalizado. En los casos en que los servicios de transporte terrestre de ambulancia lo trasladen a una instalación que no sea un hospital, se aplicará el copago de $300. Este copago es adicional al deducible anual y se debe pagar incluso después de que se haya alcanzado el deducible anual.

Si usted recibe servicios de transporte terrestre de ambulancia por una afección que es una "afección médica de emergencia", como se describe más arriba, el AMP pagará el 100 % del costo de los servicios cubiertos, incluso si el proveedor de los servicios de transporte terrestre de ambulancia es un proveedor que no es parte de la red, después de que usted haya cubierto su deducible y pagado un copago de $300. El copago de $300 se aplica a cada servicio de los servicios de transporte terrestre de ambulancia que reciba, pero no se aplicará si queda hospitalizado en las instalaciones a las que lo trasladan los servicios de transporte terrestre de ambulancia o si fallece antes de quedar hospitalizado en tales instalaciones. Este copago es adicional al deducible anual y se debe pagar incluso después de que se haya alcanzado el deducible anual.

Para los servicios de transporte terrestre de ambulancia que se faciliten para una afección que sea una "afección médica de emergencia" por un proveedor que no sea parte de la red, el cargo máximo permitido del AMP se determinará de acuerdo con los siguientes términos:

- Si no queda hospitalizado en un hospital al que lo trasladen los servicios de transporte terrestre de ambulancia y no fallece antes de quedar hospitalizado en tal hospital, el cargo máximo permitido por el AMP será el 125 % del cargo máximo permitido por Medicare.
- Si ingresa como paciente hospitalizado en un hospital al que lo traslade una ambulancia terrestre o fallece antes de ser hospitalizado en tal hospital, el cargo máximo permitido del AMP será el 200 % del 125 % del cargo máximo permitido de Medicare.

Para los servicios de transporte terrestre de ambulancia que sean servicios cubiertos para una afección que no sea una "afección médica de emergencia" facilitados por un proveedor que no pertenezca a la red, el cargo máximo permitido del AMP se determinará de acuerdo con los siguientes términos:

- Si no ingresa como paciente hospitalizado en un hospital al que lo traslade una ambulancia terrestre y no fallece, el cargo máximo permitidopor el AMP será el 125 % del cargo máximo permitido por Medicare.
- Si ingresa como paciente hospitalizado en un hospital al que lo traslade una ambulancia terrestre o fallece antes de ser hospitalizado en tal hospital, el cargo máximo permitido del AMP será el 200 % del 125 % del cargo máximo permitido de Medicare.
- Si actualmente está ingresado como paciente hospitalizado en un hospital y es transportado en ambulancia terrestre a una instalación que no sea un hospital, el cargo máximo permitido del AMP será el 125 % del cargo máximo permitido de Medicare.

Un proveedor que no es parte de la red podrá facturarle montos que excedan el cargo máximo permitido.

SERVICIOS PREVENTIVOS

El AMP pagará todo o una parte del costo de los servicios preventivos cubiertos antes de que usted alcance el deducible correspondiente de acuerdo con los siguientes términos:

- Si está inscrito en las opciones de **Plan Premier**, Plan **Contribution y Plan Saver**: el AMP pagará el 100 % del costo de los servicios preventivos cubiertos brindados por un proveedor dentro de la red. Si el proveedor es un proveedor fuera de la red, el AMP pagará el 50 % del costo de los servicios cubiertos. Además del coseguro, usted también es responsable de cualquier monto que exceda el cargo máximo permitido, y los montos que pague no se aplicarán a su deducible ni al desembolso máximo.
- Si está inscrito en los **planes locales**: el AMP pagará el 100 % del costo de los servicios preventivos cubiertos brindados por un proveedor dentro de la red. Estas opciones del AMP no brindan cobertura fuera de la red.

Puede encontrar información detallada sobre qué servicios son preventivos en la sección **Programa de atención preventiva** más adelante en este capítulo.

VISITAS DE TELESALUD POR VIDEO A TRAVÉS DE DOCTOR ON DEMAND POR INCLUDED HEALTH

Tiene acceso a Doctor On Demand de Included Health, un servicio de telesalud que ofrece consultas médicas y de salud mental por video (incluida la atención de urgencia y de cuidado primario). Los médicos de Doctor on Demand podrán diagnosticar, tratar y recetar medicamentos para una amplia gama de afecciones médicas que no sean emergencias. Este servicio se encuentra disponible en 49 estados y el Distrito de Columbia, las 24 horas del día, los 7 días de la semana por computadora, tableta o teléfono inteligente. Deberá descargar la aplicación Doctor On Demand desde la App Store o Google Play.

Doctor On Demand está disponible sin costo alguno, antes de que haya alcanzado su deducible, si está inscrito en la opción del Plan Premier, Contribution o del plan local. Si está inscrito en la opción del Plan Saver, primero deberá satisfacer su deducible. Si desea más información sobre los servicios y requisitos técnicos, visite Doctor On Demand en línea en **DoctorOnDemand.com/Walmart** o llame al **800-997-6196**.

Los servicios de asesoramiento de la salud por teléfono fuera de Doctor On Demand se pagarán de acuerdo con los términos correspondientes del AMP (por ejemplo, lo mismo que las consultas médicas para pacientes ambulatorios), según lo permita el AMP.

Centros de Excelencia

El programa de los Centros de Excelencia funciona con centros de atención específicos para proporcionar servicios cubiertos relacionados con una variedad de afecciones y enfermedades. A través de este programa, usted y los dependientes con cobertura pueden acceder a especialistas en centros de atención selectos según su experiencia en determinados procedimientos complejos.

El AMP y cada Centro de excelencia se consideran un "Acuerdo de atención médica organizada" (OHCA) a los fines de las reglas de privacidad de la HIPAA. Esto quiere decir que el AMP y cada Centro de excelencia pueden compartir información para determinar la elegibilidad y administrar el programa de los Centros de Excelencia, según lo permitido por la HIPAA.

Al realizar los servicios de evaluación o al determinar sobre la atención de los Centros de Excelencia, el Centro de excelencia no actúa como agente del AMP, sino como su proveedor de atención médica. El programa de los Centros de Excelencia cubre lo siguiente:

- Revisión del historial clínico por parte de Mayo Clinic para determinados tipos de cáncer, incluida la evaluación o el tratamiento en el lugar, cuando lo recomiende la Mayo Clinic.
- Servicios para la formación de la familia (a partir de los 18 años) en las Clínicas Kindbody Signature, que incluye, pero no se limita a, la fertilización in vitro (FIV) y la inseminación intrauterina (IIU)
- Revisión electrónica del historial clínico por parte de Cleveland Clinic para determinadas afecciones cardiacas (a partir de 18 años), incluida la cirugía cardiaca en el lugar, cuando Cleveland Clinic lo recomiende.
- Cirugía por reemplazo de cadera o rodilla
- Revisión del historial clínico a cargo de Mayo Clinic por diálisis renal ambulatoria o enfermedad renal terminal (ESRD) (todas las edades), incluyendo la evaluación o tratamiento en el lugar, si así lo recomienda Mayo Clinic
- Cirugías para ciertas afecciones de la columna vertebral (a partir de los 18 años, excepto para ciertas afecciones de la columna vertebral, como la escoliosis)
- Trasplantes de hígado, riñón, corazón (incluidos los Dispositivos de asistencia ventricular [Ventricular Assist Devices, VAD] duraderos y los corazones totalmente artificiales), pulmón (incluida la cirugía de reducción de volumen pulmonar [Lung Volume Reduction Surgery, LVRS]), páncreas, riñón y páncreas de forma simultánea, órganos múltiples y de médula ósea o células madre (incluido el tratamiento con células T CAR), y
- Cirugía para la pérdida de peso (desde los 14 años en adelante), que incluye derivación gástrica, manga gástrica y cruce duodenal

La tabla a continuación es solo un resumen. Lea toda la información de esta sección para comprender todos los requisitos y restricciones del programa de los Centros de Excelencia, incluido cuándo pueden aplicarse excepciones que le permitan recibir los servicios cubiertos en instalaciones que no sean de los Centros de Excelencia bajo los términos y condiciones regulares de cobertura del AMP.

CENTROS DE EXCELENCIA			
	Programa de Centros de Excelencia		Fuera del programa de Centros de Excelencia
	Administrador[1]	Cobertura	
Revisión del historial clínico de cáncer, evaluación en el lugar y tratamiento Puede incluir la evaluación y el tratamiento in situ, cuando lo recomiende Mayo Clinic	**Beneficios de HealthSCOPE 800-804-1289**	100 % No se requiere deducible[2]	Se aplican los términos y condiciones habituales del AMP
Tratamiento para la formación de familias en las Clínicas Kindbody Signature Sujeto a un beneficio máximo de por vida de $20,000 (gastos médicos y de farmacia) por participante individual del AMP	**Su administrador del plan médico (consulte la tarjeta de identificación del plan)** **Desplazamiento por UMR 800-804-1289**	75 % Después del deducible dentro de la red	Sin cobertura
Cirugía cardíaca La revisión electrónica de Cleveland Clinic y cirugía en el sitio cuando lo recomiende Cleveland Clinic	**Su administrador del plan médico (consulte la tarjeta de identificación del plan)** **Desplazamiento por Beneficios de HealthSCOPE 800-804-1289**	100 % No se requiere deducible[2]	Se aplican los términos y condiciones habituales del AMP
Reemplazo de cadera y rodilla	**Contigo Health 877-230-7037**	100 % No se requiere deducible[2]	**Opciones de Plan Premier, Plan Contribution y Plan Saver:** 50 % después del deducible fuera de la red El coseguro no se aplicará al desembolso máximo en efectivo **Planes locales:** Sin cobertura[3]
Revisión de historiales clínicos de diálisis renal (ambulatoria) o enfermedad renal terminal, evaluación y tratamiento en el lugar Puede incluir la evaluación o tratamiento del trasplante de riñón in situ cuando lo recomiende Mayo Clinic	**HealthSCOPE Benefits 479-621-2830**	100 % No se requiere deducible[2]	Se aplican los términos y condiciones habituales del AMP
Cirugía de columna	**Contigo Health 877-230-7037**	100 % No se requiere deducible[2]	Sin cobertura[3]
Trasplante Mayo Clinic únicamente. Excepto el trasplante de córnea y de intestinos	**HealthSCOPE Benefits 479-621-2830**	100 % No se requiere deducible[2]	Sin cobertura[3]
Cirugía para la pérdida de peso Derivación gástrica, manga gástrica y cruce duodenal	**Contigo Health 877-230-7037**	75 % Después del deducible dentro de la red	Sin cobertura

[1] Si está inscrito en un plan local, comuníquese con su asesor de atención médica para que se lo dirija al administrador correspondiente.
[2] Los participantes inscriptos en la opción de Plan Saver deben alcanzar el deducible anual dentro de la red antes de que el AMP pague cualquier beneficio.
[3] Pueden aplicarse excepciones. Consulte los detalles del programa específico en esta sección.

Como se muestra en la tabla de arriba, ciertos servicios cubiertos recibidos en un Centro de Excelencia están cubiertos al 100 % antes de que satisfaga su deducible anual (excluida la cirugía para la formación de familias y de pérdida de peso). Sin embargo, si está inscrito en el Plan Saver, debe alcanzar su deducible anual dentro de la red antes de que el AMP pague los beneficios.

Si cree que puede ser un candidato para participar de los servicios cubiertos conforme al programa de los Centros de Excelencia, llame a su asesor de atención de la salud al número telefónico que aparece en su tarjeta de identificación del plan. Si reúne los requisitos, se lo pondrá en contacto con el administrador del programa de Centros de Excelencia correspondiente para comenzar el proceso.

REQUISITOS GENERALES PARA PARTICIPAR EN EL PROGRAMA DE LOS CENTROS DE EXCELENCIA

Para participar en el programa de los Centros de Excelencia:

- Todos los servicios deben ser coordinados y aprobados por el administrador del programa de Centros de Excelencia correspondiente. El administrador o centro específico del que debe obtenerse la aprobación varía en función del servicio que se vaya a prestar y de su opción del AMP. Consulte la tabla **Centros de Excelencia** de la página anterior.
- El AMP cubre algunos servicios externos al programa de Centros de Excelencia con arreglo a los términos establecidos en el AMP. Sin embargo, hay algunos servicios que el AMP no cubre fuera del programa de Centros de Excelencia, a menos que usted haya solicitado y recibido una excepción. Consulte la tabla Centros de Excelencia de la página anterior. Estos servicios deben ser "preautorizados".
- Su solicitud de autorización previa será una reclamación previo al servicio (o reclamación urgente, si corresponde), como se describe en el capítulo **Reclamaciones y apelaciones**. Si rechazan su solicitud de autorización previa para obtener un servicio de los Centros de Excelencia, tiene derecho a apelar la decisión. Para obtener más información, consulte el capítulo **Reclamaciones y apelaciones**.
- El Centro de excelencia debe recibir los historiales clínicos pertinentes antes de ser aceptado en el programa de los Centros de Excelencia.
- Para la mayoría de los servicios cubiertos, debe poder viajar de manera segura para recibir atención médica y no debe requerir atención de emergencia al momento del viaje.
- El Centro de excelencia específico que proporciona los servicios cubiertos por el programa de los Centros de Excelencia se determina con base en el servicio indicado.
- Para la mayoría de los servicios ofrecidos conforme al programa de Centros de Excelencia, debe proporcionar la información de contacto de un proveedor local que haya aceptado controlar su atención de seguimiento luego de que regrese a su hogar de un Centro de excelencia.
- Para la mayoría de los servicios cubiertos, debe identificar a un cuidador designado que esté dispuesto y sea capaz de satisfacer los requisitos del cuidador, los cuales le explicará el administrador del programa Centros de Excelencia.
- Al realizar los servicios de evaluación o al tomar decisiones sobre la atención y el tratamiento de los Centros de Excelencia, que incluye si deben tratarlo o seguir dándole tratamiento, el Centro de excelencia no actúa como agente del AMP, sino como su proveedor de atención médica. El AMP no puede exigir a un proveedor del programa Centro de excelencia que le atienda. Si su conducta perturba la relación proveedor-paciente o si usted no sigue las instrucciones del proveedor, un proveedor puede negarse a atenderlo.
- Usted, su cuidador y cualquier visitante deben cumplir con todas las reglas y políticas del hotel, del servicio de transporte y del Centro de excelencia, incluidas las que se aplican a las comunicaciones y a la conducta en el lugar. Su incumplimiento podría dar lugar a la pérdida de elegibilidad para los beneficios en virtud del programa de los Centros de Excelencia. Toda comunicación o interacción con los centros de atención o el personal de los Centros de Excelencia que sea abusiva o perturbadora también puede resultar en la pérdida del derecho a los beneficios del programa Centros de Excelencia.
- Los servicios cubiertos que se presten en uno de los Centros de Excelencia que están fuera del ámbito de los servicios cubiertos por el programa de los Centros de Excelencia están sujetos a los términos y condiciones de cobertura regular del AMP, incluso si la facilita un proveedor de la red del AMP.
- Para reemplazo de cadera o rodilla o cirugía de columna, debe certificar que su lesión (si corresponde) no dará lugar a un litigio con un tercero, que no está sujeta a los derechos de subrogación y reembolso del AMP como se describe en el capítulo **Reclamaciones y apelaciones**, y que no es una lesión indemnizable, según lo define la ley de compensación del trabajador aplicable.
- Si tiene derecho o está cubierto por más de un plan médico, incluido Medicare (por ejemplo, si está inscrito en la Parte A de Medicare, pero no está inscrito en la Parte B), el AMP debe ser el pagador principal. Si existe la posibilidad de que cualquier otro plan médico sea o pudiera haber sido el pagador principal en cualquier circunstancia (si se hubiera inscrito en ese plan), comuníquese con el administrador del programa de los Centros de Excelencia que aparece en la tabla de la página anterior para obtener más información sobre su elegibilidad para el programa de los Centros de Excelencia.

Si el proveedor de los Centros de Excelencia determina que usted no es un candidato médicamente apropiado para los servicios de los Centros de Excelencia en ese Centro de excelencia en particular, el AMP puede pagar un beneficio por los servicios cubiertos bajo los términos del AMP que de otra forma fuesen aplicables, cuando se determine que usted es elegible médicamente para dichos servicios.

Si recibe los servicios de un proveedor de los Centros de Excelencia a través del programa de los Centros de Excelencia, se pueden proporcionar beneficios de viaje para desplazarse a uno de los Centros de Excelencia y pueden incluir el billete de avión, el millaje, el alojamiento y una asignación de gastos diarios para la comida y otros gastos, tanto para usted como para un cuidador. Los beneficios de viaje deben ser aprobados previamente y programarse a través del administrador del programa de los Centros de Excelencia (para los beneficios de viaje). Algunos beneficios de viaje se consideran ganancias imponibles y se reflejarán en su formulario W-2. Los beneficios de viaje están sujetos a los límites aplicables del IRS y del AMP.

SI RECIBE UN TRATAMIENTO ELEGIBLE FUERA DEL PROGRAMA DE LOS CENTROS DE EXCELENCIA

Si recibe servicios por una afección médica que son servicios cubiertos por el programa de Centros de Excelencia, de parte de: 1) un proveedor o una instalación que no sea un proveedor dentro de la red del AMP de los Centros de Excelencia, o 2) un proveedor o una instalación que sea un proveedor dentro de la red del AMP de los Centros de Excelencia, pero usted no trabaja a través del administrador del programa de Centros de Excelencia o no ha sido aprobado para el programa de Centros de Excelencia, usted estará sujeto a los términos que se resumen en la tabla **Centros de Excelencia** a la derecha más arriba en este capítulo, a menos que se le haya concedido una excepción. En algunos casos, en ausencia de una excepción, el AMP no cubrirá ningún beneficio si los servicios elegibles no se brindan a través del programa de Centros de Excelencia, incluso si los servicios los brinda un proveedor dentro de la red de TPA.

En circunstancias limitadas, el AMP proporciona cobertura fuera de la red para el reemplazo de cadera o rodilla, tal como se describe más adelante en la sección **Reemplazo de cadera o rodilla y cirugía de columna** y se resume en la tabla **Centros de Excelencia** de la página anterior.

Los servicios que recibe antes del ingreso y luego del alta de un Centro de excelencia, incluidos los servicios que están aprobados o recomendados por el proveedor del programa de Centros de Excelencia, estarán sujetos a los términos y condiciones de cobertura habituales del AMP.

REVISIÓN DEL HISTORIAL CLÍNICO DE CÁNCER, EVALUACIÓN EN EL LUGAR Y TRATAMIENTO

Si le han diagnosticado cáncer, excluyendo el cáncer de piel localizado, reúne los requisitos para el programa Centros de Excelencia para la revisión de historiales clínicos de cáncer, que puede incluir la evaluación y el tratamiento en el lugar por parte de Mayo Clinic:

- **Revisión de historiales clínicos.** Mayo Clinic revisará su historial clínico y hará una recomendación, basada en los historiales clínicos facilitados, de si una evaluación en el lugar se considera apropiada. La determinación de Mayo Clinic no está sujeta a los procedimientos de reclamación y apelación del AMP.
- **Evaluación en el sitio en Mayo Clinic para un posible tratamiento en Mayo Clinic.** Con base en la revisión de su historial clínico por parte de Mayo Clinic, Mayo Clinic puede recomendarle que viaje a Mayo Clinic para una evaluación en el lugar sobre un posible tratamiento en Mayo Clinic. Su viaje se facilitará a través del programa de Centros de Excelencia. La determinación de Mayo Clinic no está sujeta a los procedimientos de reclamación y apelación del AMP.
- **Tratamiento en Mayo Clinic.** Si Mayo Clinic recomienda tratamiento en Mayo Clinic, este tratamiento estará cubierto por el programa Centros de Excelencia, que pagará el 100 % del costo de los servicios cubiertos recibidos de Mayo Clinic. Los gastos médicos elegibles se pagarán antes de alcanzar el deducible de red anual, a menos que esté inscrito en la opción del Plan Saver. Si está inscrito en la opción del Plan Saver, debe alcanzar su deducible anual dentro de la red antes de que el AMP pague cualquier beneficio.

Si Mayo Clinic no recomienda el tratamiento en Mayo Clinic o usted opta por no participar en el programa de Centros de Excelencia, el AMP pagará el costo de los servicios cubiertos después de que satisfaga su deducible, sujeto a todos los demás términos y condiciones regulares de cobertura del AMP, incluso si recibe atención en Mayo Clinic fuera del programa de Centros de Excelencia.

FORMACIÓN DE FAMILIAS

El programa de los Centros de Excelencia para servicios de formación de familia ofrece beneficios de tratamiento de la fertilidad, que incluye la fertilización in vitro (FIV), la inseminación intrauterina (IIU) y otros servicios médicos y farmacéuticos aprobados que se describen a continuación, de las Clínicas Kindbody Signature. A menos que se indique algo diferente, los participantes deben ser mayores de 18 años.

Si usted es elegible para participar en el programa de los Centros de Excelencia y decide hacerlo, el AMP pagará el 75 % de los gastos médicos elegibles, incluidos los medicamentos para la fertilidad, para los servicios cubiertos recibidos de una Clínica Kindbody Signature a través del programa de los Centros de Excelencia para la formación de familias, después de que se cumpla su deducible de la red, hasta un beneficio máximo de por vida de $20,000. Los servicios cubiertos que se reciban a través del programa de los Centros de Excelencia están sujetos a los términos y condiciones habituales de cobertura del AMP, incluidos los términos aplicables a su deducible, coseguro y desembolso máximo, a menos que se disponga lo contrario. Consulte el **deducible anual** y **el desembolso máximo anual** en la sección **Evalúe sus opciones** anterior de este capítulo para conocer las excepciones.

El AMP no cubrirá ningún beneficio después de haber alcanzado el beneficio máximo de por vida de $20,000. El máximo de $20,000 es el monto de los beneficios pagados por cada participante individual del AMP. Este monto máximo de por vida del beneficio no se reajustará, incluso si usted deja su empleo y es contratado de nuevo, independientemente del momento en que deje el empleo o sea contratado de nuevo. Tampoco se restablecerá si actualmente es un dependiente elegible inscrito en el AMP y luego se convierte en un asociado de Walmart elegible directamente para inscribirse en la cobertura médica (o si actualmente es un asociado de Walmart inscrito en el AMP y luego se convierte en un dependiente elegible bajo la cobertura médica de otro asociado). El beneficio máximo de por vida de $20,000 no se aplica a los servicios ajenos al programa de los Centros de Excelencia que puedan estar cubiertos bajo otros términos y condiciones de cobertura del AMP, independientes del programa de los Centros de Excelencia.

Si usted no participa en el programa de los Centros de Excelencia, el AMP no cubrirá los servicios de tratamiento de la fertilidad que se reciban de un proveedor que no sea Kindbody o fuera del programa de los Centros de Excelencia, a menos que tales servicios estén cubiertos por otros términos y condiciones de cobertura del AMP.

Los servicios integrales de fertilidad cubiertos incluyen:

- Fertilización in vitro (FIV): tanto frescos como congelados
- Inseminación intrauterina (IIU)
- Transferencias de embriones congelados (FET)
- Descongelación de ovocitos congelados y fertilización
- Pruebas genéticas preimplantación (PGT-A; PGT-M, PGT-SR, etc.)
- Tratamientos de infertilidad masculina por azoospermia o antecedentes de vasectomía (TESE; PESE)
- Óvulos, embriones y esperma de donante (se consideran bienes imponibles)
- Criopreservación (congelación) de ovocitos (óvulos) /embriones/espermatozoides (si el paciente es menor de 18 años, Kindbody puede recomendarlo por razones médicas, como el almacenamiento de tejidos tras un diagnóstico de cáncer u otra afección médica). El pago por el almacenamiento de ovocitos/embriones/espermatozoides criopreservados de Kindbody se realizará durante un año. El pago de los años adicionales de almacenamiento por Kindbody será su responsabilidad.

Los medicamentos para la fertilidad se surtirán a través de la farmacia especializada de Kindbody, Schraft's Pharmacy, y se tramitarán a través de la cobertura médica del AMP, de acuerdo con los términos y condiciones de la cobertura del AMP, que incluye el beneficio máximo de por vida de $20,000.

Si está interesado en participar en el programa de los Centros de Excelencia para la formación de familias, debe ponerse en contacto llamando al número que figura en su tarjeta de identificación del plan. Para comenzar a desarrollar un plan de cuidado personalizado, primero tendrá una consulta inicial con un clínico de la Clínica Kindbody Signature, ya sea de forma virtual o en persona. Kindbody proporciona un navegador de atención al paciente dedicado a proporcionar apoyo para el programa para usted y su familia a lo largo de todo el proceso.

REVISIÓN ELECTRÓNICA DE CIRUGÍA CARDÍACA Y TRATAMIENTO

Antes de acceder a una cirugía de corazón que no sea de emergencia, es posible que desee considerar una revisión electrónica de Cleveland Clinic. Comuníquese con su asesor de atención de la salud al número que figura en su tarjeta de identificación del plan para iniciar el proceso de revisión electrónica. Si reúne los requisitos para la revisión electrónica de su historial clínico, Cleveland Clinic recomienda la cirugía cardiaca en el lugar y usted decide participar en el programa de Centros de Excelencia para cirugía cardiaca, se le pondrá en contacto con HealthSCOPE Benefits para organizar sus beneficios de viaje.

Si usted es elegible para participar en el programa de los Centros de Excelencia para la revisión electrónica, incluyendo la cirugía cardíaca en el sitio si lo recomienda Cleveland Clinic y usted decide hacerlo, el AMP pagará el 100 % del costo de los servicios cubiertos que se reciban a través del programa de los Centros de Excelencia. Los gastos médicos elegibles se pagarán antes de alcanzar el deducible, a menos que esté inscrito en la opción del Plan Saver. Si está inscrito en la opción del Plan Saver, debe alcanzar su deducible anual dentro de la red antes de que el AMP pague cualquier beneficio.

Si usted opta por no participar en el programa de los Centros de Excelencia, el AMP pagará el costo de los servicios cubiertos después de que se cumpla el deducible, sujeto a todos los demás términos y condiciones habituales de la cobertura del AMP.

REEMPLAZO DE CADERA O RODILLA Y CIRUGÍA DE COLUMNA

Si usted es elegible para participar en el programa de los Centros de Excelencia para el reemplazo de cadera o rodilla y la cirugía de columna vertebral, y decide hacerlo, el AMP pagará el 100 % del costo de los servicios cubiertos recibidos del proveedor y centro de atención del programa de Centros de Excelencia. Los gastos médicos elegibles se pagarán antes de alcanzar el deducible, a menos que esté inscrito en la opción del Plan Saver. Si está inscrito en la opción del Plan Saver, debe alcanzar su deducible anual dentro de la red antes de que el AMP pague cualquier beneficio.

Si es elegible para participar en el programa de los Centros de Excelencia para el reemplazo de cadera o rodilla y decide no hacerlo, el AMP puede pagar una parte del costo de los servicios cubiertos que reciba fuera del programa de los Centros de Excelencia, si solicita y recibe una excepción de la red. Si solicita y recibe una excepción de la red, como se indica a continuación, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia para el reemplazo de cadera o rodilla, con arreglo a los términos y condiciones habituales de cobertura del AMP. Si decide no participar en el programa de los Centros de Excelencia para el reemplazo de cadera o rodilla, y no recibe una excepción, el AMP solo podrá pagar beneficios limitados por los servicios cubiertos, de acuerdo con los términos descritos en la tabla **Centros de Excelencia** anterior de este capítulo y en la sección **Reemplazo de cadera o rodilla** a continuación.

Si es elegible para participar en el programa de los Centros de Excelencia para la cirugía de la columna vertebral y decide no hacerlo, el AMP no pagará el costo de ningún servicio recibido fuera del programa de los Centros de Excelencia, a menos que se solicite y reciba una excepción de la red.

Reemplazo de cadera o rodilla

Si decide no participar en el programa de los Centros de Excelencia para el reemplazo de cadera o rodilla, el AMP puede pagar solamente beneficios limitados por los servicios cubiertos si recibe tratamiento fuera del programa de los Centros de Excelencia. Si no tiene una excepción de la red, como se explica más adelante en este capítulo, los servicios recibidos fuera del programa de los Centros de Excelencia se considerarán generalmente fuera de la red, incluso si el proveedor es un proveedor dentro de la red de su AMP o de la red de su TPA.

En este caso, las condiciones de cobertura del programa de los Centros de Excelencia son las siguientes:

- Si está inscrito en la opción del **Plan Premier, Contribution o Saver**, una vez que alcance el deducible fuera de la red, el AMP pagará el 50 % de los gastos médicos que reúnan los requisitos de los servicios cubiertos, independientemente de que los servicios sean prestados por un proveedor dentro o de fuera de la red. Su coseguro no contará para su desembolso máximo en efectivo. Consulte la sección **Solicitudes de excepciones para las condiciones de cobertura para el reemplazo de cadera o rodilla o la cirugía de columna vertebral** de esta página para saber cómo solicitar una excepción de la red.
- Si está inscrito en una opción del **plan local**, el AMP no pagará el costo de ningún servicio recibido fuera del programa de los Centros de Excelencia, a menos que solicite y reciba una excepción. Consulte la sección **Solicitudes de excepciones para las condiciones de cobertura para el reemplazo de cadera o rodilla o la cirugía de columna vertebral** de esta página para saber cómo solicitar una excepción de la red.

Si solicita y recibe una excepción de la red, como se indica en la sección **Solicitudes de excepciones para las condiciones de cobertura para el reemplazo de cadera o rodilla o la cirugía de columna vertebral** de esta página, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia para el reemplazo de cadera o rodilla, con arreglo a los términos y condiciones habituales de cobertura del AMP.

Cirugía de columna

Si opta por no participar en el programa de los Centros de Excelencia para la cirugía de la columna vertebral, el AMP no pagará el costo de ningún servicio recibido fuera del programa de los Centros de Excelencia, a menos que se solicite y reciba una excepción de la red. Si solicita y recibe una excepción de la red, como se indica en la sección **Solicitudes de excepciones para las condiciones de cobertura para el reemplazo de cadera o rodilla o la cirugía de columna vertebral** de esta página, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia para la cirugía de la columna vertebral, de acuerdo a los términos y condiciones habituales de cobertura del AMP.

Fisioterapia para el reemplazo de cadera o rodilla y cirugía de columna vertebral

Si participa en el programa Centros de Excelencia para reemplazo de cadera o rodilla o cirugía de columna, es posible que tenga acceso a fisioterapia virtual. Este enfoque basado en aplicaciones está diseñado para ayudar a los participantes antes y después de los procedimientos quirúrgicos. Los servicios no tendrán costo para usted, antes de que satisfaga el deducible, a menos que esté inscrito en el Plan Saver. Si está inscrito en el Plan Saver, debe alcanzar su deducible anual dentro de la red antes de que el AMP pague cualquier beneficio. Este servicio no está disponible fuera del programa de los Centros de Excelencia, incluso cuando se concede una excepción de la red para el reemplazo de cadera o rodilla o la cirugía de columna vertebral. Comuníquese con Contigo Health, el administrador del programa, para obtener más detalles sobre este programa.

Solicitudes de excepciones para las condiciones de cobertura para el reemplazo de cadera o rodilla o la cirugía de columna vertebral

Puede solicitar una excepción para los términos y condiciones generales de cobertura de los Centros de Excelencia que se describieron anteriormente. Si usted solicita y recibe una excepción de la red, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia, después de satisfacer su deducible y sujeto a todos los demás términos y condiciones regulares de cobertura del AMP.

Dependiendo de si ya ha recibido los servicios al momento de solicitar una excepción a la red, su reclamación se tratará como una reclamación previo al servicio (“solicitud de excepción previa al servicio”) o como una reclamación posterior al servicio (“solicitud de excepción posterior al servicio”), tal como se describe detalladamente en la sección del capítulo **Reclamaciones y apelaciones** titulada **Cirugía de la columna vertebral y prótesis de cadera y rodilla: solicitud de excepción de la red para la cobertura fuera del programa de los Centros de Excelencia**. El proceso de excepción de la red se resume a continuación y se analiza con más detalle en la sección del capítulo **Reclamaciones y apelaciones** referenciado directamente arriba.

Solicitud de excepción de servicio previo: Si usted 1) aún no ha recibido un reemplazo de cadera o rodilla pero está considerando recibir servicios de un proveedor o una instalación que no pertenezca a los Centros de Excelencia, o 2) aún no ha recibido cirugía de columna vertebral, puede pedir una solicitud de excepción de red previa al servicio para recibir servicios en un proveedor o de una instalación que no pertenezca a los Centros de Excelencia y que el AMP pague el costo de los servicios cubiertos, sujeto a los términos y condiciones regulares de cobertura del AMP si:

- Existe un riesgo significativo de que el viaje al Centro de excelencia pueda provocar una parálisis o la pérdida de la vida, o
- El Centro de excelencia no recomienda el reemplazo de la cadera o la rodilla ni la cirugía de la columna vertebral porque no es el tratamiento médico adecuado, o porque usted no es un candidato adecuado para la cirugía.

Las solicitudes de excepción previa al servicio deben presentarse ante Contigo Health en la dirección indicada y de acuerdo con los procedimientos descritos en la sección del capítulo **Reclamaciones y apelaciones** titulada **Cirugía de la columna vertebral y prótesis de cadera y rodilla: solicitud de excepción de la red para la cobertura fuera del programa de los Centros de Excelencia**. Una Organización de Revisión Independiente revisará su solicitud. Si se acepta su solicitud, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia, sujeto a los términos y condiciones habituales de cobertura del AMP. Si se deniega su solicitud, se le permitirá presentar un recurso interno contra la denegación, que será determinado por una Organización de Revisión Independiente.

Su solicitud de apelación interna debe presentarse ante el AMP en la dirección indicada y de acuerdo con los procedimientos descritos en la sección del capítulo **Reclamaciones y apelaciones** titulada **Cirugía de la columna vertebral y prótesis de cadera y rodilla: solicitud de excepción de la red para la cobertura fuera del programa de los Centros de Excelencia**. Si se anula la denegación inicial y se acepta su solicitud, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia, sujeto a los términos y condiciones habituales de cobertura del AMP. Si se deniega su apelación interna, se le permitirá solicitar una revisión externa si la denegación se basó en el criterio médico.

Su solicitud de revisión externa de la denegación debe presentarse ante el AMP en la dirección indicada y de acuerdo con los procedimientos descritos en la sección del capítulo **Reclamaciones y apelaciones** titulada **Proceso de apelaciones externas para beneficios médicos, farmacéuticos o de Centros de Excelencia**.

Solicitud de excepción posterior al servicio: Si ya ha recibido los servicios de un proveedor o centro que no pertenece a los Centros de Excelencia, puede presentar una solicitud de excepción de la red posterior al servicio si sus circunstancias requerían una intervención quirúrgica inmediata, sin la cual probablemente habría sufrido parálisis o pérdida de la vida.

Las solicitudes de excepción posterior al servicio deben presentarse al AMP en la dirección y de acuerdo con los procedimientos descritos en la sección del capítulo **Reclamaciones y apelaciones** titulada **Cirugía de la columna vertebral y prótesis de cadera y rodilla: solicitud de excepción de la red para la cobertura fuera del programa de los Centros de Excelencia**. Una Organización de Revisión Independiente revisará su solicitud. Si se acepta su solicitud, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia, sujeto a los términos y condiciones habituales de cobertura del AMP. Si se deniega su solicitud, se le permitirá presentar un recurso interno contra la denegación, que será determinado por una Organización de Revisión Independiente.

Su solicitud de apelación interna debe presentarse ante el AMP en la dirección indicada y de acuerdo con los procedimientos descritos en la sección del capítulo **Reclamaciones y apelaciones** titulada **Cirugía de la columna vertebral y prótesis de cadera y rodilla: solicitud de excepción de la red para la cobertura fuera del programa de los Centros de Excelencia**. Si se anula la denegación inicial y se acepta su solicitud, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia, sujeto a los términos y condiciones habituales de cobertura del AMP. Si se deniega su apelación interna, se le permitirá solicitar una revisión externa si la denegación se basó en el criterio médico.

Su solicitud de revisión externa de la denegación debe presentarse ante el AMP en la dirección indicada y de acuerdo con los procedimientos descritos en la sección del capítulo **Reclamaciones y apelaciones** titulada **Proceso de apelaciones externas para beneficios médicos, farmacéuticos o de Centros de Excelencia**.

La decisión de un proveedor de los Centros de Excelencia de no realizar una cirugía de reemplazo de cadera o rodilla o de columna vertebral no está sujeta a revisión en virtud del proceso de solicitud de excepción de la red si la decisión del proveedor de los Centros de Excelencia se basa en su denegación a 1) seguir los términos y condiciones del Programa de los Centros de Excelencia, que incluye las normas y políticas enumeradas en otras partes de esta sección **Centros de Excelencia**, o 2) cumplir con las restricciones o requisitos médicos, incluidos, pero sin limitarse a, la pérdida de peso, dejar de fumar, dejar de beber alcohol, apoyo social, conducta o factores similares.

REVISIÓN DEL HISTORIAL CLÍNICO DE DIÁLISIS RENAL AMBULATORIA O DE ESRD

Si se le ha diagnosticado una enfermedad renal terminal (ERT), recibe diálisis renal o se le ha recomendado diálisis renal como tratamiento, reúne los requisitos para el programa Centros de Excelencia para diálisis renal o para la revisión del historial clínico de la ERT, que puede incluir la evaluación y el tratamiento en el sitio por parte de Mayo Clinic:

- **Revisión de historiales clínicos.** Mayo Clinic revisará su historial clínico y hará una recomendación, basada en los historiales clínicos facilitados, de si una evaluación en el lugar se considera apropiada. La determinación de Mayo Clinic no está sujeta a los procedimientos de reclamación y apelación del AMP.

- **Evaluación en el sitio en Mayo Clinic.** Con base en la revisión de su historial clínico por parte de Mayo Clinic, Mayo Clinic puede recomendarle que viaje a Mayo Clinic para una evaluación en el lugar sobre un posible tratamiento en Mayo Clinic. Su viaje se facilitará a través del programa de Centros de Excelencia. Mayo Clinic actúa como proveedor de atención para la salud, no como agente del AMP al realizar los servicios de evaluación, incluida la recomendación de una evaluación en persona o de tratamiento adicional en Mayo Clinic. La determinación de Mayo Clinic no está sujeta a los procedimientos de reclamación y apelación del AMP.
- **Tratamiento en Mayo Clinic.** Si Mayo Clinic recomienda tratamiento en Mayo Clinic, este tratamiento estará cubierto por el programa Centros de Excelencia, que pagará el 100 % del costo de los servicios cubiertos recibidos de Mayo Clinic. Los gastos médicos elegibles se pagarán antes de alcanzar el deducible de red anual, a menos que esté inscrito en la opción del Plan Saver. Si está inscrito en la opción del Plan Saver, debe alcanzar su deducible anual dentro de la red antes de que el AMP pague cualquier beneficio. Si Mayo Clinic recomienda un trasplante de riñón, la cobertura para un trasplante de riñón solamente está disponible conforme al programa de los Centros de Excelencia para trasplantes. Para obtener información, consulte **Trasplantes** más adelante en esta sección.

Si Mayo Clinic no recomienda el tratamiento en Mayo Clinic o usted opta por no participar en el programa de Centros de Excelencia, el AMP pagará el costo de los servicios cubiertos después de que satisfaga su deducible, sujeto a todos los demás términos y condiciones regulares de cobertura del AMP, incluso si recibe atención en Mayo Clinic fuera del programa de Centros de Excelencia.

Si se recomienda un trasplante, consulte la sección **Trasplantes** que aparece más adelante en este capítulo para conocer los términos y condiciones de los Centros de Excelencia aplicables a los servicios de trasplante.

TRASPLANTES

El programa de los Centros de Excelencia para trasplantes realizados en Mayo Clinic cubre trasplantes de hígado, riñón, corazón (incluidos los Dispositivos de asistencia ventricular [Ventricular Assist Devices, VAD] duraderos y los corazones totalmente artificiales), pulmón (incluida la cirugía de reducción de volumen pulmonar [Lung Volume Reduction Surgery, LVRS]), páncreas, riñón y páncreas de forma simultánea, órganos múltiples y de médula ósea o células madre (incluido el tratamiento con células T CAR).

Si es elegible para participar en el programa de los Centros de Excelencia para trasplantes, y decide hacerlo, el AMP pagará el 100 % del costo de los servicios cubiertos recibidos de Mayo Clinic. Los gastos médicos elegibles se pagarán antes de alcanzar el deducible, a menos que esté inscrito en la opción del Plan Saver. Si está inscrito en la opción del Plan Saver, debe alcanzar su deducible anual dentro de la red antes de que el AMP pague cualquier beneficio. Los servicios no relacionados con un trasplante, según determine Mayo Clinic, que se realicen en Mayo Clinic no están cubiertos por el programa de los Centros de Excelencia para trasplantes. Tales servicios estarán sujetos a los términos y condiciones de cobertura habituales del AMP. Esto incluye ciertos procedimientos de manga gástrica que se llevan a cabo en Mayo Clinic durante un trasplante de hígado.

Si es elegible para el programa de trasplantes de los Centros de Excelencia y decide no participar o si es elegible y decide recibir los servicios en otro lugar, el AMP no pagará el costo de ningún servicio recibido fuera del programa de los Centros de Excelencia, a menos que se solicite una excepción de la red y tal excepción sea otorgada.

Si solicita y recibe una excepción de la red, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia para trasplantes, con arreglo a los términos y condiciones habituales de cobertura del AMP. El proceso de excepción de la red se resume a continuación y se analiza con más detalle en la sección del capítulo **Reclamaciones y apelaciones** titulada **Servicios de trasplante: solicitud de excepción de la red para la cobertura fuera del programa de los Centros de Excelencia**.

La cobertura del programa de los Centros de Excelencia se limita al trasplante de órganos humanos. El AMP no cubre en ninguna circunstancia los trasplantes de partes del cuerpo (por ejemplo, cara, manos, pies, piernas, brazos, útero).

Gastos de los donantes de trasplantes: Por lo general, el AMP pagará los gastos médicos que reúnan los requisitos de los servicios cubiertos prestados a un receptor (que esté inscrito en la opción del AMP), a menos que otro plan médico o aseguradora cubra esos servicios. Solamente se cubren los servicios directamente relacionados con la condición de donante para el receptor (que está inscrito en la opción del AMP) (“servicios para el donante”). Si el donante es un donante vivo y requiere servicios postrasplante (directamente relacionado con el trasplante), el AMP pagará los gastos médicos elegibles para los servicios cubiertos.

El AMP pagará los gastos médicos elegibles de los servicios cubiertos del donante recibidos dentro de los 120 días siguientes a su trasplante al mismo nivel de beneficios que los servicios de trasplante.

También es posible que el AMP pague los gastos de viaje del donante, siempre y cuando tales gastos estén directamente relacionados con su condición de donante. Estos gastos de viaje suelen estar sujetos a los mismos términos y condiciones que se aplican a los beneficios de viaje disponibles para usted, el receptor. Antes de las citas, usted es responsable de proporcionar la información de contacto para el administrador del programa de los Centros de Excelencia al donante de trasplante elegible.

Los gastos de adquisición y obtención de órganos de cadáver solamente están cubiertos cuando se trata de gastos médicos elegibles en virtud del AMP.

Solicitudes de excepciones a las condiciones de cobertura de los trasplantes

Para recibir servicios de trasplante en un centro de atención que no sea Mayo Clinic, puede solicitar una excepción de la red previa al servicio para los términos y condiciones generales de cobertura de los Centros de Excelencia que se describieron anteriormente. Si usted solicita y recibe una excepción de la red previa al servicio, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia, después de satisfacer su deducible y sujeto a todos los demás términos y condiciones regulares de cobertura del AMP. El proceso de excepción de la red previa al servicio se resume a continuación y se analiza con más detalle en la sección del capítulo **Reclamaciones y apelaciones** titulada **Servicios de trasplante: solicitud de excepción de la red para la cobertura fuera del programa de los Centros de Excelencia**.

Solicitud de excepción de servicio previo: Si aún no ha recibido tratamiento, puede solicitar una excepción a la red previa al servicio para recibir servicios de trasplante de un proveedor o una instalación que no sea Mayo Clinic y que el AMP pague el costo de los servicios cubiertos, de acuerdo con los términos y condiciones regulares de cobertura del AMP si:

- Si existe un riesgo considerable de que el traslado hasta Mayo Clinic podría derivar en muerte, o
- Mayo Clinic no recomienda un trasplante porque no es un tratamiento médico adecuado o que usted no es un candidato apropiado para los servicios de trasplante.

Las solicitudes de excepción previa al servicio deben presentarse al AMP en la dirección y de acuerdo con los procedimientos descritos en la sección del capítulo **Reclamaciones y apelaciones** titulada **Servicios de trasplante: solicitud de excepción de la red para la cobertura fuera del programa de los Centros de Excelencia**. Una Organización de Revisión Independiente revisará su solicitud. Si se acepta su solicitud, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia, sujeto a los términos y condiciones habituales de cobertura del AMP. Si se deniega su solicitud, se le permitirá presentar un recurso interno contra la denegación, que será determinado por una Organización de Revisión Independiente.

Su solicitud de apelación interna debe presentarse ante el AMP en la dirección indicada y de acuerdo con los procedimientos descritos en la sección del capítulo **Reclamaciones y apelaciones** titulada **Servicios de trasplante: solicitud de excepción de la red para la cobertura fuera del programa de los Centros de Excelencia**. Si se anula la denegación inicial y se acepta su solicitud, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia, sujeto a los términos y condiciones habituales de cobertura del AMP. Si se deniega su apelación interna, se le permitirá solicitar una revisión externa si la denegación se basó en el criterio médico.

Su solicitud de revisión externa de la denegación debe presentarse ante el AMP en la dirección indicada y de acuerdo con los procedimientos descritos en la sección del capítulo **Reclamaciones y apelaciones** titulada **Proceso de apelaciones externas para beneficios médicos, farmacéuticos o de Centros de Excelencia**.

El rechazo de trasplantes por parte de Mayo Clinic no está sujeto a revisión en virtud de este proceso si Mayo Clinic decide no: 1) tratarlo debido a su negativa por respetar los términos y las condiciones del programa de Centros de Excelencia, incluyendo las reglas y políticas enumeradas en otras partes de esta sección **Centros de Excelencia**, o 2) bien determina que el trasplante no es apropiado porque usted se niega a cumplir con las restricciones o los requisitos médicos, incluidos, entre otros, perder peso, dejar de fumar, dejar de consumir bebidas alcohólicas, recibir apoyo social o factores similares.

Solicitud de excepción de servicio posterior: Si ya ha recibido un trasplante porque requería un trasplante inmediato debido a sus circunstancias, sin el cual probablemente habría sufrido la pérdida de la vida, puede solicitar que el AMP pague los beneficios de un trasplante recibido en un centro distinto a Mayo Clinic en los términos que sean aplicables, presentando una reclamación posterior al servicio.

Las solicitudes de excepción posterior al servicio deben presentarse al AMP en la dirección y de acuerdo con los procedimientos descritos en la sección del capítulo **Reclamaciones y apelaciones** titulada **Servicios de trasplante: solicitud de excepción de la red para la cobertura fuera del programa de los Centros de Excelencia**. Una Organización de Revisión Independiente revisará su solicitud. Si se acepta su solicitud, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia, sujeto a los términos y condiciones habituales de cobertura del AMP. Si se deniega su solicitud, se le permitirá presentar un recurso interno contra la denegación, que será determinado por una Organización de Revisión Independiente.

Su solicitud de apelación interna debe presentarse ante el AMP en la dirección indicada y de acuerdo con los procedimientos descritos en la sección del capítulo **Reclamaciones y apelaciones** titulada **Servicios de trasplante: solicitud de excepción de la red para la cobertura fuera del programa de los Centros de Excelencia**. Si se anula la denegación inicial y se acepta su solicitud, el AMP pagará el costo de los servicios cubiertos recibidos fuera del programa de los Centros de Excelencia, sujeto a los términos y condiciones habituales de cobertura del AMP. Si se deniega su apelación interna, se le permitirá solicitar una revisión externa si la denegación se basó en el criterio médico.

Su solicitud de revisión externa de la denegación debe presentarse ante el AMP en la dirección indicada y de acuerdo con los procedimientos descritos en la sección del capítulo **Reclamaciones y apelaciones** titulada **Proceso de apelaciones externas para beneficios médicos, farmacéuticos o de Centros de Excelencia**.

BENEFICIO DE LA CIRUGÍA PARA LA PÉRDIDA DE PESO

Las siguientes cirugías para la pérdida de peso están cubiertas por el programa de los Centros de Excelencia, para cirugía para la pérdida de peso: derivación gástrica, manga gástrica y cruce duodenal. Debe tener al menos 14 años para participar. Los servicios deben ser brindados por un centro de atención de los Centros de Excelencia designados por el AMP.

Si usted es elegible para participar en el programa de los Centros de Excelencia para la cirugía de pérdida de peso y decide hacerlo, el AMP pagará el 75 % del costo de los servicios cubiertos recibidos del proveedor y el centro de atención del programa de los Centros de Excelencia después de que usted satisfaga su deducible dentro de la red.

Si usted es elegible para participar en el programa de los Centros de Excelencia para la cirugía de pérdida de peso y decide no hacerlo, el AMP no pagará el costo de ningún servicio recibido fuera del programa de los Centros de Excelencia. No se aplica ninguna excepción.

Para participar en los Centros de Excelencia para la cirugía de pérdida de peso, debe cumplir los siguientes requisitos:

- Usted debe cumplir alguno de los siguientes requisitos:
  - Un índice de masa corporal (IMC) de 40 o más, o
  - Un IMC de 35 o superior y al menos un factor de comorbilidad relacionado con la obesidad (diabetes de tipo 2, hipertensión, enfermedad cardiovascular, etc.).
- Debe comprometerse a cumplir todos los requisitos mientras dure el tratamiento de cirugía de pérdida de peso, incluidas las reglas y políticas enumeradas en otras partes de este capítulo.

Si cumple con los requisitos establecidos anteriormente y el médico le recomienda la cirugía para la pérdida de peso, llame a su asesor de atención de la salud al número que aparece en su tarjeta de identificación del plan a fin de obtener un Formulario de solicitud, el cual debe completar usted y su médico. Debe enviar el Formulario de solicitud completado a Contigo Health a la dirección que figura en el formulario. La presentación del formulario es la presentación de una solicitud de autorización previa con Contigo Health. Contigo Health determinará su reclamación de autorización previa según los procedimientos para las reclamaciones previas al servicio que se describen en el capítulo **Reclamaciones y apelaciones**.

Si se sometió a una cirugía de pérdida de peso o a un procedimiento para la pérdida de peso, y ahora necesita la revisión quirúrgica debido a complicaciones médicas, puede solicitar la evaluación del beneficio de cirugías para la pérdida de peso a cargo de un Centro de Excelencia para determinar si cumple con los criterios médicos para una revisión o para cambiar a una cirugía cubierta para la pérdida de peso. Deberá presentar documentación para demostrar que cumplió con los criterios clínicos requeridos para la cirugía bariátrica antes de la intervención o cirugía original. Comuníquese con Contigo Health para más información.

Periodo de espera 12 meses

A fin de ser elegible para participar en el programa de los Centros de Excelencia para la cirugía de pérdida de peso, debe estar inscrito en el AMP durante al menos 12 meses. Si está inscrito en el plan PPO o en una opción del plan HMO, no es elegible para el programa de los Centros de Excelencia para la cirugía de pérdida de peso que se describe en este capítulo. No obstante, si posteriormente se inscribe en una de las opciones de AMP elegibles, el tiempo que haya estado inscrito en el plan PPO o en una opción del plan HMO contará para el periodo de espera de 12 meses. El tiempo que esté inscrito en un seguro contra accidentes o por enfermedades críticas no se contará para el periodo de espera de 12 meses.

El periodo de espera de 12 meses se aplica a usted y, por separado, a cada uno de sus dependientes cubiertos que tengan al menos 14 años; esto significa que cada persona cubierta debe satisfacer su propio periodo de espera de 12 meses. Todo el tiempo que haya estado inscrito en el AMP antes de cumplir los 14 años cuenta para el periodo de espera de 12 meses.

El periodo de espera de 12 meses se omite para los asociados localizados y sus dependientes con cobertura.

Si ya estaba inscrito en el AMP y la cobertura finalizó por cualquier motivo después de haber satisfecho el periodo de espera de 12 meses (por ejemplo, si dejó de trabajar y fue contratado de nuevo o si abandonó voluntariamente la cobertura), su periodo anterior de inscripción en el AMP contará para el periodo de espera de 12 meses. No obstante, si no había cumplido el periodo de espera de 12 meses antes de la finalización de la cobertura, el tiempo anterior de inscripción en el AMP no contará para el periodo de espera de 12 meses y deberá satisfacer un nuevo periodo de espera de 12 meses tras su reinscripción.

COORDINACIÓN LIMITADA DE LOS BENEFICIOS

Por lo general, el AMP no coordina los beneficios en relación con las reclamaciones conforme al programa de los Centros de Excelencia, excepto la coordinación con Medicare en el caso de ciertos beneficios en materia de trasplantes o según lo exija la ley.

En el caso de todos los demás servicios de los Centros de Excelencia, si una parte de un beneficio de los Centros de Excelencia podría haber sido pagada por otro de salud, incluido Medicare Parte A o Parte B como plan principal, el AMP no pagará el monto de la reclamación.

Diabetes y control metabólico por Twin Health

Si le han diagnosticado diabetes de tipo 2, es posible que reúna los requisitos para el programa Diabetes and Metabolic Management de Twin Health. Las metas de este programa clínico digital y de telemedicina son ayudarle a mejorar su salud, perder peso, controlar la diabetes y otras afecciones metabólicas crónicas, y reducir su necesidad de tomar medicamentos con receta. La participación es voluntaria y Twin Health debe determinar que usted satisface los requisitos del programa. Debe tener al menos 18 años para participar y disponer de un teléfono inteligente que sea compatible. El programa se le ofrece sin costo alguno.

Si decide participar en el programa, Twin Health utilizará dispositivos inteligentes y portátiles para recopilar datos en tiempo real que le ayuden a desarrollar su "Gemelo digital", que replica su metabolismo y predice cómo responde su organismo a la comida, el ejercicio, el sueño, el estrés y otros factores ambientales y de estilo de vida. Con base en esta información, Twin Health le ofrece recomendaciones personalizadas y basadas en pruebas para ayudarle a llevar un estilo de vida más saludable.

- **Educación y proceso de admisión:** Si está interesado en inscribirse en el programa Twin Health, primero debe descargar la aplicación Twin Health y aceptar los términos del programa Twin, incluyendo las prácticas de privacidad. Luego, podrá programar una llamada con Twin Health para determinar su elegibilidad inicial.
- **Inscripción y adecuación médica:** Twin Health evaluará si usted es médicamente adecuado como candidato para los servicios del programa, y para esto, le hará preguntas sobre su salud y su estilo de vida, como la dieta, el ejercicio, el sueño y la gestión del estrés, la obtención de análisis de sangre, y la revisión de sus análisis de laboratorio. Tenga en cuenta que ciertas condiciones, como el embarazo, el cáncer y la insuficiencia renal terminal, pueden significar que el programa Twin Health no es médicamente adecuado para usted. Si Twin Health considera que usted no es un candidato adecuado desde el punto de vista médico, puede plantearse participar en un programa alternativo en virtud del AMP, tal como a través de Agile Health, para apoyar su salud metabólica y diabética.
- **Dispositivos portátiles:** Una vez inscrito, Twin Health le enviará por correo uno o varios dispositivos portátiles para que los utilice mientras esté inscrito en el programa. Estos dispositivos pueden ser un monitor continuo de glucosa (MCG), una báscula digital de composición corporal, un esfigmomanómetro digital y un monitor de actividad. Twin le ayudará a sincronizar estos dispositivos con su aplicación Twin, y los datos le ayudarán a desarrollar a su gemelo (Twin) para ofrecerte recomendaciones diarias personalizadas. Algunos dispositivos pueden estar sujetos a los impuestos aplicables si no los devuelve al final de su participación en el programa cuando se le solicite que lo haga.
- **Participación en el programa.** Su participación en el programa requerirá que se comprometa activamente con el equipo de atención de Twin Health, que consiste de médicos, proveedores de práctica avanzada y entrenadores de salud certificados que coordinarán su atención con su proveedor de atención primaria y sus especialistas. Su compromiso incluye hablar o charlar con el equipo de asistencia de Twin Health, registrar los alimentos que consume, someterse a análisis de sangre trimestrales, adoptar recomendaciones sobre el estilo de vida (es decir: dieta y ejercicio) y revisar los medicamentos de acuerdo con los protocolos basados en la evidencia. Si necesita abandonar el programa, existe un periodo de gracia de 60 días coordinado por Twin Health. Si no reanuda su participación a los 60 días, se le dará de baja y deberá completar de nuevo la evaluación inicial para determinar si puede volver a participar.
- **Metas del programa.** La finalidad del programa es ayudarle a construir un estilo de vida saludable que fomente la actividad, la nutrición, la flexibilidad, la fuerza, el peso saludable, la mejora del control glucémico, la reducción de la A1C y la disminución de la dependencia de medicamentos para afecciones metabólicas como la diabetes. Cuando la salud física, el estado de ánimo, los niveles de energía y el sueño mejoran, la salud mental y el bienestar general también pueden mejorar.
- **Ayuda con el copago:** Si participa activamente en el programa, se reducirán sus copagos para medicamentos específicos relacionados con la diabetes. Si Twin Health determina que usted no es un candidato adecuado desde el punto de vista médico o si deja de participar en Twin Health, podrá obtener la misma ayuda para el copago mediante la participación en un programa alternativo dentro del AMP, como por ejemplo a través de Agile Health, siempre y cuando participe activamente. (consulte **Autocuidado de la diabetes** en la sección **Navegar sus beneficios** que sigue).

Asistencia en el control de su salud

Además de los servicios específicos cubiertos analizados en las secciones anteriores, hay una serie de servicios que se ofrecen en el AMP que lo ayudan a poner todos los beneficios del AMP a su servicio. En la tabla que figura a continuación y en las páginas siguientes se describen estos programas y servicios. Tenga en cuenta que algunos servicios están ubicados solo con ciertas opciones de planes, según se indica. Si está inscrito en la opción de Plan PPO totalmente asegurado, algunos de estos programas también están disponibles para usted, como se describe en el cuadro. Todos los servicios son voluntarios y están disponibles sin costo alguno para usted, a menos que se indique lo contrario.

NAVEGAR SUS BENEFICIOS

GUÍA PARA PROVEEDORES DE EMBOLD HEALTH

La Guía para proveedores de Embold Health está disponible para ayudarle a seleccionar un proveedor, ya que incluye la evaluación de Embold Health sobre el grado en que un proveedor sigue las normas médicas de atención basadas en la evidencia. La finalidad de la información que se incluye en la Guía para proveedores de Embold Health es proporcionarle información adicional que puede tener en cuenta al elegir al proveedor adecuado para sus necesidades del cuidado de la salud en particular. La evaluación de Embold Health se proporciona solo para aquellos proveedores que han firmado contratos con su TPA para ser incluidos en la red del TPA. Las evaluaciones de Embold Health se basan en datos históricos de rendimiento clínico de visitas de pacientes anteriores. Las evaluaciones no tienen en cuenta sus necesidades específicas de cuidado de la salud ni sus afecciones médicas y no constituyen una garantía de la calidad de la atención que recibirá en el futuro de un proveedor que Embold Health haya evaluado. Otros factores también pueden ser relevantes al elegir un proveedor, como la conveniencia geográfica y los tiempos de espera para las citas. Las evaluaciones de los proveedores son creadas únicamente por Embold Health, no por Walmart ni por el Plan.

Embold Health es una compañía de análisis del cuidado de la salud dirigida por médicos que utiliza datos objetivos de rendimiento clínico a nivel de proveedor individual para comparar cómo el proveedor usa las pruebas diagnósticas, las recomendaciones de tratamientos adecuados y los resultados generales de los pacientes con los de sus pares a nivel nacional. Se evalúa a los proveedores individuales utilizando medidas de calidad específicas que indican en qué medida siguen las normas de atención médica basadas en la evidencia. Solo se revisan los proveedores de las siguientes especialidades: cirugía bariátrica, cardiología, dermatología, endocrinología, gastroenterología, cirugía general, cirugía pulmonar, neurología, obstetricia, oftalmología, ortoarticular, pediatría, podología, atención primaria, neumología, cirugía de la columna vertebral y urología. Otras especialidades pueden agregarse de vez en cuando. Puede consultar la lista completa de medidas de calidad del rendimiento que Embold Health utiliza para su evaluación de todas las especialidades visitando la Guía del proveedor de Embold Health y seleccionando “Medidas de calidad del rendimiento” en el menú “Soporte” de la parte superior de la página.

Embold Health utiliza un conjunto de datos que abarca un periodo de cuatro años y 200 millones de vidas. Solo se otorgará una puntuación de rendimiento a un proveedor individual si tal proveedor tiene al menos 10 observaciones en al menos cuatro medidas de calidad aplicables a su especialidad médica en las que pueda medirse la utilización y/o los resultados para esa medida de calidad en particular.

Embold Health se reunirá con cualquier proveedor que lo solicite para responder a preguntas sobre su puntaje individual y los datos en los que se basa.

Visite **IncludedHealth.com/Walmart** para ver la Guía de proveedores de Embold Health, que incluye un directorio de proveedores y la evaluación de Embold Health de proveedores individuales. Included Health luego lo dirigirá a la Guía de proveedores de Embold Health.

Este servicio está disponible para usted si se cumplen los siguientes requisitos:

- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver:

DIRECTORIOS DE PROVEEDORES Y HERRAMIENTAS DE COMPARACIÓN DE PRECIOS

También puede encontrar directorios de proveedores en el sitio web de su administrador externo:

- **aetna.com**
- **blueadvantagearkansas.com**
- **UMR.com**

Estos directorios incluyen una lista de proveedores de la red, pero no incluyen la evaluación de Embold Health de los proveedores individuales. Visite **IncludedHealth.com/Walmart** si está inscrito en la opción del plan Premier, Contribution o Saver para visitar la Guía de proveedores de Embold Health, que incluye un directorio de proveedores y la evaluación de Embold Health de proveedores individuales. Included Health luego lo dirigirá a la Guía de proveedores de Embold Health.

Puede encontrar una herramienta de comparación de precios en **IncludedHealth.com/Walmart**.

Asegúrese de verificar también **One.Walmart.com/health**.

Estos servicios están disponibles para usted si se cumplen los siguientes requisitos:

- Está inscrito en la opción de Plan Premier, Plan Contribution, Plan Saver, Banner o la opción de plan local de Mercy Arkansas o Plan PPO.

NAVEGAR SUS BENEFICIOS

ASESOR DE ATENCIÓN DE LA SALUD

Su asesor de atención de la salud es su único punto de contacto para todas las consultas. Según la naturaleza del problema, el asesor responderá sus preguntas o lo guiará para que se comunique con el lugar correcto. Llame al número de su asesor de atención de la salud que figura en su tarjeta de identificación del plan.

Este servicio está disponible para usted si se cumplen los siguientes requisitos:

- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, Banner o la opción de plan local de Mercy Arkansas o Plan PPO.

INCLUDED HEALTH: BÚSQUEDA DE PROVEEDORES, SEGUNDAS OPINIONES Y DEFENSA DE RECLAMACIONES

Included Health ofrece varias herramientas y servicios para ayudarle a repasar sus beneficios, incluyendo una herramienta de autoservicio para ayudarle a encontrar un proveedor de la red del TPA, un servicio de segunda opinión de expertos y un servicio de defensa de reclamaciones para ayudarle a comprender el aspecto financiero de sus reclamaciones de beneficios. Puede inscribirse ingresando a **IncludedHealth.com/Walmart** o llamando a IncludedHealth.com al **800-941-1384**. También se puede descargar la aplicación Included Health desde App Store o Google Play. El uso de la herramienta Included Health no tiene ningún costo, pero cualquier gasto médico en el que incurra como resultado del uso de estos servicios y herramientas estará sujeto a los términos y condiciones regulares de AMP.

Herramienta de autoservicio de Included Health: Si está inscrito en la opción del plan Premier, Contribution o Saver, Included Health lo derivará a la Guía de proveedores de Embold Health. Si está inscrito en un plan local o en el plan PPO, puede utilizar la herramienta de autoservicio para buscar proveedores de la red del TPA.

Este servicio está disponible para usted si se cumplen los siguientes requisitos:

- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, Banner o la opción de plan local de Mercy Arkansas o Plan PPO.

Apoyo en vivo de Included Health: Llame a Included Health al **800-941-1384** para que lo ayuden a programar y a prepararse para una cita.

Este servicio está disponible para usted si se cumplen los siguientes requisitos:

- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, Banner o la opción de plan local de Mercy Arkansas o Plan PPO.

Segundas opiniones de expertos

Los participantes y dependientes inscritos en el AMP pueden ser elegibles para obtener una segunda opinión de un experto con Included Health. En ciertos casos, cuando haya recibido un diagnóstico o le hayan recomendado una intervención quirúrgica o un tratamiento en particular.

Este servicio está disponible para usted si se cumplen los siguientes requisitos:

- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, Banner o la opción de plan local de Mercy Arkansas o Plan PPO.

Defensa de reclamaciones

El equipo de atención de Included Health puede ayudarle con los temas financieros de las reclamaciones médicas. Los expertos especializados en reclamaciones pueden responder las preguntas que tenga sobre facturas médicas o explicaciones de beneficios, organizar la documentación relacionada con el seguro, auditar los costos del proveedor y del hospital, abogar en su nombre para resolver los errores de facturación y negociar con los proveedores y las compañías de seguro, según sea necesario, con respecto a los rechazos de reclamaciones.

Este servicio está disponible para usted si se cumplen los siguientes requisitos:

- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver:

NAVEGAR SUS BENEFICIOS

INCLUDED HEALTH: BENEFICIO DE VIAJE PARA CUIDADOS

(No aplicable a los beneficios del programa de los Centros de Excelencia)

En algunos casos, el AMP puede consultar con Included Health para determinar si tiene derecho a un beneficio por desplazamiento para atención en el que se requiere una visita en persona. Es posible que reúna los requisitos para el beneficio si:

- Usted reside a más de 100 millas de un proveedor que tenga suficiente experiencia para facilitar los servicios cubiertos necesarios, según la definición de Included Health.
- Usted reside en un estado en el que está prohibido que un proveedor que tenga suficiente experiencia preste los servicios cubiertos necesarios y usted reside a más de 100 millas de un proveedor que Included Health haya determinado que sí tiene experiencia suficiente y está legalmente autorizado a prestar los servicios cubiertos necesarios.

Si es elegible, el AMP pagará los gastos de viaje cubiertos para trasladarse al proveedor identificado por Included Health. Los beneficios de viaje pueden incluir el billete de avión, el millaje, el alojamiento y un viático diario para la comida y otros gastos, tanto para usted como para el cuidador. Algunos beneficios de viaje se consideran ganancias imponibles y se reflejarán en su formulario W-2. Los beneficios de viaje están sujetos a los límites aplicables del IRS y del AMP.

El beneficio de viaje solamente está disponible para la atención médica o de salud mental, según lo determine Included Health. No incluye lo siguiente, pero esta no es una lista exhaustiva:

- Servicios que no están cubiertos por el AMP
- Servicios cubiertos por el programa de los Centros de Excelencia
- Servicio de audiología para obtener audífonos/dispositivos
- Ensayos clínicos que no están obligados a ser cubiertos por la Ley de Cuidado de Salud Asequible (Affordable Care Act)
- Servicios dentales
- Atención en centros de cuidados paliativos
- Podología para fines de plantillas, juanetes, etc.
- Cirugía reconstructiva (no relacionada con el cáncer de mama)
- Servicios de la visión relacionados con los controles rutinarios de la visión

Included Health debe aprobar previamente los beneficios de viaje para la atención. Si Included Health determina que usted es elegible para el beneficio de viaje, Included Health identificará a un proveedor que tenga suficiente experiencia para facilitar los servicios cubiertos necesarios que esté más cerca de su residencia y, a su solicitud, le ayudará a programar una cita con el proveedor identificado.

El beneficio de viaje para atención facilita un beneficio de viaje solamente para el desplazamiento al proveedor identificado por Included Health. Si Included Health da aprobación previa para el viaje, tal aprobación previa se aplica únicamente a los gastos de viaje que pague el AMP en virtud de este beneficio. No se aplica a los servicios que pueda recibir del proveedor identificado en el destino del viaje, los cuales están sujetos a todos los términos y condiciones de cobertura aplicables del AMP, incluidas las limitaciones y exclusiones.

Si opta por no viajar al proveedor identificado para recibir los servicios, o si Included Health no da aprobación previa para el viaje, el AMP no pagará los gastos de viaje, incluso si se hubieran proporcionado al recibir aprobación previa.

Si se concede aprobación previa para los beneficios de viaje, HealthSCOPE Benefits debe organizarlos previamente.

Ni Included Health ni el AMP pueden garantizar que el proveedor identificado en el destino del viaje acepte facilitar los servicios cubiertos, y ni Included Health ni el AMP son responsables de las decisiones sobre los servicios que usted pueda recibir del proveedor identificado. Las decisiones sobre la atención médica del proveedor identificado son entre usted y tal proveedor.

Si desea confirmar su derecho a los beneficios de viaje, llame al número que figura en su tarjeta de identificación del plan. Included Health determinará si tiene derecho al beneficio de viaje. Si no está de acuerdo con la decisión de elegibilidad de Included Health, puede presentar una reclamación de beneficios previa al servicio. Consulte **Presentar una reclamación de beneficios de viaje por atención** al final de este capítulo para más información.

Este servicio está disponible para usted si se cumplen los siguientes requisitos:

- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, o en la opción de plan local de Mercy Arkansas o Banner.

NAVEGAR SUS BENEFICIOS

SALUD PARA TODOS

Included Health le brindará asistencia para encontrar proveedores de atención médica que reconozcan a la comunidad LGBTQ+ y negra o afroamericana dentro de la red. También recibirá servicios de defensa y apoyo para ayudarlo con preguntas familiares, sociales y laborales relacionadas con ser parte de la comunidad LGBTQ+. Puede inscribirse en IncludedHealth.com/Walmart o por teléfono al **800-941-1384**.

Este servicio está disponible para usted si se cumplen los siguientes requisitos:
- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, Banner o las opciones de plan local de Mercy Arkansas o Plan PPO.

CONTROL DE LA ATENCIÓN

Cuenta con el beneficio de los servicios voluntarios de gestión del cuidado, incluido un equipo médico personal. La administración de la atención aporta coherencia en toda la gama de atención y servicios que se le proporcionan en virtud del AMP. La administración de la atención tiene como objetivo observar al individuo en su totalidad en vez de analizar solo los síntomas o las afecciones que se diagnostican por separado. Esto puede dar como resultado una atención de mayor calidad, mejoras en la experiencia con los proveedores, así como también una posible disminución de los gastos médicos en efectivo.

Entre algunas de las circunstancias en las que un administrador de la atención puede trabajar con usted, se incluyen las siguientes:
- Está enfermo o lesionado y hospitalizado
- Tiene una cirugía programada
- Descubre que tiene una enfermedad crónica o viene enfrentando una enfermedad crónica en curso
- Tiene un trastorno relativo a la salud mental o al abuso de sustancias
- Le indican varios medicamentos recetados con posibles interacciones.
- Simplemente tiene una pregunta sobre su salud
- Vuelve del hospital y necesita ayuda para entender el plan de alta, o
- Está participando en el programa de maternidad Vida con Bebé o un programa de maternidad similar que ofrecen ciertas opciones de planes locales

Su administrador de atención, junto con el equipo médico, puede aprobar determinados servicios médicamente necesarios que de otro modo no están cubiertos por el AMP ya que exceden un límite en cuanto al tratamiento (es decir, cantidad de días o consultas). Las reglas del AMP con respecto a los deducibles anuales y el coseguro se continuarán aplicando a cualquier beneficio adicional que apruebe el programa de administración de la atención. Los servicios también deben ser médicamente necesarios.

Su equipo médico también puede revisar los costos médicos por los servicios "involuntarios" fuera de la red. En algunos casos, los beneficios fuera de la red pueden pagarse como beneficios dentro de la red (consulte más arriba en este capítulo **Cuándo se pagan beneficios de la red para servicios fuera de la red**). En otros casos, su TPA puede negociar con los proveedores que no son parte de la red antes o después del beneficio de los servicios para reducir los cargos facturados de los que usted es responsable en virtud del beneficio fuera de la red del AMP. No se garantiza que se produzca una reducción de sus costos fuera de la red.

Si se comunica con el asesor de atención de la salud o asistente personal de salud, según la naturaleza de su pregunta, es posible que lo deriven a su administrador de atención. En otras ocasiones, es posible que el administrador de atención se comunique con usted, por ejemplo, para invitarlo a participar en el programa de control de la salud o para ayudarlo a encontrar ciertos recursos y servicios en su comunidad.

Para comunicarse con su administrador de atención, llame a su asesor de atención de la salud o asistente personal de salud al número que figura en su tarjeta de identificación del plan. La participación en el programa es voluntaria y no afecta su elegibilidad para participar en el AMP.

Este servicio está disponible para usted si se cumplen los siguientes requisitos:
- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, Banner o la opción de plan local de Mercy Arkansas o Plan PPO.

ORIENTACIÓN A LO LARGO DEL CUIDADO

Se le pueden ofrecer servicios voluntarios de orientación a lo largo del cuidado, incluido un equipo médico personal especializado. La orientación a lo largo del cuidado va más allá del beneficio de gestión del cuidado, ya que le ofrece asistencia personalizada para toda la gama de servicios cubiertos por el plan AMP. La meta de la orientación a lo largo del cuidado es proporcionarle servicios mejorados, que pueden incluir programación de citas, acompañamiento a citas médicas, visitas a domicilio, seguimiento a distancia y colaboración con recursos comunitarios locales.

Entre algunas de las circunstancias en las que una navegación de la atención puede trabajar con usted, se incluyen las siguientes:
- Está enfermo o lesionado y hospitalizado
- Tiene una cirugía programada
- Corre el riesgo de desarrollar una enfermedad
- Descubre que tiene una enfermedad crónica o viene enfrentando una enfermedad crónica en curso
- Tiene un trastorno relativo a la salud mental o al abuso de sustancias

Si reúne los requisitos, su navegador de atención se va a comunicar con usted para invitarlo a participar en el programa o para ayudarlo a encontrar ciertos recursos y servicios en su comunidad. La participación en el programa es totalmente voluntaria.

Este servicio puede estar disponible para usted si se cumplen todos los siguientes requisitos:
- Vive en ciertas áreas de Arizona, Florida, Georgia, Illinois, Oklahoma o Texas;
- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver; y
- Su TPA es Aetna o BlueAdvantage Administrators of Arkansas

NAVEGAR SUS BENEFICIOS

ATENCIÓN PRIMARIA VIRTUAL

Además de usar Doctor On Demand de Included Health para telesalud por video a fin de recibir atención de urgencia y servicios de salud mental, también puede utilizar Doctor On Demand para atención primaria virtual. Puede obtener ayuda con sus necesidades de salud cotidianas o problemas de salud graves en curso por parte de un médico de atención primaria virtual que puede derivarlo a especialistas clínicos cuando sea necesario. Si su proveedor de atención primaria virtual ordena análisis, puede realizar algunos de ellos desde la comodidad de su hogar a través de Quest Diagnostics. No todos los análisis de laboratorio pueden hacerse desde casa. Los análisis de laboratorio que se pueden hacer desde casa son gratuitos para usted, antes de que alcance su deducible si está inscrito en la opción del plan Premier, Contribution, o Banner o Mercy Arkansas Local. Si está inscrito en el plan Saver, los análisis de laboratorio serán gratuitos una vez que haya satisfecho el deducible. Visite Doctor On Demand en línea en **DoctorOnDemand.com/WalmartCare** o llame al **800-941-1384**.

Este servicio está disponible para usted si se cumplen los siguientes requisitos:
- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, o en la opción de plan local de Mercy Arkansas o Banner.

PROGRAMA QUIT TOBACCO PARA DEJAR EL TABACO

De acuerdo con los Institutos Nacionales de Salud, el consumo de tabaco es una de las principales causas de enfermedad que se pueden prevenir y de muerte en los Estados Unidos. El AMP ofrece un programa para dejar el tabaco llamado Kick Buts que es administrado por Agile Health para usted y sus dependientes cubiertos de 18 años o más, sin costo alguno para usted para ayudarle a dejar de fumar, mascar tabaco o vapear.

Si usted o su cónyuge consumen tabaco y, durante la inscripción inicial o la Inscripción anual, aceptan inscribirse y participar en el programa para dejar de fumar o en un programa de su elección antes de que finalice el año del Plan al que se están inscribiendo, recibirán tarifas más bajas para no consumidores de tabaco para la cobertura médica y de medicamentos recetados, el seguro de vida asociado opcional, el seguro de vida opcional para dependientes de un cónyuge y el seguro de enfermedad crítica durante todo el año del Plan al que se están inscribiendo. Su elegibilidad para las tarifas para personas libres de tabaco se puede establecer solo en su inscripción inicial y cada año en la Inscripción anual.

Para ofrecerle los recursos y el apoyo necesarios para ayudarte a dejar de consumir tabaco, el programa incluye:
- Apoyo diario por mensajes de texto (hasta tres mensajes al día) para ayudarle a prepararse mental y físicamente para la fecha cuando va a dejar de consumir tabaco.
- Habilidades prácticas para controlar los antojos y evitar las tentaciones
- Apoyo en el momento en caso de antojos, deslices y recaídas
- Un entrenador personal de salud disponible a través de mensajes de texto de lunes a viernes de 9 a. m. a 6 p. m. Hora central
- Hasta dos tarjetas de regalo de $50 para utilizar en la compra de terapia de sustitución de nicotina (parches, chicles o pastillas) en Walmart, Sam's Club o **Walmart.com.**

Para inscribirse, llame a Kick Buts al **855-955-1905** o visite **Kickbuts.com/kbewmt**. Obtenga más información sobre el programa Quit Tobacco en **One.Walmart.com/QuitTobacco**.

Usted es elegible para este programa si cumple los siguientes requisitos:
- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, Banner o la opción de plan local de Mercy Arkansas o Plan PPO.

PROGRAMA DE MATERNIDAD VIDA CON BEBÉ

El programa Vida con Bebé es un programa exclusivo de atención prenatal que se ofrece sin costo para usted, su cónyuge o pareja con cobertura y otros dependientes con cobertura. El programa está disponible para usted si está inscrito en las opciones de AMP que se enumeran a continuación, todo lo cual ofrece a sus participantes programas de maternidad comparables. (Comuníquese con su asesor de atención de la salud o asistente personal de salud para obtener más información).

Si está formando una familia, uniéndose a una o simplemente considerándolo, el programa de maternidad Vida con bebé la puede ayudar a tener un embarazo favorable. Se brinda asistencia durante la preconcepción, el embarazo, el parto (incluidas tres consultas para apoyo a la lactancia) y educación sobre el desarrollo del niño. Para inscribirse, llame a su asesor de atención de la salud al número de teléfono que figura en su tarjeta de identificación del plan. Una vez inscrita, tendrá la oportunidad de hablar en forma confidencial con un enfermero personal registrado antes, durante y después del embarazo. La participación en el programa es voluntaria y no afecta su elegibilidad para participar en el AMP.

Usted es elegible para este programa si cumple los siguientes requisitos:
- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, o en la opción del Plan Banner Local o Plan PPO.

Programas adicionales

Si está inscrito en la opción del plan Premier, Contribution, Saver o Banner Local, también tiene acceso a:
- Aplicaciones para embarazadas y de crianza a través de Ovia Health.
- Una tarjeta de pago digital emitida por IQPay para comprar suministros de lactancia, incluido un extractor de leche, bolsas de almacenamiento, etc., en línea en **One.Walmart.com** o en una tienda Walmart.
- Hay servicios de doula disponibles. Para obtener detalles, consulte **Cuándo se aplican beneficios limitados al AMP** más adelante en este capítulo.

NAVEGAR SUS BENEFICIOS

PROGRAMA PARA REDIRECCIONAR MEDICAMENTOS ESPECIALIZADOS

Si usted recibe medicamentos de especialidad mediante una inyección o infusión, este programa opcional apoya la transición de los servicios en un entorno hospitalario a lugares de atención alternativos, como el consultorio de un médico, una sala de infusión o su hogar. Los médicos del programa evalúan los lugares de infusión adecuados, a partir de un análisis minucioso de cada caso, y le sugieren lugares de atención alternativos. Para obtener información adicional, llame a OptumRx al **844-705-7493** o a su asesor de atención de la salud al número que figura en su tarjeta de identificación del plan.

Usted es elegible para este programa si cumple los siguientes requisitos:

- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, o en la opción de plan local de Mercy Arkansas o Banner.

AUTOCUIDADO DE LA DIABETES

Como parte de myAgileLife, tendrá acceso a copagos más bajos para ciertos medicamentos relacionados con la diabetes si se inscribe en el programa de autocuidado de la diabetes. Este es un programa voluntario en el que los incentivos se basan en la participación en los programas de myAgileLife y no en el logro de un estado de salud.

El programa presenta un plan de estudio de asesoramiento basado en mensajes de texto diseñado para ayudarlo a desarrollar conductas que apoyen los objetivos y resultados de salud establecidos (es decir, el cumplimiento de la toma de medicamentos, la dieta, la actividad física, el autocontrol y el compromiso/interacción del proveedor como parte de un régimen efectivo de autocontrol de la diabetes para reducir la A1C, mejorar la calidad de vida y evitar el uso innecesario de los servicios de atención médica).

Para continuar en el programa, debe cumplir con los requisitos del listado y de abastecimiento que especifique el AMP, cuando corresponda, y permanecer activo en el programa de acuerdo con los términos establecidos.

Para inscribirse u obtener más información, llame a myAgileLife al **855-955-1905**.

Usted es elegible para este programa si cumple los siguientes requisitos:

- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, Banner o la opción de plan local de Mercy Arkansas o Plan PPO.
- No participa en el programa de control de la diabetes y el metabolismo de Twin Health.

Si le han diagnosticado diabetes tipo 2, es posible que haya recursos adicionales disponibles para usted. Consulte **Diabetes y control metabólico por Twin Health** que se encuentra anteriormente en este capítulo.

ATENCIÓN DE LA SALUD EMOCIONAL Y MENTAL

Tendrá el beneficio de los servicios voluntarios de administración de la atención a través de AiRCare, además de los otros recursos de administración de la atención que se describen en esta sección. El objetivo de todos los recursos de administración de la atención médica que están a su disposición en el marco del AMP es promover coherencia en toda la gama de atención y servicios que se le proporcionan, y tratarlo como una persona en su totalidad.

AiRCare es una compañía de servicios clínicos que ofrece un enfoque clínico integral para los servicios de gestión de cuidado relacionados con las afecciones de salud emocional y mental. AiRCare analiza los datos del AMP para identificar a los participantes en el AMP que podrían beneficiarse de los servicios de manejo de cuidados. Los médicos autorizados de AiRCare pueden comunicarse de manera proactiva con usted para ofrecerle apoyo y asesoramiento, y lo conectan con otros beneficios del AMP, incluidos los servicios de salud mental, y con recursos comunitarios para mejorar la atención, si corresponde.

Usted no tiene la obligación de utilizar los servicios de AiRCare ni de contratar a ningún médico clínico autorizado de esta compañía que se comunique directamente con usted. Este recurso de gestión de atención médica es voluntario.

Usted es elegible para este programa si cumple los siguientes requisitos:

- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, o en la opción de plan local de Mercy Arkansas o Banner. Es posible que la legislación estatal no contemple la fisioterapia virtual.

FISIOTERAPIA A TRAVÉS DE OMADA PARA LA SALUD DE LOS MÚSCULOS Y LAS ARTICULACIONES

Tiene acceso a Omada para cuidar la salud muscular y articular, un enfoque basado en aplicaciones para la fisioterapia. Ya sea que desee prevenir una lesión, recuperarse de una o controlar el dolor, Omada brinda atención personalizada, kits de ejercicio e incluye consultas ilimitadas por chat y video, lo que le facilita el cumplimiento de su plan de atención. Omada está disponible sin costo alguno, antes de que satisfaga su deducible, para las opciones del plan Premier, Contribution, o Banner o Mercy Arkansas Local. Si está inscrito en el plan Saver, no tendrá que pagar nada una vez que haya satisfecho el deducible. Únase hoy mismo visitando **OmadaHealth.com/Walmart**.

Usted es elegible para este programa si cumple los siguientes requisitos:

- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, o en la opción de plan local de Mercy Arkansas o Banner.

ATENCIÓN DE LA SALUD DIGESTIVA A TRAVÉS DE CYLINDER

Tiene acceso a Cylinder, un programa basado en una aplicación en el cual colabora un equipo de atención para el cuidado gastrointestinal. Cylinder ofrece un programa personalizado de salud digital para aliviar las afecciones digestivas y mejorar la salud intestinal. El programa puede ayudar a aliviar una amplia variedad de síntomas relacionados con la salud digestiva, sin costo alguno para usted. Cylinder incluye citas ilimitadas con un nutricionista profesional y un asesor de salud, planes de acción personalizados, una prueba casera de microbioma intestinal y métodos probados para manejar el estrés y la ansiedad que afectan su salud intestinal. Descargue la aplicación en **Cylinder.com/Walmart**.

Usted es elegible para este servicio si cumple los siguientes requisitos:

- Está inscrito en la opción de Plan Premier, Plan Contribution o Plan Saver, o en la opción de plan local de Mercy Arkansas o Banner.

Programa de atención preventiva

De acuerdo con la Ley de Cuidado de Salud Asequible (Affordable Care Act), para que un servicio de atención preventiva sea elegible para obtener una cobertura del 100 %, debe estar sujeto a la recomendación de uno de los organismos responsables de mantener las pautas de atención preventiva de Estados Unidos. Muchas de estas pautas están relacionadas con el género, la edad o los factores de riesgo de una enfermedad o afección. Consulte a su TPA para conocer los detalles. Consulte las tablas con los términos de **Opciones del AMP disponibles para usted** cobertura en la sección anterior en este capítulo para determinar cuándo el AMP paga el costo total de los servicios preventivos de su opción. Es posible que los servicios preventivos no se paguen al 100 % si los recibe de parte de un proveedor que no sea parte de la red.

Se aplica una regla especial a los servicios preventivos que se realicen durante las visitas al consultorio. Es posible que los servicios preventivos no se paguen al 100 % del beneficio si estos se facturan por separado de una visita al consultorio o no son la finalidad principal de una visita al consultorio. En cambio, los servicios preventivos se pagan al 100 % del beneficio cuando estos no se facturan por separado de una visita al consultorio y son la finalidad principal de una visita al consultorio. Asimismo, el AMP puede utilizar procedimientos razonables de manejo de la atención médica, según lo permita la ley, cuando deba determinar qué servicios de atención preventiva se pagan al 100 %, como por ejemplo, que solamente se cubran los medicamentos genéricos o que sea necesario tener una receta o que la atención preventiva sea realizada por un proveedor dentro de la red para estar cubierta al 100 %. Si el médico tratante cree que es médicamente necesario que estos servicios de atención preventiva o medicamentos se faciliten de alguna forma diferente, usted o su médico pueden solicitar una excepción. Consulte **Proceso de excepciones de atención preventiva** más adelante en este capítulo.

Los servicios cubiertos son aquellos que se enumeran en las siguientes páginas. Consulte con su administrador de terceros para obtener información sobre los servicios preventivos que no figuran aquí. Para obtener la lista más actualizada de servicios preventivos cubiertos, ingrese a **One.Walmart.com/Health** o comuníquese con su administrador de terceros al número que aparece en su tarjeta de identificación del plan.

SERVICIOS PREVENTIVOS CUBIERTOS PARA ADULTOS

- **Un único examen de detección de aneurisma** aórtico abdominal para hombres de edades específicas que hayan fumado alguna vez
- **Abuso de alcohol** examen de detección y asesoramiento
- **Evaluación por ansiedad** para adultos de 64 años o menos
- **Prueba de detección de presión arterial** para adultos
- **Examen para la detección de cáncer** colorrectal para adultos mayores de 45 años
- **Prueba de detección de depresión** para adultos
- **Análisis de la diabetes (tipo 2) y la prediabetes** en adultos de 35 a 70 años con sobrepeso u obesidad, y oferta o derivación de intervenciones preventivas para aquellos pacientes que tengan prediabetes
- **Asesoramiento dietario y de actividad física** para adultos con mayor riesgo de enfermedades cardiovasculares.
- **Ejercicios o fisioterapia** para adultos de 65 años o más que viven en la comunidad y presentan mayores riesgos de sufrir caídas
- **Prueba de detección de hepatitis B** para personas con alto riesgo.
- **Prueba de detección de hepatitis C** para todos los adultos de 18 a 79 años
- **Prueba de detección de VIH** para los adultos con mayores riesgos
- **Vacunas para adultos** las dosis, edades y poblaciones recomendadas varían:
  - COVID-19
  - Haemophilus influenzae tipo B
  - Hepatitis A
  - Hepatitis B
  - Herpes Zóster
  - Virus del papiloma humano
  - Gripe (vacunación contra la gripe)
  - Sarampión, papera, rubéola
  - Enfermedad meningocócica
  - Mpox
  - Enfermedad neumocócica
  - Virus respiratorio sincitial (VRS)
  - Tétanos, difteria, tos ferina
  - Varicela

Obtenga más información sobre las vacunas y consulte los últimos cronogramas de vacunación en: **cdc.gov/vaccines/imz-schedules**.

- **Prueba de detección de infección de tuberculosis latente (Latent tuberculosis infection, LTBI)** en personas de alto riesgo.
- **Prueba de detección de cáncer de pulmón** para ciertos adultos de entre 50 y 80 años con antecedentes de tabaquismo.
- **Prueba de detección y asesoramiento en obesidad** para todos los adultos
- **Profilaxis preexposición (PrEP)** con una terapia antirretroviral eficaz para las personas que corren un mayor riesgo de contraer VIH
- **Asesoramiento para la prevención de infecciones de transmisión sexual (ITS)** para adultos con mayor riesgo de infección
- **Asesoramiento en cáncer de piel** para adultos jóvenes hasta la edad de 24 años
- **Estatina** para la prevención primaria de enfermedades cardiovasculares en adultos de 40 a 75 años que presenten uno o más factores de riesgo de enfermedad cardiovascular y un riesgo estimado a 10 años de sufrir un acontecimiento cardiovascular igual o superior al 10 % (requiere receta médica). Consulte **Beneficio de farmacia** para obtener más información.
- **Prueba de detección de sífilis** para todos los adultos con mayores riesgos
- **Prueba de detección de consumo de tabaco** para todos los adultos e intervenciones para dejar de fumar para fumadores
- **Prueba de detección** (es decir, mediante preguntas) de consumo de drogas nocivas para adultos mayores de 18 años.

SERVICIOS PREVENTIVOS CUBIERTOS PARA MUJERES, INCLUIDAS EMBARAZADAS

- **Pruebas de detección de ansiedad** en mujeres adolescentes y adultas, incluidas las que están embarazadas o atravesando el periodo de posparto.
- **Aspirina (dosis baja)** para mujeres con 12 semanas de gestación y que presenten alto riesgo de padecer preeclampsia (se requiere receta médica). Consulte **Beneficio de farmacia** para obtener más información.
- **Prueba de detección de bacteriuria** en el tracto urinario y otras infecciones para mujeres embarazadas
- **Asesoramiento sobre pruebas genéticas para el análisis de BRCA** para mujeres con mayores riesgos y, de indicarse después del asesoramiento, pruebas para el análisis de BRCA
- **Asesoramiento sobre quimioprevención** de cáncer de mama para mujeres con mayor riesgo
- **Mamografía para la detección de cáncer** de mama cada 1 a 2 años para mujeres mayores de 40 años
- **Medicamentos recetados para reducir el riesgo de cáncer de mama** (tal como tamoxifén, raloxifeno o inhibidores de la aromatasa) para determinadas mujeres que corren mayor riesgo de padecer cáncer de mama
- **Apoyo integral para lactancia** y tres visitas de asesoramiento de proveedores capacitados, así como también acceso a insumos para la lactancia, para mujeres embarazadas o que están amamantando. Consulte con su administrador de la red subcontratado (TPA) para obtener información sobre cómo obtener un extractor de leche.
- **Prueba de detección del cáncer de cuello** uterino para mujeres de entre 21 y 65 años.
- **Examen para la detección de infección** por clamidia para mujeres jóvenes y otras mujeres con mayor riesgo.
- **Métodos anticonceptivos** asesoramiento y educación para pacientes, procedimientos de esterilización y métodos anticonceptivos aprobados por la Administración de Alimentos y Medicamentos, sin incluir medicamentos abortivos. Consulte la sección **Beneficio de farmacia** para obtener información sobre métodos anticonceptivos.
- **Pruebas de diabetes** para mujeres con antecedentes de diabetes gestacional que no estén actualmente embarazadas y que no hayan recibido previamente un diagnóstico de diabetes tipo 2
- **Prueba de detección y asesoramiento para la violencia** doméstica e interpersonal para todas las mujeres y, según corresponda, servicios de intervención inicial
- **Suplementos de ácido fólico** para mujeres que pueden llegar a quedar embarazadas (se requiere receta médica). Consulte **Beneficio de farmacia** para obtener más información.
- **Examen de detección de diabetes** gestacional para mujeres con embarazos de 24 a 28 semanas y aquellas con alto riesgo de padecer diabetes gestacional
- **Examen de detección de gonorrea** para mujeres jóvenes y otras mujeres con mayor riesgo
- **Asesoramiento sobre peso saludable y aumento de peso** para mujeres embarazadas
- **Examen para la detección de Hepatitis B** para mujeres embarazadas en su primera visita prenatal
- **Prueba de detección y asesoramiento sobre el Virus de inmunodeficiencia humana (VIH)**
- **Cribado de trastornos hipertensivos del embarazo** con mediciones de presión arterial durante el embarazo.
- **Pruebas de detección de depresión** materna para madres en ciertas consultas de control de niños sanos
- **Asesoramiento para la prevención de la obesidad** en mujeres de 40 a 60 años que tengan un índice de masa corporal normal o con sobrepeso
- **Examen de detección de osteoporosis** para mujeres mayores de 65 años y mujeres posmenopáusicas más jóvenes según los factores de riesgo
- **Intervenciones de asesoramiento sobre la depresión perinatal** o derivaciones para mujeres embarazadas y que estén atravesando el periodo posparto, que corran un mayor riesgo de padecer depresión perinatal
- **Examen para la detección de incompatibilidad de Rh** para todas las mujeres embarazadas y pruebas de seguimiento para mujeres con mayor riesgo.
- **Asesoramiento para prevenir infecciones de transmisión sexual (ITS)** para mujeres sexualmente activas
- **Examen de detección de sífilis** para todas las mujeres embarazadas u otras mujeres con mayor riesgo
- **Exámenes de detección de consumo de tabaco** e intervenciones para todas las mujeres, y asesoramiento ampliado para fumadoras embarazadas
- **Examen anual de detección de incontinencia urinaria** y derivación para evaluación y tratamiento adicionales si se indica
- **Visitas para mujeres sanas** para obtener servicios preventivos recomendados para mujeres

SERVICIOS PREVENTIVOS CUBIERTOS PARA NIÑOS

- **Prueba de detección de anemia** para niños de 12 meses
- **Evaluación de ansiedad** en niños y adolescentes de 8 a 18 años
- **Examen para la detección de autismo** para niños de entre 18 y 24 meses
- **Análisis conductual/social/emocional** para niños de todas las edades
- **Prueba de detección de la bilirrubina** para recién nacidos
- **Examen para la detección de presión arterial** para niños de todas las edades
- **Análisis de sangre** para recién nacidos
- **Examen de detección de displasia** cervical para mujeres sexualmente activas
- **Examen para la detección de hipotiroidismo** congénito para recién nacidos
- **Prueba de detección de insuficiencias cardíacas congénitas** críticas para recién nacidos
- **Análisis de la depresión y del riesgo de suicidio** en adolescentes
- **Examen para detección de trastornos** del desarrollo para niños menores de 3 años y seguimiento durante la niñez.
- **Prueba de detección de dislipidemia** para niños con alto riesgo de trastornos de lípidos
- **Suplementos de fluoruro para quimioprevención** para niños sin fluoruro en la fuente de agua y barniz de fluoruro para los dientes de leche para todos los bebés y niños (se requiere receta médica)

- **Medicamentos oftalmológicos para la prevención de la gonorrea** para todos los recién nacidos
- **Examen de la audición** para todos los niños
- **Mediciones de altura, peso, longitud, circunferencia del cráneo, peso por longitud e índice** de masa corporal para niños
- **Examen de células falciformes o hemoglobinopatías** para recién nacidos
- **Prueba de detección de hepatitis B** para adolescentes con alto riesgo
- **Prueba de detección de VIH** para adolescentes
- **Vacunas** para niños recién nacidos hasta los 18 años; las dosis, las edades, y poblaciones recomendadas varían:
  - COVID-19
  - Dengue
  - Difteria, tétanos, tos ferina (DTaP y Tdap)
  - Haemophilus influenzae tipo B
  - Hepatitis A
  - Hepatitis B
  - Virus del papiloma humano
  - Poliovirus inactivo
  - Gripe (vacunación contra la gripe)
  - Sarampión, papera, rubéola
  - Enfermedad meningocócica
  - Mpox
  - Enfermedad neumocócica
  - Rotavirus
  - Virus respiratorio sincitial (VRS)
  - Varicela

Obtenga más información sobre las vacunas y consulte los últimos cronogramas de vacunación en: **cdc.gov/vaccines/imz-schedules**.

- **Examen de detección de plomo** para niños con riesgo de exposición
- **Historia clínica** para todos los niños durante el periodo de desarrollo
- **Asesoramiento y examen para la detección de obesidad**
- **Evaluaciones de riesgo para la salud bucal** para niños pequeños (recién nacidos hasta 10 años)
- **Examen para la detección de fenilcetonuria (PKU)** para este desorden genético en recién nacidos
- **Examen físico** para niños de todas las edades
- **Exámenes y asesoramiento para la prevención de infecciones de transmisión sexual (STI)** para adolescentes con alto riesgo de infección
- **Asesoramiento sobre cáncer de piel** para adultos jóvenes de hasta 24 años y padres de niños pequeños
- **Análisis de detección de paro cardiaco súbito y la muerte súbita** en adolescentes
- Evaluación sobre el consumo de tabaco, alcohol o drogas para adolescentes que presentan mayor riesgo
- **Intervenciones contra el consumo de tabaco** en niños y adolescentes que se encuentran en edad escolar que no han comenzado a consumir tabaco
- **Prueba de tuberculina** para niños con alto riesgo de tuberculosis
- **Examen de la visión** para todos los niños.

PROGRAMA DE VACUNA CONTRA LA GRIPE

La vacunación anual contra la gripe es un servicio preventivo y está cubierto de acuerdo con los términos detallados en esta sección que describe **Programa de atención preventiva**. La vacuna también se puede administrar en las farmacias de Walmart y de Sam's Club participantes.

PROGRAMA DE VACUNACIÓN CONTRA COVID-19

La vacunación anual contra COVID-19 es un servicio preventivo y está cubierto de acuerdo con los términos detallados en esta sección que describe **Programa de atención preventiva**. La vacuna también se puede administrar en las farmacias de Walmart y de Sam's Club participantes.

PROCESO DE EXCEPCIONES DE ATENCIÓN PREVENTIVA

El AMP puede utilizar procedimientos razonables de manejo de la atención médica, según lo permita la ley, cuando deba determinar qué servicios de atención preventiva se pagan al 100 %, como por ejemplo, que solamente se cubran los medicamentos genéricos o que sea necesario tener una receta o que la atención preventiva sea realizada por un proveedor dentro de la red para estar cubierta al 100 %. Si el médico tratante cree que es médicamente necesario que estos servicios de atención preventiva o medicamentos se faciliten de alguna forma diferente, usted o su médico pueden solicitar una excepción. Para los servicios de atención preventiva que se indicaron anteriormente, usted o el médico tratante deben solicitar una excepción al TPA que se lista en su tarjeta de identificación del plan. Su TPA puede pedir a su médico que responda preguntas sobre las razones por las cuales se necesita médicamente una excepción. Si desea solicitar una excepción relacionada con los medicamentos de atención preventiva o los anticonceptivos, consulte **Proceso de excepciones de atención preventiva** en el capítulo **Beneficio de farmacia**.

Salud mental y trastornos por abuso de sustancias

Sujeto a otros términos del AMP, el plan incluye una cobertura para servicios de salud mental y trastornos por abuso de sustancias de la misma forma que otros beneficios médicos y de hospitalización, incluida la atención en instituciones de salud mental. Un centro de salud mental es aquel que brinda:

- Atención a pacientes hospitalizados las 24 horas
- Tratamiento residencial
- Hospitalización parcial o atención para pacientes ambulatorios que requiere un servicio de seis a ocho horas por día, de cinco a siete días por semana o
- Atención intensiva para pacientes ambulatorios que requiere de dos a cuatro horas por día, de tres a cinco días por semana.

Qué está cubierto por el AMP

El AMP paga los beneficios para los servicios cubiertos, que incluyen cargos por procedimientos, servicios, equipos, e insumos que cumplan con los siguientes requisitos:

- No exceden el cargo máximo permitido por AMP
- Médicamente necesario (a menos que se indique lo contrario)
- No estén excluidos conforme al AMP (consulte la sección **Qué no está cubierto por el AMP** que aparece más adelante en este capítulo).
- No superen los límites del AMP.

CARGO MÁXIMO PERMITIDO

El término "cargo máximo permitido" (MAC) se refiere al monto máximo que el AMP cubrirá o pagará por cualquier servicio de atención de la salud, medicamentos, dispositivos médicos, equipos, insumos o beneficios cubiertos por el AMP. El MAC se aplica tanto a los servicios que brindan los proveedores dentro de la red como los que brindan los proveedores fuera de la red.

En el caso de los servicios dentro de la red cubiertos, el MAC consiste en la parte de los cargos de un proveedor que cubre el AMP, según lo establece el contrato del proveedor con el TPA o el contrato del proveedor con el AMP, según corresponda. En el caso de BlueAdvantage Administrators of Arkansas, esto incluye contratos con una compañía autorizada, independiente de Blue Cross Blue Shield Association.

De vez en cuando, y a pesar de cualquier otra disposición del AMP que establezca lo contrario, el AMP puede celebrar un acuerdo con un proveedor fuera de la red (de manera directa o indirecta) en el que se establezca el monto que el AMP pagará por un servicio o suministro. En estos casos, el MAC será el monto establecido en el acuerdo con el proveedor fuera de la red.

Para los servicios de transporte terrestre de ambulancia, cada TPA determinará el MAC tal y como se describe en la sección **Transporte terrestre de ambulancia** de la sección **Servicios de emergencia, ambulancia de transporte terrestre, prevención y telesalud** .

Para los servicios cubiertos para el tratamiento de una afección médica de emergencia en un departamento de emergencias, ciertos servicios cubiertos proporcionados por un proveedor fuera de la red en una instalación de la red sujeta a requisitos de notificación y consentimiento que no ha obtenido su consentimiento para facturarle cantidades que excedan el cargo máximo permitido, o servicios proporcionados por un proveedor de ambulancia aérea fuera de la red que estarían cubiertos por el AMP si los proporcionara un proveedor de servicios de ambulancia aérea dentro de la red del TPA, cada TPA determinará el MAC como se describe en la sección **Cuándo se pagan beneficios de la red para servicios fuera de la red**.

Para todos los demás servicios cubiertos fuera de la red, el MAC se determina a través de cada TPA, tal como se describe a continuación: En algunos casos, es posible que se paguen beneficios dentro de la red por servicios fuera de la red, como se describe anteriormente en este capítulo en la sección **Cuándo se pagan beneficios de la red para servicios fuera de la red**.

Aetna (Plan Premier, Plan Contribution, Plan Saver y Plan local de Banner): En el caso del plan local Banner, no existen beneficios para los servicios fuera de la red que los participantes soliciten de manera voluntaria. Para las opciones del plan Premier, Contribution y Saver, el MAC representa el 125 % del cargo máximo permitido de Medicare para servicios voluntarios fuera de la red. Para las opciones del plan Premier, Contribution, Saver y Banner Local, el MAC también es el 125 % del cargo máximo permitido por Medicare para servicios involuntarios fuera de la red, a menos que el proveedor sea parte del Programa Nacional Advantage (NAP) de Aetna. Los cargos de proveedor de NAP se abonan con descuento. En los casos en que un cargo máximo permitido de Medicare no sea publicado por los Centros de Servicios de Medicare y Medicaid para un servicio específico, Aetna usa una metodología de intervalo para calcular al MAC que se basa en el cargo máximo permitido de Medicare. El cargo máximo permitido de Medicare se basa en el área geográfica en la que se presta el servicio.

BlueAdvantage Administrators of Arkansas: El método que se usa para establecer el MAC para los servicios cubiertos fuera de la red depende de si el servicio se prestó a través de un proveedor de atención médica individual (p. ej., un médico), un servicio de ambulancia terrestre o aérea, o bien un hospital o institución.

Para los servicios que presten los proveedores individuales, el MAC es el 125 % del cargo máximo permitido por Medicare para tales servicios en la fecha en que se administren. Si no existe un cargo máximo permitido de Medicare, el MAC es el 70 % de los gastos facturados.

En el caso de los servicios de hospitales e instituciones de salud o para cualquier otro beneficio cubierto (por ejemplo, medicamentos, dispositivos médicos, productos o implantes, equipos o insumos), el MAC para servicios cubiertos fuera de la red se limita al precio o asignación ofrecida por el Plan Blue Cross and Blue Shield en el estado donde se prestan los servicios. Si el plan de Blue Cross and Blue Shield en el estado donde se prestan los servicios no tiene su propio método o punto de referencia en un caso en particular, el MAC para servicios cubiertos fuera de la red se limita a la asignación establecida por BlueAdvantage Administrators of Arkansas con base en su metodología local de fijación de precios para los proveedores.

Para los servicios cubiertos fuera de la red, el AMP pagará el MAC menor o los cargos facturados reales del proveedor. Si los cargos facturados del proveedor superan el MAC del AMP, usted será responsable de pagar la diferencia.

UMR (Plan local Mercy Arkansas): En el caso del plan local Mercy Arkansas administrado por UMR, no existen beneficios para los servicios fuera de la red que los participantes soliciten de manera voluntaria. En el caso de servicios fuera de la red que se proveen de emergencia o involuntarios aprobados, el MAC es el 125 % del cargo máximo permitido por Medicare para los servicios voluntarios y no voluntarios fuera de la red, a menos que el servicio fuera de la red sea involuntario y el proveedor participe en el Programa de ahorros compartidos (SSP) de UMR. Los cargos del proveedor de SSP se abonan con un descuento. En los casos en que un cargo máximo permitido de Medicare no sea publicado por los Centros de Servicios de Medicare y Medicaid para un servicio específico, UMR usa una metodología de intervalo para calcular el MAC.

UMR (opciones del Plan Premier, Contribution y Saver): El MAC es el 125 % del cargo máximo permitido por Medicare para los servicios voluntarios y no voluntarios fuera de la red, a menos que el servicio fuera de la red sea involuntario y el proveedor participe en el Programa de ahorros compartidos (SSP) de UMR. Los cargos del proveedor de SSP se abonan con un descuento. En los casos en que un cargo máximo permitido de Medicare no sea publicado por los Centros de Servicios de Medicare y Medicaid para un servicio específico, UMR usa una metodología de intervalo para calcular el MAC.

MÉDICAMENTE NECESARIO

"Médicamente necesario" (o de "necesidad médica") significa que el TPA determinó que los procedimientos, servicios, equipos o insumos cumplen con los siguientes requisitos:

- Son adecuados para los síntomas, el diagnóstico o el tratamiento de una afección médica
- Son suministrados para el diagnóstico o la atención y el tratamiento directos de la afección médica
- Se encuentran dentro de los estándares de la buena práctica médica en la comunidad médica organizada
- No están destinados principalmente a la comodidad del paciente ni del médico u otro proveedor del paciente, y
- Son los procedimientos, servicios, equipos o insumos más adecuados que se puedan administrar de manera segura.

"Más adecuados" significa:

- Que existe una evidencia científica válida que demuestra que los beneficios de salud esperados con el procedimiento, servicio, equipo o insumo son clínicamente significativos y producen mayor probabilidad de beneficios sin un riesgo desproporcionadamente mayor de daños o complicaciones para el participante del AMP con una afección médica particular que está siendo tratada en comparación con otras alternativas posibles,
- Se probaron formas aceptadas en términos generales que son menos invasivas y se descubrió que son ineficaces o inapropiadas para el caso, y
- En el caso de las hospitalizaciones, es necesaria la atención hospitalaria intensiva debido a la clase de servicios que está recibiendo el participante o la gravedad de la condición médica, y no se puede recibir atención segura y adecuada como paciente externo o en un entorno médico menos intensivo.

Los TPA siguen sus propias políticas internas para determinar si un procedimiento, servicio, equipo o insumo resulta médicamente necesario. Los beneficios del AMP están sujetos a todos los términos, condiciones, limitaciones y exclusiones establecidos en las políticas de cobertura que gestiona el TPA con respecto a la necesidad médica. Para obtener más información, comuníquese con su TPA.

Notificación previa

Usted o su proveedor pueden comunicarse de forma voluntaria con su TPA para obtener información sobre la cobertura antes de obtener la mayoría de los servicios médicos y de salud mental al número que figura en su tarjeta de identificación del plan. Si opta por notificar al TPA sobre una admisión programada en un centro médico o de salud mental, debe hacerlo con 24 horas de anticipación a la fecha de admisión.

En el caso de los servicios de emergencia, los TPA deben ser notificados lo antes posible, antes de las 24 horas después de la admisión. No obstante, no es una condición de la cobertura dar aviso dentro de las 24 horas luego de la admisión.

Las respuestas del TPA a sus preguntas durante un llamado de aviso previo no garantizan el pago ni aseguran la cobertura conforme al AMP, como así tampoco ninguna declaración que realice el TPA crea un contrato, vincula al AMP ni anula ninguna condición del AMP correspondiente a su reclamación para los beneficios. El TPA no puede tomar una decisión final sobre la reclamación por teléfono ni por correo electrónico. Esto significa que todas las respuestas que se otorguen por teléfono o correo electrónico siempre quedan sujetas a futura revisión con base en los hechos particulares y en virtud de los términos, las condiciones, las limitaciones y las exclusiones por escrito del AMP.

Autorización previa

Se requiere autorización previa para algunos servicios del Plan, de lo contrario, no estarán cubiertos. En la siguiente página, se presenta una lista de los tipos de servicios para los cuales se requiere autorización previa.

Si visita un proveedor de la red, es posible que tal proveedor deba, por contrato, obtener una autorización previa para ciertos servicios. Si visita un proveedor fuera de la red, usted o su proveedor deben llamar a su TPA al número que figura en su tarjeta de identificación del plan para verificar si es necesario obtener una autorización previa.

Debe presentar su reclamación de autorización previa tal como se describe en el capítulo **Reclamaciones y apelaciones**. Cuando sea necesario obtener autorización previa, estos servicios se considerarán "reclamaciones previas al servicio". Si se deniega una reclamación previa al servicio, puede presentar una apelación, como se describe en el capítulo **Reclamaciones y apelaciones**.

En los casos en los que no se requiera autorización previa, es posible que quiera informar de antemano a su administrador externo, como se ha indicado anteriormente, aunque la notificación previa no garantiza que los servicios vayan a estar cubiertos. Independientemente de si se necesita o no una autorización previa, todos los servicios siguen estando sujetos a los términos y condiciones de cobertura del AMP, incluido el reparto de costos y otras limitaciones aplicables. Los proveedores dentro y fuera de la red deben dar autorización previa para los siguientes servicios, según las condiciones de AMP, independientemente del TPA:

Esta lista no es exhaustiva. Para obtener una lista completa de servicios para los cuales se requiere una autorización previa, usted o su proveedor pueden llamar al TPA al número que figura en su tarjeta de identificación del plan. Consulte la tabla Recursos en la primera página de este capítulo para obtener información sobre la entidad que determina las solicitudes de autorización previa para su opción del AMP. Tenga en cuenta que los requisitos de autorización previa pueden variar dependiendo del TPA, por lo que es importante verificar la lista más reciente de su TPA en particular.

- Servicios avanzados de diagnóstico por imágenes: resonancias magnéticas y tomografías computarizadas.
- Los siguientes servicios brindados conforme al programa de los Centros de Excelencia:
  - Cirugía de columna
  - Reemplazo de cadera y rodilla
  - Tratamiento y servicios para la formación de familia
  - Trasplantes de hígado, riñón, corazón (que incluye los dispositivos de asistencia ventricular duraderos [VAD] y los corazones artificiales totales), pulmón (que incluye la cirugía de reducción del volumen pulmonar), páncreas, trasplantes simultáneos de riñón y páncreas, de múltiples órganos y de médula ósea y células madre (que incluye el tratamiento con células T CAR)
  - Cirugía para la pérdida de peso
- Beneficios de viaje para atención (para obtener más información, consulte la sección **Presentar una reclamación de beneficios de viaje por atención** de este capítulo).

Cuándo se aplican beneficios limitados al AMP

Además de los requisitos de deducible anual y coseguro/copago, ciertos servicios están sujetos a restricciones y limitaciones específicas. Si tiene alguna duda sobre la cobertura de un servicio en particular, comuníquese con el TPA llamando al número que figura en su tarjeta de identificación del plan.

Las limitaciones y restricciones que se describen a continuación son adicionales a otras normas del AMP, como los deducibles, el coseguro/copago, los requisitos de la red y las exclusiones. Es posible que se considere una cobertura adicional cuando lo autorice su administrador de atención, tal como se describe en la sección **Control de la atención**.

Consulte también **Qué no está cubierto por el AMP**, más adelante en este capítulo.

Ambulancia: La cobertura del transporte terrestre en ambulancia o en ambulancia aérea se limita al hospital más cercano o al centro de tratamiento más cercano que pueda facilitar atención, y solamente si tal transporte es médicamente necesario en comparación con otros métodos de transporte cuyo costo y seguridad sea menor.

El AMP cubre el transporte terrestre en ambulancia o en ambulancia aérea cuando un director médico de un TPA recomienda el transporte a unas instalaciones específicas por ser médicamente necesario, con base en su condición individual y otros factores contribuyentes que haya citado el médico tratante, y cuando tal transporte sea médicamente necesario en comparación con otros métodos de transporte cuyo costo y seguridad sea menor.

El AMP cubre el servicio de transporte terrestre en ambulancia terrestre o aérea entre centros de atención de la salud si el tratamiento es médicamente necesario y no está disponible en el primer centro.

El AMP cubre el transporte terrestre en ambulancia y en ambulancia aérea desde un hospital hasta instalaciones de cuidados paliativos (incluso hasta una residencia en la que se proporcionarán cuidados paliativos).

El AMP cubre el transporte en ambulancia aérea de los proveedores de servicios de ambulancia aérea fuera de la red de la misma manera que tales servicios están cubiertos para los proveedores de ambulancia aérea dentro de la red.

No se cubren los costos de traslado en ambulancia para la conveniencia exclusiva de usted, su acompañante o proveedor.

Anticonceptivos: Los métodos anticonceptivos prescritos por la FDA para las mujeres y la esterilización femenina están cubiertos bajo los servicios de atención preventiva para la mujer, incluyendo, pero sin limitarse a, los siguientes:

- Diafragmas: colocación e insumos
- Capuchón cervical: colocación e insumos
- Dispositivo intrauterino (DIU): colocación, insumos y remoción (incluido el de cobre o con progestina)
- Píldoras anticonceptivas (incluidas la píldora combinada, solo con progestina y de uso extendido/permanente)
- Parche para el control de la natalidad
- Anillo vaginal
- Inyección (por ejemplo, Depo Provera) colocada por un médico o un enfermero cada tres meses
- Método anticonceptivo implantable (por ejemplo, Implanon)
- Plan B, cuando sea recetado
- Ella, cuando sea recetado
- Esterilización femenina (incluidos el implante de esterilización quirúrgica y la cirugía)
- Esponja vaginal, cuando sea recetada
- Condones comprados por una mujer, cuando sean recetados
- Espermicida, cuando sea recetado

El AMP cubrirá los anticonceptivos genéricos solo cuando un médico los recete (y los anticonceptivos de marca cuando sea médicamente necesario). Si el médico tratante considera que un anticonceptivo de marca es médicamente necesario, usted o su médico pueden solicitar una excepción para la cobertura del medicamento de marca. Consulte **Proceso de excepciones de atención preventiva** en el capítulo **Beneficio de farmacia**.

La atención y los dispositivos que no se incluyen en el beneficio de anticonceptivos son:

- Aborto, salvo lo dispuesto en **Interrupción del embarazo** en esta sección
- Medicamentos abortivos prescritos, incluido, por ejemplo, el RU486
- Métodos anticonceptivos de venta libre que no se recetan, incluido, pero sin limitarse al Plan B, espermicidas, condones, esponjas vaginales, termómetros basales y kits de predicción de la ovulación.

Ensayos clínicos: Los ensayos clínicos aprobados están cubiertos en circunstancias limitadas. Los costos de rutina para los pacientes que estén relacionados con la participación en las fases I a IV de los ensayos clínicos aprobados para tratar el cáncer u otras enfermedades que ponen en peligro la vida, según lo determine la TPA y lo exija la ley. Estos costos están sujetos a los deducibles y las limitaciones correspondientes del AMP y no incluyen los costos del elemento, dispositivo o servicio en investigación, elementos que se proporcionan para la recolección de datos o servicios que son incompatibles con las normas de atención establecidas.

Servicios de comadrona: El AMP cubre los servicios de doula para las mujeres embarazadas inscritas en los planes Premier, Contribution o Saver, o en las opciones locales del plan Mercy Arkansas o Banner, independientemente de la necesidad médica. El beneficio tiene un límite de $1,000 por embarazo. La cobertura no está sujeta al deducible y no se requiere coseguro ni copago. Los montos pagados por los servicios de doula no se aplican al deducible ni al gasto de desembolso máximo. El beneficio forma parte del Programa vida con bebé. Para comenzar, llame al TPA al número que figura en la tarjeta de identificación de su plan y el gerente de cuidados que facilita apoyo para el Programa vida con bebé le indicará cómo puede acceder a los servicios de doula. Asimismo, puede comunicarse con una doula virtual a través de Kindbody. Este programa de doula virtual facilita atención, educación y recursos de doula virtual para facilitar apoyo durante el embarazo, el parto y el posparto, para que usted y su bebé logren los mejores resultados. Obtenga más información en **Kindbody.com/Walmart**. Las doulas en persona deben contar con acreditación a través de DONA International o la National Black Doula Association, o si están afiliadas a otra organización de doulas, deben aceptar firmar un formulario de certificación que indique que han completado la capacitación profesional de doula. Los montos por los servicios de doula están sujetos a impuestos.

Equipo médico duradero (DME)/suministros médicos para el hogar: Los equipos médicos duraderos que satisfacen todos los criterios siguientes están cubiertos, salvo lo indicado en la sección de **equipos médicos duraderos no cubiertos** abajo.

Estas son algunas características del equipo DME:

- Se puede utilizar repetidamente
- Se utiliza principalmente por un motivo médico y no por comodidad o conveniencia
- Por lo general, no resulta útil en ausencia de una enfermedad o lesión
- Está relacionado con una afección médica y es recetado por un médico
- Es adecuado para el uso en el hogar y
- Está determinado que cumple con los criterios médicos de cobertura para diagnosticar o tratar una enfermedad o lesión, ayudar a mejorar el funcionamiento de una parte malformada del cuerpo, ayudar a que una parte dañada del cuerpo funcione dentro de los parámetros funcionales o evitar que una afección empeore.

La cobertura para insumos médicos para el hogar, tales como insumos para ostomías, para el tratamiento de heridas, insumos para traqueotomías y ortótica. Un doctor en medicina (MD) o un doctor en osteopatía (DO) deben recetar los insumos para que puedan obtener cobertura. Las medias quirúrgicas están limitadas a 12 pares por año calendario.

Para tener cobertura, un médico debe incluir un diagnóstico, el tipo de equipo necesario y el tiempo esperado de uso. Algunos ejemplos de DME son las sillas de ruedas, las camas de hospital y los andadores. Si el equipo se alquila, el beneficio total no puede exceder el precio de la compra en el momento en que comenzó el alquiler.

La reparación del DME se cubre si se cumplen todas las condiciones siguientes:

- El paciente es el propietario del equipo
- Las reparaciones necesarias no son consecuencia de la negligencia del paciente o el uso indebido del equipo
- El gasto que conlleva una reparación no excede el gasto de la compra de un equipo nuevo y
- La garantía no cubre el equipo.

Si el DME que posee el paciente se encuentra en reparación, se cubrirá el alquiler por hasta un mes de ese DME. El pago depende del tipo de dispositivo de reemplazo que se proporciona, pero no excederá el alquiler del equipo que está en reparación.

Los equipos médicos que no están cubiertos son: scooters eléctricos, estimuladores implantables e invasivos para el crecimiento de los huesos (excepto en el caso de cirugías de columna), bañeras en forma de silla, asientos elevables, sillas rodantes, vaporizadores, orinales, un sistema de terapia de luz ultravioleta para el hogar, equipo para bañeras de hidromasaje, bacinillas, baños portátiles de parafina, almohadillas térmicas, lámparas térmicas, compresas frías, calientes o de vapor, dispositivos para medir o registrar la presión arterial (excepto cuando se proporcionan junto con la atención primaria virtual a través de Doctor On Demand) y otros equipos o productos médicos que sean para investigación no son médicamente necesarios.

Tratamiento para la formación de familias: Es posible que los servicios de fertilidad, como la FIV y la IIU, estén cubiertos por el programa Centros de Excelencia. Tales servicios cubiertos están sujetos a un beneficio máximo de por vida de $20,000 por participante individual, y solo cuando los servicios sean facilitados por Kindbody. Para más información, consulte la sección **Centros de Excelencia** de este capítulo.

Cuidado de los pies: para la atención podológica no quirúrgica en relación con el tratamiento de las siguientes afecciones, el AMP permite un total de tres visitas al proveedor por año calendario:

- Juanetes
- Callos o callosidades
- Pies planos, desequilibrados o con falta de estabilidad
- Metatarsalgia
- Dedo en martillo
- Hallux valgus/dedos en garra
- Fascitis plantar

La prescripción de los servicios debe estar a cargo de un doctor en medicina (MD), doctor en osteopatía o doctor en podología (DPM).

La atención quirúrgica de corte abierto (incluida la extracción de las raíces de las uñas) y la atención no quirúrgica a causa de una enfermedad metabólica y vascular periférica no están sujetas al límite por año calendario.

Es posible que haya cobertura para los dispositivos ortopédicos para los pies si los receta un médico calificado y se moldean a medida bajo la supervisión del médico, sujetos a un máximo de tres visitas al proveedor por año natural. Los zapatos ortopédicos recetados por un médico se limitan a dos pares de zapatos ortopédicos por año calendario.

Tratamiento para la disforia de género: los servicios médicamente necesarios para el tratamiento de la disforia de género se incluyen dentro de la cobertura:

- Cirugía de reasignación de sexo, incluida la cirugía para que un hombre se convierta en mujer y viceversa
- Terapia de sustitución hormonal, incluidas las pruebas de laboratorio para controlar la terapia hormonal y
- Visitas para psicoterapia.

Los servicios de salud cosmética que no son médicamente necesarios no están cubiertos. La cirugía de cambio de sexo no se considera necesaria a efectos médicos para los menores de 18 años.

Dispositivos auditivos: se proporciona cobertura para audífonos externos y las visitas al médico relacionadas, sujeto a las condiciones del AMP aplicables, una vez cada cinco años para los adultos y una vez cada dos años para los niños de 18 años o menos. El cambio de las baterías no está cubierto.

Atención de enfermería domiciliaria: se cubrirán los servicios de enfermería profesional de atención privada domiciliaria si los presta un enfermero vocacional autorizado aprobado por el estado (LVN), un enfermero autorizado matriculado (LPN) o un enfermero licenciado (RN). Estos servicios no pueden ser prestados por un pariente ni una persona del mismo grupo familiar que el paciente. Los beneficios de atención de enfermería en el hogar están cubiertos hasta un máximo de 100 visitas por año calendario. Una visita comprende dos horas o menos. Este máximo no se aplica a las afecciones de salud menta.

Cuidados paliativos: Los cuidados paliativos son un programa integrado que ofrece servicios de comodidad y apoyo a las personas que padezcan enfermedades terminales. Los cuidados paliativos están cubiertos si la esperanza de vida estimada es de 12 meses o menos, de acuerdo con el certificado del médico que trata la enfermedad. La atención en centros de cuidados paliativos puede proporcionarse a un paciente hospitalizado o externo e incluye atención física, psicológica, social, espiritual y de relevo para la persona con una enfermedad terminal así como apoyo a los familiares más cercanos, incluidas las parejas, mientras la persona recibe la atención en centros de cuidados paliativos. Los beneficios están disponibles solo cuando la atención en centros de cuidados paliativos se recibe de una agencia de cuidados paliativos con licencia, que puede ser un hospital.

La atención en centros de cuidados paliativos para pacientes hospitalizados y ambulatorios está cubierta hasta 365 días por enfermedad. Los participantes pueden continuar recibiendo tratamiento y participando de ensayos clínicos aprobados mientras se obtienen servicios en centros de cuidados paliativos. Es posible que haya cobertura disponible para días adicionales si se determina que es médicamente necesaria.

Tratamiento de la infertilidad: Los servicios para el diagnóstico y la corrección de una condición subyacente de infertilidad generalmente están cubiertos bajo los términos de AMP que de otra forma puedan ser aplicables. Algunos servicios de fertilidad, como la FIV y la IIU, pueden estar cubiertos por el programa de Centros de Excelencia, sujetos a un beneficio máximo de por vida de $20,000. Consulte la sección **Centros de Excelencia** de este capítulo para obtener información sobre los servicios de fertilidad cubiertos.

Consulte **Qué no está cubierto por el AMP** que aparece más adelante en este capítulo y obtenga una lista de los servicios no cubiertos para la infertilidad.

Cobertura médica internacional para viajes de negocios: Walmart ofrece seguro médico internacional para negocios a través de una póliza de seguro de GeoBlue. Si participa en el Plan de Ahorro, no es elegible para realizar aportes a una HSA durante ningún mes en el que se encuentre viajando por negocios de la compañía fuera de los EE. UU. y cuente con cobertura conforme a la póliza de GeoBlue, la cual proporciona una cobertura de beneficio médico para los asociados que viajan por negocios al exterior. Se le recomienda consultar con su asesor impositivo si tiene preguntas sobre el monto para reducir sus aportes en función de sus circunstancias individuales.

Terapia matrimonial, familiar o relacional o terapia para ayudar a conseguir un desarrollo intra o interpersonal más efectivo: Los servicios solo están cubiertos cuando el diagnóstico está relacionado con una afección mental.

Asesoramiento nutricional: Se cubre dentro del Plan el asesoramiento nutricional para niños si es médicamente necesario debido a una enfermedad crónica (por ejemplo, PKU, enfermedad de Crohn, enfermedad celíaca, galactosemia, etc.) o un trastorno alimenticio en el que una adaptación en la alimentación tiene una función terapéutica cuando lo receta un médico y lo ofrece un proveedor (por ejemplo, un dietista licenciado, un nutricionista licenciado u otro profesional de la salud licenciado y calificado) reconocido bajo el AMP. Los beneficios se limitan a tres consultas por afección por año para enfermedades crónicas. Este límite de visitas no se aplica a las afecciones mentales. Consulte la **Programa de atención preventiva** sección para obtener información sobre beneficios adicionales relacionados con el asesoramiento nutricional y de obesidad para adultos y niños.

Uso no autorizado de medicamentos inyectables para la quimioterapia para pacientes con cáncer: Estos medicamentos se cubrirán siempre que se consideren médicamente necesarios, los recomiende uno de los siguientes tres compendios de medicamentos y no los recomiende uno o más de los mismos compendios (pertinente a la fecha de servicio):

- Información sobre medicamentos del AHFS
- Farmacología clínica; o
- La Red Nacional Integral del Cáncer (NCCN) (consenso), categoría 1 (la recomendación se basa en evidencia de alto nivel y hay un consenso uniforme de la NCCN), o categoría 2A (la recomendación se basa en evidencia de nivel inferior y hay un consenso uniforme de la NCCN).

Si usted o su médico no están seguros sobre cuál es la cobertura del AMP para algún tipo de medicamento recetado, verifique los detalles de la cobertura llamando al TPA de su plan médico al número que figura en la tarjeta de identificación de su plan. También puede llamar a OptumRx al **844-705-7493**.

Uso no autorizado de medicamentos inyectables para la quimioterapia para pacientes que no tienen cáncer: Estos medicamentos se cubrirán siempre que se consideren médicamente necesarios y los recomiende uno de los siguientes compendios de medicamentos (pertinente a la fecha de servicio):

- Información sobre medicamentos del AHFS, o
- Farmacología clínica en línea.

El AMP no cubre ningún medicamento que la Administración de Alimentos y Medicamentos (FDA) haya determinado que su administración está contraindicada o no es recomendable. La cobertura para los medicamentos aprobados por la FDA está sujeta a los requisitos y las limitaciones correspondientes del AMP.

Tratamiento bucal: Los cargos por el cuidado de los dientes y las encías están cubiertos si los solicita un médico o dentista; los cuales incluyen, entre otros:

- Recetas, incluidas las que no están cubiertas por el beneficio de farmacia
- Servicios en Departamento de Emergencia por dolor bucal
- Tratamiento de fracturas o dislocaciones de la mandíbula como resultado de una lesión accidental
- Lesión accidental de las piezas dentarias naturales hasta un año después de la fecha del accidente (no se incluyen las lesiones causadas por el acto de morder o masticar; es posible que se cubra conforme al plan dental)
- Procedimientos odontológicos que son necesarios debido a una enfermedad grave (por ejemplo, cáncer) o a un evento traumático, si el servicio odontológico sea médicamente necesario y sea inherente y parte integral del servicio cubierto por los beneficios médicos del AMP. Algunos ejemplos de servicios son, entre otros, la extracción de dientes antes o después de quimioterapia o radioterapia de cabeza y cuello. El tratamiento de tejidos bucales relacionados con la quimioterapia debe estar fundamentado con documentación que demuestre una relación directa entre las encías o el hueso destruidos y la quimioterapia.
- Procedimientos de cortes no odontológicos en la cavidad bucal
- Complicaciones médicas que son el resultado de un procedimiento odontológico
- Los gastos por servicios odontológicos realizados en un ambiente hospitalario, que incluyen cargos de centros de atención y profesionales por procedimientos generales en los que un cirujano bucal no puede suministrar anestesia general en un consultorio o por circunstancias que limitan la capacidad de un cirujano bucal de brindar servicios en un consultorio. Dichas circunstancias incluyen, entre otras, situaciones en las que la persona cubierta cumple las siguientes condiciones:
  - El niño es menor de 4 años
  - Entre 4 y 12 años, cuando se cumple alguna de estas condiciones:
- La atención en un consultorio odontológico y los métodos comunes de modificación de la conducta no fueron exitosos; o
- Se requieren cantidades extensas de atención (más de cuatro citas).
  - Un individuo con una de las siguientes afecciones médicas, que requiere hospitalización o anestesia general para el tratamiento odontológico:
- Enfermedades respiratorias
- Afecciones cardíacas
- Trastornos de coagulación
- Discapacidad grave (por ejemplo, parálisis cerebral, autismo, discapacidad del desarrollo)
- Otra enfermedad grave (por ejemplo cáncer o trastorno neurológico)
- Tracto respiratorio comprometido
  - Un individuo de cualquier edad cuya afección requiere procedimientos extensos que impiden que un cirujano bucal utilice anestesia general en el consultorio

Terapia ocupacional/física para pacientes ambulatorios: Los cargos por fisioterapia y terapia ocupacional para pacientes ambulatorios están cubiertos cuando los servicios cumplen las siguientes condiciones:

- Los servicios son recetados por un doctor en medicina (MD), un doctor en osteopatía o un doctor en podología (DPM), y
- Los servicios son prestados por un fisioterapeuta o un terapeuta ocupacional matriculado o por uno de los tipos de médicos antes mencionados.

Este beneficio es pagado hasta un máximo de 20 visitas para fisioterapia y 20 visitas para terapia ocupacional por año calendario. Las consultas adicionales pueden cubrirse en caso de que los administradores de salud lo consideren adecuado. Este máximo no se aplica a las condiciones de salud mental.

Beneficios para embarazos: Los gastos de embarazos se cubren de igual manera que cualquier otra afección médica. Vea la sección titulada **Servicios de doula** más arriba en esta sección para obtener información sobre los servicios de doula. (Los servicios prenatales elegibles están cubiertos en virtud del programa de atención preventiva).

Se pagan beneficios por los gastos relacionados con embarazos de hijos dependientes. El recién nacido recibirá cobertura únicamente si es un dependiente cubierto del asociado con cobertura. Consulte **Cómo cambiar sus opciones debido a un evento de cambio de elección** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información sobre cómo inscribir a un recién nacido en la cobertura.

Pruebas de antígeno prostático específico (PSA): Solamente se cubren cuando se realizan como parte de un diagnóstico clínico.

Protésicos: Los dispositivos protésicos (como las extremidades artificiales) están cubiertos si son médicamente necesarios y los receta un médico, sujeto a los términos y condiciones del AMP. Se permitirá la sustitución de prótesis solo con un cambio de receta. Un traumatólogo especialista en ortopedia matriculado debe realizar las sustituciones de miembros artificiales.

La rehabilitación: para pacientes hospitalizados o de día está cubierta hasta un máximo de 120 días por afección, si se cumplen los criterios clínicos, para los siguientes grupos clínicos:

- Accidente cerebrovascular
- Lesión de la médula espinal
- Lesión cerebral
- Enfermedad congénita
- Trastornos neurológicos
- Amputación
- Osteoartritis grave o avanzada que afecte a dos o más articulaciones que soportan el peso del cuerpo
- Artritis reumatoide o de otro tipo
- Vasculitis sistémica con inflamación de las articulaciones
- Traumatismo múltiple grave, o
- Quemaduras

Atención de las especialidades: La atención médica que se brinda habitualmente en los siguientes establecimientos se cubre si se lo admite en este nivel de atención después de una hospitalización elegible para recibir cuidados intensivos:

- Centro de atención prolongada
- Centro de atención intensiva especializada a largo plazo
- Centro de atención de casos subagudos
- Centro de enfermería especializada, o
- Centro de atención transitoria.

Los beneficios se limitan a un máximo de 60 días calendario por periodo de discapacidad. Los periodos sucesivos de hospitalización debidos a los mismos motivos o a causas relacionadas se consideran como un periodo de discapacidad, a menos que estén separados por un periodo de recuperación completa.

Fonoaudiología: La terapia: está limitada a 60 consultas por año calendario cuando:

- Es recetada por un doctor en medicina (MD) o un doctor en osteopatía (DO); y
- Es provista por un terapeuta de comunicación licenciado.

Puede solicitarle al médico que emite la receta informes de progreso sobre los planes de tratamiento iniciales y en curso. Para tener cobertura, el tratamiento ortofónico debe realizarse por una deficiencia residual del habla como resultado de:

- Un accidente cerebrovascular
- Una lesión en la cabeza o el cuello
- Parálisis parcial o completa de las cuerdas vocales o la laringe
- Intervención quirúrgica de cabeza o cuello, o
- Trastornos del habla congénitos y graves del desarrollo. El límite de visitas no se aplica a las condiciones de salud mental.

Visita de telesalud: Las visitas de telesalud a través de Doctor On Demand de Included Health son sin costo alguno antes de que alcance su deducible, a menos que esté inscrito en la opción del plan Saver. Si está inscrito en la opción del Plan Saver, primero deberá satisfacer su deducible. Las visitas de telesalud que no se hagan a través de Doctor On Demand de Included Health están cubiertas en las mismas condiciones que las visitas en persona, incluido el reparto de costos y la cobertura que dependa de si el proveedor es o no parte de la red.

Terminación del embarazo: Los gastos por procedimientos, servicios, medicamentos y suministros relacionados con la interrupción del embarazo, incluidos los servicios de aborto, no están cubiertos, excepto cuando la ley lo permita: 1) cuando el médico que atiende a la mujer determina que su salud estaría en peligro si el feto llegara a término, el feto no podría sobrevivir hasta el momento del parto o nacimiento, o la muerte del feto sería inminente tras el nacimiento, 2) en los casos en que la mujer está embarazada debido a una violación o incesto, o 3) en caso de embarazo ectópico o aborto espontáneo. Consulte **Beneficio de viaje para atención** en la tabla **Navegar sus beneficios** para más información sobre los servicios de viaje que pueden estar disponibles.

Servicios de trasplante: Consulte la sección de este capítulo **Centros de Excelencia** para obtener información sobre los servicios de trasplante que están cubiertos por el programa de los Centros de Excelencia. Los servicios de trasplante de córnea e intestino no están cubiertos por el programa de los Centros de Excelencia, pero son servicios cubiertos según las condiciones del AMP que sean aplicables. El trasplante de partes del cuerpo (por ejemplo, cara, manos, pies, piernas, brazos, útero) no está cubierto en ningún caso.

Servicios para la vista: el diagnóstico y el tratamiento de una lesión o enfermedad en los ojos tienen cobertura (por ejemplo, retinopatía diabética, glaucoma y degeneración macular, etc.). No están cubiertos los cargos por atención de la visión de rutina, por ejemplo, análisis de la visión, exámenes oculares o intervenciones quirúrgicas de los ojos para corrección de miopía o corrección de la visión, excepto los exámenes oftalmológicos para niños cubiertos conforme a las pautas de atención preventiva. Algunos de estos servicios pueden estar cubiertos conforme al plan de la visión. Consulte el capítulo **Plan de la visión**.

Tratamiento de pérdida de peso: La cirugía de pérdida de peso está cubierta solo por el programa de los Centros de Excelencia cuando cumple con las pautas específicas de elegibilidad y los criterios clínicos. Los tratamientos para adelgazar, incluidos los medicamentos, los suplementos dietarios y las cirugías que se encuentran fuera del alcance del programa de los Centros de Excelencia, no se encuentran cubiertos. Consulte la sección **Centros de Excelencia** de este capítulo para obtener información sobre la cirugía para la pérdida de peso. Los medicamentos recetados únicamente para adelgazar tampoco están cubiertos por el beneficio de farmacia. Para obtener información detallada sobre otros medicamentos recetados no cubiertos por el beneficio de farmacia, consulte el capítulo **Beneficio de farmacia**.

Qué no está cubierto por el AMP

Además de las exclusiones y limitaciones que se indican en la sección **Cuándo se aplican beneficios limitados al AMP** de este capítulo, la siguiente lista incluye los servicios que no están cubiertos por el AMP. Los descuentos de la red no se aplican a estos servicios.

Si se inscribe en el Plan Saver, es posible que pueda utilizar los fondos de su HSA para estos servicios y costos y otros gastos médicos calificados. Para obtener información, comuníquese con el administrador de la HSA.

Si desea averiguar si un servicio está cubierto por el AMP, comuníquese con el TPA al número que figura en su tarjeta de identificación del plan o consulte **Para obtener más información** al final de este libro para obtener los detalles de contacto.

Acupuntura

Servicios Administrativos y Comisiones por Intereses: Costos provenientes de emisión de formularios de reclamaciones, citas incumplidas, costos adicionales por citas acordadas los fines de semana o feriados, comisiones por intereses, tarifa de cobro u honorarios de abogados.

Tratamiento no tradicional/alternativo (incluidos la homeopatía, naturopatía, hipnosis y terapia con masajes).

Autopsia

Más allá del ámbito de la licencia o sin licencia: Servicios prestados por un médico, trabajador del cuidado de la salud o institución no acreditados o sin licencia, o los servicios que se presten más allá del ámbito de la licencia de tal persona o entidad, o los servicios prestados en una jurisdicción en la que tales servicios no pueden prestarse legalmente.

Biorretroalimentación

Reconstrucción o reducción de mamas: No se cubre ningún gasto o costo que resulte del agrandamiento de mamas (aumento), que incluye la colocación de los implantes y la extracción de estos, ya sea que se trate de hombres o de mujeres, excepto cuando el implante se extrae debido a daños o roturas de este. No se cubre la sustitución de un implante dañado o roto, a menos que el implante original se haya colocado según las condiciones elegibles que deberá pagar el AMP.

No se cubre ningún gasto o costo que resulte de reducciones de mamas, implantes o de la extracción total de mamas, ya sea que se trate de un hombre o de una mujer, a menos que estos procedimientos estén relacionados directamente con el tratamiento de una mastectomía, como estipula la ley (consulte **Ley de Derechos sobre la Salud y el Cáncer de la Mujer de 1998** más adelante en este capítulo), o a menos que el AMP realice una revisión médica y determine que el procedimiento es médicamente necesario.

Servicios de quiropraxia: La manipulación de la columna, las articulaciones o el tejido blando, más allá del tipo de proveedor que brinde el servicio, excepto por la cobertura limitada de los servicios dentro de la red proporcionados a los participantes inscritos en el plan local de Mercy Arkansas.

Copagos o descuentos, deducibles o coseguros

Servicios de salud estética o cirugía reconstructiva: Excepto en caso de anomalía congénita, servicios cubiertos por la ley (consulte **Ley de Derechos sobre la Salud y el Cáncer de la Mujer de 1998** más adelante en este capítulo), tratamiento de la disforia de género médicamente necesario o afecciones derivadas de lesiones accidentales, tumores o enfermedades.

Cuidados Especiales o de Relevo: Atención o servicios que se proporcionan en una institución u hogar para mantener el estado de salud actual de una persona que no se puede esperar que mejore de manera significativa.

Medicamentos, artículos y equipos no cubiertos por la FDA: El hecho de que un medicamento, artículo o equipo esté aprobado por la FDA no garantiza que sea un artículo o servicio cubierto.

Servicios educativos: Incluye cualquier servicio para los trastornos del aprendizaje y la educación (que incluyen, pero no se limitan a los trastornos de la lectura, la alexia, la dislexia del desarrollo, la discalculia, los trastornos de ortografía y otras dificultades de aprendizaje), pero excluye los servicios que son servicios preventivos descritos en la sección **Programa de atención preventiva**.

Hospitalizaciones o servicios optativos para pacientes hospitalizados y ambulatorios fuera de los Estados Unidos

Gastos relacionados con citas incumplidas, y revisión o almacenamiento de la información o los datos de atención de la salud

Tratamientos y servicios experimentales, de investigación y/o que no son médicamente necesarios: Los servicios médicos experimentales y/o de investigación son aquellos que se definen como experimentales y/o de investigación de acuerdo con los protocolos establecidos por su TPA. El TPA de los Centros de Excelencia es quien toma esta determinación para los servicios de los Centros de Excelencia.

Tratamiento con ondas de choque extracorpóreas: Para la fascitis plantar y otras afecciones musculoesqueléticas.

Compensación del Gobierno: Costos que se compensen o que otorgue el gobierno local, estatal o federal o cualquier organismo de estos, salvo que se exija el pago legalmente.

Copagos de la HMO

Ocupación ilegal, asalto, delito grave, disturbios o insurrección: Cargos por servicios, insumos o tratamientos médicos que surgen de su participación en una ocupación ilegal, un asalto, un delito grave o una ofensa criminal (excepto en el caso de infracción de tráfico), o de su participación en un disturbio o insurrección, o que se prestan durante tales circunstancias.

Servicios de infertilidad, incluyendo:

- Cargos para revertir un procedimiento de esterilización; y
- Cargos por, o relacionados con, los servicios de un vientre de alquiler.

Algunos servicios de fertilidad pueden prestarse bajo los Centros de Excelencia; consulte la sección **Centros de Excelencia** de este capítulo.

Juicios y acuerdos

Reclamaciones tardías: reclamaciones recibidas más de 12 meses después de la fecha de servicio. Consulte **Presentar una reclamación médica (que no sean los beneficios de viaje por atención)** que aparece más adelante en este capítulo para obtener información sobre la coordinación de beneficios.

Lesión o enfermedad relacionada con el servicio militar: incluidas lesiones o enfermedades relacionadas con actos de guerra, declarados o no, o provocadas por estos.

Neurorretroalimentación

Proveedores o instituciones no acreditados/no autorizados

Servicios no cubiertos:

- Servicios no incluidos como beneficio en este Libro de Beneficios para Asociados
- Servicios prestados después de exceder el beneficio máximo o las visitas máximas para servicios específicos
- Servicios por los cuales usted debe pagar, por ejemplo, cargos no cubiertos.
- Servicios que se faciliten en una jurisdicción en la que tales servicios no pueden prestarse legalmente
- Servicios que no son médicamente necesarios (a menos que se indique lo contrario)
- Cargos por servicios que excedan el cargo máximo permitido por el AMP
- Cargos relacionados con los trámites de certificación de licencia, o
- Cargos por historiales médicos.

Gastos en efectivo

Medicamentos y equipos de venta libre: excepto medicamentos específicos para el cuidado preventivo. Para obtener más información, consulte el capítulo **Beneficio de farmacia**.

Artículos para el cuidado personal: Artículos principalmente para la comodidad o conveniencia personal, incluidos, entre otros, pañales, barandillas en bañeras, pasamanos, sillas elevadoras, mesas para comer en la cama, toallitas para incontinencia,

rampas, asientos ajustados, artículos recreativos, mejoras para el hogar y electrodomésticos, bañeras de hidromasaje, pelucas y almohadillas para rodillas para la práctica de deportes.

Servicios prestados por un miembro de la familia cercana del paciente

Servicios prestados por una entidad gubernamental mientras se encuentra encarcelado

Servicios y productos farmacéuticos relacionados con la disfunción sexual: Incluye terapia, tratamiento o productos farmacéuticos para el tratamiento de la disfunción sexual, excepto la disfunción sexual que resulte de una lesión accidental o del tratamiento de una enfermedad o afección (por ejemplo, disfunción eréctil que resulte de una prostatectomía o de una lesión de la médula espinal).

Exámenes físicos escolares/deportivos: Los cargos relacionados con los exámenes físicos realizados para determinar si una persona está en condiciones de practicar un deporte o realizar una actividad escolar.

Maternidad subrogada: Tarifas relacionadas con la subrogación (que no sean los costos de atención de maternidad para un participante que esté cubierta por el AMP), ya sea para pagar servicios de otros o actuar como sustituta.

Viaje y alojamiento, a excepción de lo especificado en los Centros de Excelencia o en los beneficios de viaje para cuidados: Consulte el **Beneficio de viaje para cuidados** en la tabla **Navegar sus beneficios** para más información sobre los servicios de viaje que pueden estar disponibles.

Vitaminas: Cargos por vitaminas no recetadas (orales o inyectables), minerales, suplementos nutricionales o suplementos dietarios, excepto según se establece en la sección **Programa de atención preventiva** de este capítulo.

Programas diseñados para el fortalecimiento del trabajo o de las profesiones; Compensación de trabajadores: El tratamiento de cualquier lesión compensable, según se define en la Ley de Compensación para Trabajadores vigente, independientemente de si presentó o no la reclamación de los beneficios de compensación para trabajadores de forma oportuna.

Presentar una reclamación médica (que no sean los beneficios de viaje por atención)

La información de esta sección es solo un resumen. Consulte el capítulo **Reclamaciones y apelaciones** para obtener instrucciones para presentar una reclamación de beneficios. No satisfacer las instrucciones del capítulo **Reclamaciones y apelaciones** podría dar lugar a la denegación de la reclamación.

Si utiliza un proveedor de la red, el proveedor generalmente presentará la reclamación en su nombre. Si utiliza un proveedor fuera de la red, es posible que usted deba presentar la reclamación. Puede encontrar los formularios de reclamación en **One.Walmart.com/Medical**. Debe presentar la reclamación dentro de los 12 meses a partir de la fecha de servicio.

NOTA: El plazo para presentar reclamaciones que sucedieron antes del 1 de enero de 2025 es de 18 meses.

Si necesita presentar una reclamación, esta debe incluir la siguiente información:

- Nombre del paciente
- Nombre, dirección y número de identificación fiscal del proveedor
- Identificación del seguro del asociado (aparece en la tarjeta de identificación del plan)
- Fecha del servicio
- Monto de los costos
- Códigos del procedimiento médico (deben figurar en la factura)
- Diagnóstico

Busque la dirección correcta a la que debe enviar la reclamación en su tarjeta de identificación del plan. El envío de su reclamación a la dirección incorrecta puede resultar en el rechazo de su reclamación. Las reclamaciones se determinan dentro de los plazos y requisitos que se indican en el capítulo **Reclamaciones y apelaciones**.

Una vez que incurra en gastos médicos y presente una reclamación, o se presente una reclamación en su nombre, los beneficios se pagarán directamente al proveedor de servicios de la red. El pago al proveedor exime al Plan de las obligaciones hacia usted por dicho beneficio.

Si su plan proporciona cobertura para proveedores fuera de la red y usted utiliza uno, es posible que el pago se le realice directamente a usted luego de que presente un comprobante de pago en su totalidad a su proveedor. Usted es responsable de pagar su costo compartido, más cualquier monto que supere el cargo máximo permitido. Para su comodidad, el pago también se puede realizar a un proveedor fuera de la red, si usted autoriza explícitamente dicho pago. Su proveedor, pertenezca o no a la red, puede no presentar apelaciones en su nombre, a menos que designe a su proveedor como representante autorizado, tal como se describe en el capítulo **Reclamaciones y apelaciones**. El Plan prohíbe la asignación de beneficios o reclamaciones legales, o causa de acción (ya sea conocida o no).

Tiene derecho a apelar una reclamación rechazada, tal como se describe en el capítulo **Reclamaciones y apelaciones**.

Presentar una reclamación de beneficios de viaje por atención

Si Included Health no da aprobación previamente de sus beneficios de viaje para la atención y usted no está de acuerdo con tal determinación, puede presentar una reclamación de beneficios previa al servicio por escrito. Puede encontrar los formularios de reclamación en **One.Walmart.com/Medical** o bien puede llamar a Included Health at **800-941-1384** para solicitar una copia impresa.

Las reclamaciones de beneficios de viaje para la atención se decidirán de acuerdo con los procedimientos y plazos generales para las reclamaciones previas al servicio que se detallan en la sección **Proceso de reclamaciones de beneficios médicos, farmacéuticos, de Centros de Excelencia, dentales y de la vista** del capítulo **Reclamaciones y apelaciones**. Para obtener información sobre dónde presentar una reclamación, consulte el formulario de reclamación en **One.Walmart.com/Medical**.

Si tiene cobertura conforme a más de un plan médico

El AMP tiene el derecho de coordinar con "otros planes" que le ofrecen cobertura de manera que los beneficios médicos totales que se deben cubrir no excedan el nivel de beneficios que, en caso contrario, se deben cubrir conforme al AMP. La denominación "otros planes" se refiere a los siguientes tipos de cobertura médica:

- Cobertura conforme a un programa de gobierno otorgado o exigido por ley, incluida la cobertura sin designación de culpa en la medida en que se exija en pólizas o contratos por una ley de seguros de vehículos motorizados o legislación similar;
- Seguro grupal u otra cobertura para un grupo de personas, incluida la cobertura conforme a otro plan del empleador o la cobertura para estudiantes obtenida a través de una institución educativa
- Toda cobertura conforme a los planes fiduciarios de gestión laboral, planes de gremios para el bienestar, planes de organizaciones de empleadores o planes de organizaciones de beneficios para empleados;
- Toda cobertura conforme a planes gubernamentales, como Medicare o Tricare, excepto en el caso de un plan estatal de Medicaid u otro plan gubernamental cuando, por ley, sus beneficios son secundarios a los de otro seguro privado o programa no gubernamental; y
- Toda póliza o plan de asociación o privados de reembolso de gastos médicos con capacidad grupal o individual.

Cuando tiene la cobertura de más de un plan, se designa a uno de ellos como el plan principal. El plan principal paga primero e ignora los beneficios que se deben cubrir conforme a otros planes cuando se los determine. Se designa cualquier otro plan como el plan secundario que paga los beneficios después del plan principal. Un plan secundario resta de sus beneficios el monto de beneficios que se deben cubrir conforme a "otros planes" y puede limitar los beneficios que paga.

Debe cumplir con las cláusulas del plan principal a fin de que el AMP pague como pagador secundario. Estas reglas se aplican independientemente de que se presente o no una reclamación conforme al otro plan. Si no se presenta una reclamación en el otro plan y el otro plan es el principal, los beneficios conforme al AMP quedarán pendientes o se rechazarán hasta que se reciba una explicación de los beneficios que demuestre que se presentó la reclamación ante el plan principal.

El AMP no coordinará como pagador secundario para ninguno de los copagos que usted realice con respecto a otro plan o con respecto a las reclamaciones de medicamentos recetados o trasplantes (excepto cuando el otro plan sea Medicare).

Si reside en un estado en el que es obligatorio tener cobertura de seguro de automóviles sin designación de culpa, cobertura de protección por lesiones personales o cobertura de pagos médicos, esa cobertura es la principal y el AMP adopta la condición de secundario. El AMP reduce los beneficios por un monto igual al requisito mínimo obligatorio del estado.

Otras reglas:

- El AMP tiene máxima prioridad de derecho a la reducción, al reembolso y a la subrogación.
- El AMP no coordinará beneficios con una HMO o con un plan de atención administrada similar en el que usted solo paga un copago o un monto fijo en dólares.
- El AMP no coordinará con ningún otro plan que no sea Medicare con respecto a un trasplante cubierto.

COORDINACIÓN DEL AMP CON OTROS PLANES

	Ejemplo 1	Ejemplo 2	Ejemplo 3
Si otro plan paga como plan principal al	80 %	80 %	0 %
Y el pago del AMP es:	75 %	100 %	75 %
El beneficio total del AMP es:	0 %	20 %	75 %

DETERMINAR CUÁL ES EL PLAN PRINCIPAL

Un plan sin una disposición de coordinación es siempre principal. El AMP incluye una disposición de coordinación. Si todos los planes incluyen una disposición de coordinación, se aplicarán las siguientes disposiciones:

- El AMP siempre es el pagador secundario para cualquier política de vehículos de motor que tenga a su disposición, incluida la protección contra lesiones personales o cobertura sin designación de culpa. Si el plan paga beneficios como resultado de lesiones o enfermedades que usted tuvo y otra parte (por ejemplo, una compañía aseguradora) tiene responsabilidad principal para sus gastos médicos cubiertos, el Plan tiene un derecho legal para el reembolso de beneficios. Consulte el capítulo **Reclamaciones y apelaciones** para obtener más información.
- El plan que cubre al participante para el que se realizó la reclamación, que no sea como dependiente, paga primero y el otro plan paga en segundo término.
- Si el participante del plan está cubierto conforme al plan médico para jubilados que incluye una disposición de coordinación de beneficios, prevalecerá la disposición.
- En lo que respecta a las reclamaciones de hijos dependientes, el plan del progenitor que primero cumple años en el año calendario es el primario.
- Cuando las fechas de cumpleaños de ambos progenitores coinciden en el mismo día, el plan que ha cubierto a la persona a cargo por un periodo de tiempo mayor es el primario.
- Cuando los progenitores de un hijo dependiente están divorciados o separados, o la pareja de hecho o relación legal se termina, y el progenitor que tiene la custodia no se ha casado de nuevo, el plan de ese progenitor es el principal.
- Cuando el progenitor con custodia se ha casado de nuevo, o ha iniciado una relación de hecho con otra persona, el plan de ese progenitor es el primario, el plan del nuevo cónyuge paga en segundo término y el plan del progenitor sin custodia paga en última instancia.

- Cuando existe una sentencia del tribunal que establece la responsabilidad financiera de los gastos de atención de la salud del niño, el plan que cubre al progenitor con responsabilidad financiera es el principal.
- Si estas reglas no establecen un orden de determinación de beneficios, el plan que ha cubierto al afiliado para el que se realizó la reclamación durante el periodo más extenso será el principal.
- Si usted está cubierto conforme a un derecho de continuación de cobertura según la ley federal o estatal (por ejemplo, la cobertura de continuación de COBRA) y también está cubierto conforme a otro plan que lo cubre como empleado, suscriptor afiliado o jubilado (o como dependiente de esa persona), el último plan es el plan principal y la continuación de la cobertura es secundaria. Si el otro plan no tiene esta norma, y los planes no llegan a un acuerdo con respecto al orden de los beneficios, esta norma no se aplica.

SI USTED O UN DEPENDIENTE ESTÁ CUBIERTO CONFORME A MEDICAID

Si usted o su dependiente son participantes del AMP y tienen la cobertura de Medicaid, el AMP pagará antes que Medicaid. El AMP no tendrá en cuenta la cobertura de Medicaid a los fines de la inscripción o del pago de beneficios.

Si, mientras usted está cubierto conforme a Medicaid, el AMP debe pagar beneficios, pero primero los paga el plan estatal, el pago a cargo del AMP se realizará según los requisitos de las leyes estatales correspondientes que establezcan que el pago se realizará al estado.

SI USTED O UN DEPENDIENTE ES ELEGIBLE PARA MEDICARE O ESTÁN INSCRITOS EN MEDICARE

Si está inscrito en un plan de medicamentos recetados de Medicare, no podrá inscribirse en el AMP. Además, si su dependiente está inscrito en un plan de medicamentos recetados de Medicare y usted no lo está, usted es elegible para inscribirse en el AMP, pero su dependiente no será elegible para esa cobertura.

En general, la Ley de Seguridad Social exige que el AMP sea el pagador principal si usted o un dependiente es elegible para Medicare Parte A o Partes A y B, o está inscrito en tales planes, y cumple con uno de los siguientes criterios:

- En la actualidad es empleado de Walmart y tiene más de 65 años
- En la actualidad es empleado de Walmart y su cónyuge/pareja tiene más de 65 años
- Es un participante activo o participante de COBRA que tiene derecho a Medicare sobre la base de una enfermedad renal terminal, pero sólo durante el primer periodo de 30 meses de elegibilidad para la cobertura de Medicare (se encuentre realmente inscrito en Medicare durante este periodo)
- Tiene menos de 65 años y tiene derecho a Medicare debido a una discapacidad y tiene cobertura conforme al Plan porque es un empleado de Walmart; o
- Su dependiente tiene menos de 65 años y tiene derecho a Medicare debido a una discapacidad y tiene cobertura conforme al Plan porque es un empleado de Walmart.

El AMP es secundario si usted o su dependiente están inscritos en Medicare y cumplen con uno de los siguientes criterios:

- Usted o su dependiente es participante de COBRA, excepto en el caso del vencimiento de inscripción de Medicare debido a enfermedad renal terminal, para el cual el Plan sea primario para el primer periodo de elegibilidad de 30 meses para la cobertura de Medicare; o
- Usted o su dependiente son participantes activos o participantes de COBRA inscritos para recibir Medicare debido a una enfermedad renal en etapa terminal, después de que finaliza el periodo de coordinación de 30 meses con Medicare.

SI USTED TIENE 65 AÑOS O MÁS Y ES UN ASOCIADO ACTIVO

Si aún trabaja para Walmart, puede continuar su cobertura conforme al AMP. Si también tiene Medicare, el AMP por lo general será la principal cobertura y Medicare será la secundaria. Presente su reclamación ante el AMP en primer lugar.

También puede optar por dar de baja la cobertura conforme al AMP y elegir Medicare como su cobertura principal. Si opta por Medicare como su cobertura principal, no puede elegir el AMP como su plan secundario.

COBERTURA DE SEGURO DE AUTOMÓVILES CONTRA LESIONES PERSONALES O COBERTURA DE PAGO MÉDICO EXIGIDAS POR LEY

Si reside en un estado en el que es obligatorio tener cobertura de seguro de automóviles sin designación de culpa, cobertura de protección por lesiones personales o cobertura de pagos médicos, esa cobertura es la principal y el AMP adopta la condición de secundario. El AMP reducirá los beneficios por un monto igual, pero no inferior, al requisito mínimo obligatorio del estado.

Interrupción de la cobertura

Es posible que en ocasiones deba hacer arreglos especiales para pagar sus primas médicas para evitar que se suspenda la cobertura. Estas situaciones se producen con mayor frecuencia si se encuentra en una licencia de ausencia o si su cheque de pago no es suficiente para pagar por completo la parte que le corresponde del costo de la cobertura (como por ejemplo después de una reducción de horas). El incumplimiento del pago de las primas antes de la fecha de vencimiento puede interrumpir el pago de cualquier reclamación de beneficio o una interrupción de la cobertura.

Para más detalles sobre cómo una interrupción de la cobertura puede afectarlo y sobre cómo realizar los pagos personales para continuar con la misma, consulte **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

SI SE TOMA UNA LICENCIA DE AUSENCIA

Puede continuar su cobertura hasta el último día de una licencia de ausencia aprobado, solo si paga sus primas antes de que comience la licencia de ausencia o durante este. Para obtener información sobre cómo realizar los pagos durante una licencia, consulte la sección **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Cuándo finaliza su cobertura médica

Su cobertura finaliza el último día de trabajo o cuando deja de ser elegible conforme a los términos del AMP. La cobertura para los dependientes finaliza cuando su cobertura termina o cuando un dependiente deja de ser un dependiente que reúne los requisitos (como se define en el capítulo **Elegibilidad, inscripción y fechas de vigencia**). Usted o sus dependientes cubiertos pueden ser elegibles para obtener una cobertura permanente a través de la Ley Ómnibus Consolidada de Reconciliación (COBRA) de 1985 y sus enmiendas. Para obtener información, consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)**.

Si su cobertura se cancela debido a que no pagó las primas requeridas, la cobertura finaliza el último día por el que se pagaron las primas. Para obtener más información, consulte **Pago de los beneficios** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**. No existe derecho a continuar con la cobertura conforme a la ley COBRA cuando la cobertura se cancela debido a la falta de pago de los aportes requeridos.

Si su clasificación de empleo cambia, consulte la tabla correspondiente en la sección **Cambio de una clasificación laboral a otra** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información sobre cualquier repercusión en su cobertura.

Si cancela voluntariamente la cobertura después de un evento de cambio de elección o en la Inscripción Anual, la cobertura finaliza de la siguiente manera:

- **Tras un evento de cambio de elección:** la cobertura finaliza en la fecha efectiva del evento. Para obtener más información, consulte la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** del capítulo **Elegibilidad, inscripción y fechas de vigencia**.
- **En la Inscripción anual: la cobertura** finaliza el 31 de diciembre del año en curso.

Si deja Walmart y vuelve a ser contratado

Si es usted un asociado a tiempo parcial o temporal que está sujeto a las verificaciones de elegibilidad de 60 días, una sola vez y anualmente para los beneficios médicos, consulte la sección **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener detalles sobre cómo el hecho de terminar el empleo con Walmart y luego volver a trabajar afecta sus beneficios. Consulte a continuación para obtener los detalles sobre el impacto en su deducible, el desembolso máximo y la HRA.

Si es un asociado a tiempo completo por hora, un miembro de la gerencia o conductor de camión, consulte la sección **Si deja Walmart y lo contratan nuevamente** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para saber cómo el hecho de dejar de trabajar en Walmart y volver a hacerlo afecta sus beneficios. Consulte a continuación para obtener los detalles sobre el impacto en su deducible, el desembolso máximo y la HRA.

Impacto en el deducible, el desembolso máximo y la HRA:

- Si deja de trabajar y vuelve a incorporarse al trabajo dentro de los 30 días siguientes a la fecha de haber dejado de trabajar, el deducible, el desembolso máximo y la cuenta de ahorro para gastos médicos (si corresponde) no se restablecerán a menos que haya dejado de trabajar en un año calendario y vuelva a incorporarse al trabajo en el año calendario siguiente.*
- Si deja de trabajar y vuelve a incorporarse al trabajo después de 30 días, pero antes que pasen 13 semanas después de la fecha de cuando deja de trabajar, se restablecerán el deducible, el desembolso máximo y la HRA (si corresponde).*
- Si deja de trabajar y vuelve a incorporarse al trabajo después de 13 semanas o más de la fecha en que deja de trabajar, se le considerará un nuevo asociado y deberá completar cualquier periodo de espera de elegibilidad u otros requisitos aplicables. Para obtener información, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.*

*Si usted o un dependiente elegible estaban inscritos en el AMP y habían acumulado montos para alcanzar, o habían alcanzado, el beneficio máximo de por vida aplicable a los beneficios de fertilidad conforme al programa de formación de familias de los Centros de Excelencia, ninguna porción del beneficio máximo de por vida se restablecerá por ninguna razón.

Otra información acerca del plan médico

LEY DE DERECHOS SOBRE LA SALUD Y EL CÁNCER DE LA MUJER DE 1998

La Ley de Derechos sobre la Salud y el Cáncer de la Mujer de 1998 establece que todos los planes médicos grupales que ofrecen beneficios médicos y quirúrgicos relacionados con la mastectomía deben ofrecer cobertura para lo siguiente:

- Todas las etapas de reconstrucción de la mama en la cual se realizó la mastectomía
- Cirugía y reconstrucción de la otra mama para lograr una apariencia simétrica, y
- Prótesis y complicaciones físicas de la mastectomía, incluidos los linfedemas, según se determine tras la consulta de la paciente con el médico.

Esa cobertura estará sujeta a deducibles anuales y coseguros o copagos establecidos para el AMP y aplicables de otro modo. Debe comunicarse por escrito la disponibilidad de tal cobertura al participante en el momento del registro y en forma anual posteriormente. Para obtener más información, comuníquese con Servicios al Personal al **800-421-1362**.

COMENTARIOS SOBRE LAS ADMISIONES POR MATERNIDAD

Los planes de salud grupales y las entidades emisoras de seguros de salud generalmente no pueden, según la ley Federal, restringir los beneficios de la duración de una hospitalización relacionada con un parto para la madre o el recién nacido a menos de 48 horas después de un parto natural, o a menos de 96 horas después de una operación cesárea. Sin embargo, en general la ley federal no prohíbe al proveedor que le presta atención a la madre o al recién nacido, después de consultar a la madre, que se dé el alta hospitalaria a la madre o al recién nacido antes de las 48 horas (o de las 96 horas según corresponda). En cualquier caso, los planes y los emisores no pueden, según la ley federal, obligar a un proveedor a obtener autorización del plan o de la compañía del seguro para que indique una hospitalización que no exceda 48 horas (o 96 horas, según corresponda).

Beneficio de farmacia

La información de este capítulo describe los beneficios de farmacia que pueden estar disponibles para usted si está inscrito en el Plan médico para asociados. Para obtener información, consulte el capítulo Plan médico.

Si tiene preguntas sobre la elegibilidad, la inscripción y los requisitos para que la cobertura sea efectiva, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Beneficio de farmacia

Mantenga su buena salud y la de sus dependientes elegibles con sus beneficios de farmacia. Se incluye automáticamente en su plan de seguro médico.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Encontrar una farmacia de Walmart o Sam's Club	Visite **One.Walmart.com** u **OptumRx.com/Walmart**	
Consulte la farmacia especializada de Walmart	Visite **One.Walmart.com**	Llame a la farmacia especializada de Walmart al **800-284-9770**
Encontrar una farmacia de la red de OptumRx	Visite **OptumRx.com**	Llame a OptumRx al **844-705-7493**
Obtenga información sobre farmacias con servicio de entrega a domicilio de Walmart	Visite **One.Walmart.com**	Llame a Walmart para servicio de farmacia de entrega a domicilio al **866-855-0740**
Para consultas sobre beneficios farmacéuticos		Llame a OptumRx al **844-705-7493**
Obtener la lista de medicamentos de marca cubiertos	Visite **One.Walmart.com** u **OptumRx.com/Walmart**	Llame a OptumRx al **844-705-7493**

Lo que debe saber sobre el beneficio de farmacia

- Tiene cobertura automática del beneficio de farmacia si se inscribe en el Plan Premier, el Plan Contribution o el Plan Saver o en una de las opciones de plan locales, disponibles conforme al Plan Médico para Asociados (AMP). Si está inscrito en un plan de Organización de Mantenimiento de la Salud (HMO) o el Plan de Organización de Proveedor Preferido (PPO), sus beneficios de farmacia se ofrecen por medio de su plan HMO o PPO, respectivamente.
- Los medicamentos recetados que estén excluidos en virtud de las condiciones del AMP, incluidos los medicamentos recetados para adelgazar no están cubiertos por el beneficio de farmacia.
- El beneficio de farmacia cubre solo los medicamentos recetados que figuran específicamente en el listado de beneficios de farmacia.
- Las farmacias contempladas en este capítulo son:
  - Farmacias de Walmart o Sam's Club, incluidas las farmacias en tiendas y clubes.
  - Farmacia de entrega a domicilio de Walmart: farmacia de entrega por correo de Walmart.
  - Farmacia de medicamentos especializados de Walmart: farmacia de medicamentos especializados de entrega por correo de Walmart.
  - Farmacias de la red OptumRx: incluye farmacias de Walmart o Sam's Club, y cualquier farmacia de la red OptumRx.
- El lugar en el que deben surtirse las recetas depende del tipo de medicamento que se haya recetado:
  - Los medicamentos de mantenimiento (fármacos que se toman de forma regular para enfermedades crónicas como la hipertensión, la artritis, la diabetes o el asma, entre otras) deben surtirse a través de Farmacia de entrega a domicilio de Walmart o de cualquier farmacia de Walmart o Sam's Club. Para más información, consulte más adelante en este capítulo **Medicamentos de uso crónico**.
  - Los medicamentos especializados (excepto los medicamentos para la fertilidad, como se describe en este capítulo) deben surtirse a través de la Farmacia de medicamentos especializados de Walmart.
  - Todos los demás medicamentos deben surtirse en una farmacia de Walmart o Sam's Club, a menos que se aplique alguna excepción. Consulte la sección de este capítulo **Beneficio de farmacia**.

Beneficio de farmacia

Los beneficios de farmacia cubren los medicamentos recetados elegibles adquiridos en determinadas farmacias de la red minoristas y con servicio de pedido por correo. No se pagarán beneficios de farmacia si utiliza una farmacia que no sea de la red. Las farmacias específicas de la red de venta al por menor y de venta por correo que debe utilizar dependen del tipo de receta que necesite surtir. Debe inscribirse en la cobertura médica del AMP para obtener medicamentos recetados bajo la cobertura del beneficio de farmacia. Si se inscribe en la cobertura médica, la cobertura de medicamentos recetados entra en vigencia en la fecha en que entra en vigencia su cobertura médica del AMP y finaliza en la fecha en que finaliza su cobertura médica.

OPCIONES DE FARMACIA

Si está inscrito en la opción del Plan Premier, Contribution o Saver, o en una de las opciones del plan local, los medicamentos de mantenimiento deben surtirse a través de cualquier farmacia de Walmart o Sam's Club o de la Farmacia de entrega a domicilio de Walmart. Consulte **Medicamentos de uso crónico** más adelante en este capítulo. Los medicamentos especializados (excepto los medicamentos para la fertilidad, como se describe en este capítulo) deben surtirse a través de la Farmacia de medicamentos especializados de Walmart. Consulte **Medicamentos especializados** más adelante en este capítulo. Todos los demás medicamentos deben surtirse en una farmacia de Walmart o Sam's Club, a menos que se aplique alguna excepción.

En casos limitados, puede surtir las recetas en una farmacia de la red OptumRx, por ejemplo:

- Si el AMP determina que algún medicamento cubierto no está actualmente disponible en una farmacia de Walmart o Sam's Club ubicada dentro del código postal de su lugar de trabajo o a través de Walmart Home Delivery o Walmart Specialty, si corresponde.
- Si es necesario surtir una receta de emergencia fuera del horario de atención de la farmacia de Walmart o Sam's Club.
- Si debe tomar un medicamento que no sea de mantenimiento para tratar un problema de salud inmediato.

Para obtener más información, llame a OptumRx al **844-705-7493**.

Nota: Se aplican ciertas restricciones para surtir recetas para narcóticos y otras sustancias controladas. Llame a OptumRx al **844-705-7493** para obtener más información y detalles.

MEDICAMENTOS RECETADOS CUBIERTOS

El beneficio de farmacia cubre solo los medicamentos recetados que figuran específicamente en el listado de beneficios de farmacia, que consiste en una lista de los medicamentos genéricos y de marca que se han evaluado para probar su calidad y eficacia, y que se consideran parte necesaria de un programa de tratamiento de calidad. OptumRx administra este listado. Puede ver una lista abreviada en **One.Walmart.com** o puede llamar a OptumRx al **844-705-7493** para obtener una lista completa. Si su medicamento no figura, llame a OptumRx para ver si se encuentra en el listado. El listado de medicamentos está sujeto a cambios sin previo aviso en cualquier momento del año.

El beneficio de farmacia tiene un listado cerrado. Esto significa que los medicamentos recetados, ya sean genéricos, de marca, o de especialidad, deben estar incluidos en el listado para que se paguen los beneficios de farmacia.

Para obtener información sobre los medicamentos recetados que no están cubiertos, consulte **Qué no está cubierto por el beneficio de farmacia**.

SU COSTO COMPARTIDO PARA MEDICAMENTOS RECETADOS CUBIERTOS

Consulte la tabla **Beneficios de farmacia** que aparece en la siguiente página para obtener detalles sobre los copagos y el coseguro.

Si está inscrito en el **Plan Premier, el Plan Contribution o en una opción del plan local**, deberá pagar el copago o el coseguro de su propio bolsillo al comprar medicamentos recetados. (Si está cubierto por el Plan Contribution, los fondos de la HRA no pueden utilizarse para comprar recetas o para reembolsar los copagos o coseguros relacionados con las recetas). Sus copagos se aplican al máximo anual de desembolso de su plan médico. Una vez que alcanza el desembolso máximo anual, los medicamentos recetados elegibles se pagan al 100 % por el resto del año calendario.

Si está inscrito en el **Plan Saver**, en la mayoría de los casos, usted paga el precio total de los medicamentos recetados hasta que alcance el deducible anual de la red del Plan Saver. Una vez que satisfaga su deducible anual de la red, pagará el copago o coseguro requerido. (Las excepciones son los medicamentos de la lista de medicamentos preventivos aprobados de OptumRx, que no están sujetos al deducible anual de la red del Plan Saver. Para más información, consulte más adelante en este capítulo **Medicamentos preventivos no sujetos al deducible anual de la red del Plan Saver**). Sus copagos se aplican al máximo anual de desembolso del Plan Saver. Una vez que alcanza el desembolso máximo anual, los medicamentos recetados elegibles se pagan al 100 % por el resto del año calendario.

En todas las opciones del AMP, el beneficio de farmacia brinda descuentos para los medicamentos genéricos y de marca cubiertos en el listado y surtidos en una farmacia de la red elegible. Si, cuando surte su receta, el precio, con descuento disponible es menor que el copago, se le cobrará el monto menor, que puede incluir una comisión del farmacéutico.

BENEFICIOS DE FARMACIA		
Medicamentos genéricos del listado* Suministro de hasta 30 días Suministro de 31 a 60 días Suministro de 61 a 90 días *Los medicamentos genéricos de alto costo no están cubiertos cuando existe un medicamento genérico disponible, equivalente desde el punto de vista terapéutico y de menor costo.*	Copago de $4 Copago de $8 Copago de $12	**Cómo surtir sus recetas** • Presente la tarjeta de identificación del plan en una farmacia de Walmart o Sam's Club. • El resurtido de recetas está disponible después de que haya utilizado el 75 % de su receta anterior. • Consulte **Opciones de farmacia** en la página anterior, para obtener más información. • Si el AMP determina que algún medicamento cubierto no está disponible en la farmacia de Walmart/Sam's Club, Farmacia de entrega a domicilio de Walmart o Farmacia de medicamentos especializados de Walmart durante un tiempo prolongado, es posible que pueda obtener el medicamento en una farmacia de la red OptumRx; consulte los detalles sobre las excepciones en **Opciones de farmacia**.
Medicamentos de marca del listado* Suministro de hasta 30 días. *Los suministros de más de 30 días se deben comprar a través del servicio de pedido por correo.*	$50 o el 25 % del costo permitido, lo que sea mayor	
Medicamentos fuera del listado	Sin cobertura	
Medicamentos de especialidad *Estarán disponibles únicamente en la farmacia especializada de Walmart (excepto los medicamentos para la fertilidad)*	$50 o el 20 % del costo permitido, lo que sea mayor	
*Los medicamentos de mantenimiento deben surtirse en la Farmacia de entrega a domicilio de Walmart o en cualquier farmacia de Walmart o Sam's Club. Consulte **Medicamentos de uso crónico** adelante.		
Al comprar medicamentos por pedido por correo: Debe utilizar la Farmacia de entrega a domicilio de Walmart o cualquier farmacia de Walmart o Sam's Club para los medicamentos que se consideran "de mantenimiento". Consulte **Medicamentos de uso crónico** adelante. Su costo para un suministro de 90 días es tres veces el costo de un suministro de 30 días comprado en una farmacia de Walmart o Sam's Club, tal como se indica más arriba. Puede obtener un suministro para 30, 60 o 90 días a través de la venta por correo cuando utiliza la Farmacia de entrega a domicilio de Walmart.		

TIPOS DE MEDICAMENTOS

Recetas genéricas: Un medicamento genérico es un equivalente de menor costo de un medicamento de marca. Cuando hay un equivalente genérico disponible, se dejará de cubrir el medicamento de marca. Los equivalentes genéricos funcionan como el medicamento de marca en cuanto a la dosificación, la potencia, los efectos y el uso, y deben satisfacer los mismos estándares de calidad y seguridad. Todos los medicamentos genéricos deben ser revisados por la Administración de Alimentos y Medicamentos (FDA) de los Estados Unidos. Para obtener más información, visite **One.Walmart.com**.

Un medicamento de marca: Un medicamento de marca cubierto es un medicamento elaborado por un fabricante único que ha sido evaluado para determinar su seguridad y efectividad en comparación con medicamentos similares para el tratamiento de la misma afección y ha sido identificado para su inclusión en la lista de medicamentos de marca cubiertos.

Medicamentos de especialidad: Los medicamentos de especialidad son aquellos que se utilizan para tratar enfermedades complejas tales como cáncer, deficiencia de la hormona del crecimiento, hemofilia, hepatitis C, inmunodeficiencia, esclerosis múltiple y artritis reumatoide. Se requiere un nivel de servicio superior para los medicamentos especializados, ya sean administrados por un profesional de la salud, auto inyectados o tomados por vía oral. (Los medicamentos que se utilizan para tratar la diabetes no se consideran medicamentos especializados). Consulte la siguiente página para conocer las reglas especiales para los medicamentos especializados para fines de fertilidad.

MEDICAMENTOS DE USO CRÓNICO

Si está inscrito en la opción del Plan Premier, Plan Contribution, Plan Saver o en una opción del plan local, debe utilizar la Farmacia de entrega a domicilio de Walmart o cualquier farmacia de Walmart o Sam's Club para los medicamentos que se consideran "de mantenimiento". Los medicamentos de mantenimiento son fármacos que generalmente se recetan para tratar una enfermedad crónica o a largo plazo y que se toman de forma regular y recurrente. Algunos ejemplos de medicamentos de mantenimiento incluyen, pero no se limitan a, los que se utilizan para tratar la presión arterial, las enfermedades cardíacas, la diabetes, el asma, la artritis, etc. Consulte el listado para ver la lista de medicamentos de mantenimiento. Puede ver una lista abreviada en **One.Walmart.com** o puede llamar a OptumRx al **844-705-7493** para obtener una lista completa.

Puede obtener un suministro para 30, 60 o 90 días de la mayoría de los medicamentos de mantenimiento a través de una Farmacia de entrega a domicilio de Walmart, al igual que la comodidad de que se los envíen directamente a usted. ¿Necesita ayuda? Llame a la Farmacia de entrega a domicilio de Walmart al **866-855-0740** para transferir sus medicamentos de mantenimiento al servicio por correo.

MEDICAMENTOS ESPECIALIZADOS

Debe utilizar la farmacia especializada de Walmart para los medicamentos especializados. Consulte el listado para ver la lista de medicamentos especializados. Puede ver una lista abreviada en **One.Walmart.com** o puede llamar a OptumRx al **844-705-7493** para obtener una lista completa. Todos los medicamentos especializados deben surtirse a través de la

farmacia especializada de Walmart. Si tiene preguntas sobre sus recetas de medicamentos especializados, llame a la farmacia especializada de Walmart al **800-284-9770**.

Debe obtener una autorización previa para los medicamentos especializados. OptumRx trabajará con su médico para asegurarse de que el medicamento sea clínicamente necesario para su tratamiento. Algunos medicamentos especializados solamente están disponibles en ciertas farmacias especializadas. Estos medicamentos se clasifican como medicamentos de distribución limitada (LDD). Si un cierto LDD no está disponible en la Farmacia de medicamentos especializados de Walmart, tal medicamento se transferirá a la farmacia de medicamentos especializados de OptumRx o a otra farmacia especializada dentro de la red para poder surtirlo. Si tiene preguntas sobre los medicamentos especializados, llame a OptumRx al **844-705-7493**. Consulte a continuación las reglas especiales para los medicamentos especializados para la fertilidad.

CONTROL DE LA DIABETES

Como parte de myAgileLife, tendrá acceso a copagos más bajos para ciertos medicamentos relacionados con la diabetes si se inscribe en el programa de autocuidado de la diabetes. Este es un programa voluntario en el que los incentivos se basan en la participación en los programas de myAgileLife y no en el logro de un estado de salud.

Para obtener más información sobre myAgileLife y otros recursos para controlar la diabetes tipo 2, consulte el capítulo **Plan médico**.

MEDICAMENTOS PARA LA FERTILIDAD

El beneficio médico del AMP cubre los medicamentos para la fertilidad aprobados por la FDA, cuando son recetados por Kindbody, el proveedor de los Centros de Excelencia para la formación de familias. Estos medicamentos son exclusivos para el tratamiento de fertilidad y se surtirán a través de la farmacia especializada de Kindbody, Schraft's Pharmacy, y se procesarán bajo los términos y condiciones que se describen en el capítulo **Plan médico**.

MEDICAMENTOS QUE REQUIEREN AUTORIZACIÓN PREVIA

Se exige una autorización previa para que algunos medicamentos sean cubiertos por el AMP, incluyendo medicamentos especializados. OptumRx puede solicitar más información a su médico. Esto se denomina “autorización de cobertura”.

Una vez que OptumRx recibe la información necesaria, se comunicará con usted y su médico (por lo general, dentro de dos días hábiles) para confirmar si se ha autorizado la cobertura. Si se determina que la receta no es un medicamento cubierto o que usted no es elegible para recibir el medicamento en virtud del AMP, no se pagará. Si el medicamento con receta requiere autorización previa, puede apelar esta decisión, tal como se describe en el capítulo **Reclamaciones y apelaciones**. Si decide surtir la receta sin autorización previa, debe pagar el precio minorista total, incluso si la receta se hubiera autorizado si hubiera esperado. El monto pagado no se aplicará para el gasto máximo en efectivo. Las solicitudes de medicamentos recetados que no están cubiertos por el AMP, que incluye el beneficio de farmacia, no son solicitudes de autorización previa y no podrán someterse a apelación.

Si tiene preguntas sobre las autorizaciones previas, llame a OptumRx al **844-705-7493**.

MEDICAMENTOS CON LÍMITES DE CANTIDAD

Para ciertos medicamentos, existen límites sobre la cantidad que puede recibir por cada receta, según las pautas de las dosis aprobadas por la FDA. En **One.Walmart.com**, puede encontrar una lista de estos medicamentos.

Los medicamentos para cantidades que superen la cantidad aprobada por la FDA no están cubiertas por el AMP. Si decide surtir la receta, debe pagar el precio minorista total.

Cuidado preventivo

ANTICONCEPTIVOS PARA MUJERES

El AMP cubre todos los métodos anticonceptivos aprobados por la Administración de Alimentos y Medicamentos (FDA), incluidas las variaciones de venta libre para mujeres, según lo exige la Ley de Cuidado de Salud Asequible. El AMP cubre algunos métodos anticonceptivos genéricos aprobados por la FDA (y los anticonceptivos de marca cuando sean médicamente necesarios) al 100 %, sin deducible, para las mujeres con capacidad de gestar, cuando lo receta un médico. Si el médico tratante considera que un anticonceptivo de marca es médicamente necesario, consulte en esta sección **Proceso de excepciones de atención preventiva**.

PREVENCIÓN DEL VIH

El AMP cubre la profilaxis preexposición (“PrEP”) con una terapia antirretrovírica eficaz al 100 %, sin deducible, cuando un médico le receta el medicamento a una persona con mayor riesgo de contraer VIH.

MEDICAMENTOS PREVENTIVOS NO SUJETOS AL DEDUCIBLE ANUAL DE LA RED DEL PLAN SAVER

Si está inscrito en el Plan Saver, se cubren algunos medicamentos preventivos antes de alcanzar el deducible anual de la red del Plan. Los medicamentos recetados que evitan una afección médica se llaman “medicamentos preventivos”. Si toma medicamentos recetados para ciertos problemas de salud, como presión arterial alta, diabetes, colesterol alto, etc., puede ser elegible para obtener estos medicamentos sin costo antes de alcanzar el deducible anual de la red del Plan Saver. OptumRx administra la lista de medicamentos preventivos aprobados. Para obtener más información, llame a OptumRx al **844-705-7493** o visite **One.Walmart.com** para ver una lista.

MEDICAMENTOS PREVENTIVOS DE VENTA LIBRE

El AMP cubre algunos medicamentos de atención preventiva de venta libre al 100 % cuando los receta un médico y se compran en las farmacias de Walmart o Sam's Club. Deberá presentar su tarjeta de identificación del plan y una receta de su médico al momento de la compra. Los medicamentos de atención preventiva de venta libre cubiertos son los que exige la Ley de Cuidado de Salud Asequible. Si su médico considera que un medicamento preventivo de venta libre de marca es médicamente necesario en lugar de uno genérico, consulte **Proceso de excepciones de atención preventiva** a continuación.

En la tabla **Medicamentos preventivos de venta libre** a continuación, se incluyen algunos de los medicamentos preventivos de venta libre comunes identificados por la Fuerza de Tareas Preventivas de los Estados Unidos (USPSTF). Para obtener una lista actualizada de los medicamentos de venta libre de atención preventiva cubiertos, llame a OptumRx al **844-705-7493** o visite **One.Walmart.com** para ver una lista.

MEDICAMENTOS PREVENTIVOS DE VENTA LIBRE Recomendados por la Fuerza de Tareas Preventivas de los Estados Unidos (USPSTF)	
Flúor oral	Con receta cuando sea apropiado para niños de 6 meses a 6 años
Ácido fólico	Con receta para todas las mujeres que planean o pueden quedar embarazadas
Aspirina genérica	Aspirina de dosis baja (81 mg/día) por receta médica después de 12 semanas de gestación para las mujeres embarazadas con alto riesgo de preeclampsia
Estatinas	Receta para la prevención primaria de enfermedades cardiovasculares en adultos de 40 a 75 años que presenten uno o más factores de riesgo de enfermedad cardiovascular y un riesgo estimado a 10 años de sufrir un acontecimiento cardiovascular igual o superior al 10 %.
Agentes de preparación intestinal	Con receta, según corresponda, para una colonoscopia de detección para adultos a partir de los 45 años

PROCESO DE EXCEPCIONES DE ATENCIÓN PREVENTIVA

Como se ha indicado anteriormente en este capítulo, el Plan cubre los medicamentos genéricos de atención preventiva y los anticonceptivos, tal y como exige la Ley de Cuidado de Salud Asequible. Si el médico tratante considera que un medicamento anticonceptivo o de atención preventiva de marca es médicamente necesario, el proveedor puede recetarle ese medicamento de marca y se le concederá una excepción. Para obtener más información, su médico puede comunicarse con OptumRx al **844-705-7493**.

Qué no está cubierto por el beneficio de farmacia

Los medicamentos no cubiertos por el beneficio de farmacia incluyen, entre otros, los siguientes:

- Los medicamentos recetados que estén excluidos en virtud de las condiciones del AMP, incluidos los medicamentos recetados para adelgazar.
- Medicamentos compuestos, que constan de dos o más ingredientes que se miden, preparan o mezclan de acuerdo con una orden de receta. No se cubrirán ciertos ingredientes compuestos. Como ingredientes que no están aprobados por la FDA o que están disponibles para su venta libre.
- Medicamentos de venta libre, a excepción de insulina, cuando el estado no requiere receta para ella. Ciertos medicamentos de venta libre están cubiertos como parte del beneficio de atención preventiva en virtud de la Ley de Cuidado de Salud Asequible, cuando se proporciona una receta médica. Consulte **Medicamentos preventivos de venta libre** más arriba en este capítulo para obtener más información.
- Las recetas surtidas en una farmacia que no sea de Walmart ni Sam's Club o servicio de farmacia de entrega a domicilio de Walmart (salvo las excepciones mencionadas).
- Las recetas surtidas por una farmacia que no sea una farmacia elegible para su opción de plan de seguro médico.
- Los medicamentos recetados que no están incluidos en la lista.
- Los medicamentos recetados con equivalentes de venta libre.
- Los medicamentos recetados comprados mediante un programa de descuentos de farmacia.
- Los medicamentos para los cuales no se ha obtenido una autorización previa (cuando se requiere una autorización previa).
- Las reclamaciones de medicamentos recetados que sean reducidos, subsidiados o pagados por otro plan de salud, proveedor de seguros o programa de descuentos de farmacia. El AMP no coordina los beneficios para reclamaciones de farmacia.
- Los medicamentos recetados que se administran, se infunden o se inyectan durante un tratamiento hospitalario o que están cubiertos por el AMP como beneficio médico, y no como beneficio de farmacia.

Esta lista no intenta abarcar todos los medicamentos y fármacos excluidos. Si tiene preguntas sobre los medicamentos excluidos, llame a OptumRx al **844-705-7493**.

Descuentos de farmacia para medicamentos recetados no cubiertos

Si el beneficio de farmacia cubre el medicamento recetado, se aplicará el copago o coseguro correspondiente. Sin embargo, si la receta tiene cobertura conforme al AMP, pero no es elegible para la cobertura conforme a un servicio de farmacia (p. ej., se presenta con demasiada anticipación o se receta para un uso no autorizado), el medicamento no será cubierto por el beneficio de farmacia y no será elegible para el descuento en farmacias descrito en esta sección.

Si está inscrito en el AMP, es elegible para un descuento en farmacias sobre ciertos medicamentos no cubiertos por el beneficio de farmacia. El descuento varía según el medicamento recetado. Los medicamentos recetados adquiridos con el descuento de farmacias minoristas no se consideran para el deducible anual de la red ni para el gasto máximo en efectivo.

Para utilizar el descuento en farmacias, presente la tarjeta de identificación del plan en la farmacia cuando retire su medicamento. Si el beneficio de farmacia no cubre la receta, la farmacia minorista descontará automáticamente el costo del medicamento.

Para obtener más información, llame a OptumRx al **844-705-7493**.

Asistencia del fabricante, y otros descuentos o cupones

Los descuentos, los cupones, los programas de descuento en farmacias, las tarjetas de débito o los arreglos similares provistos por los fabricantes de medicamentos o las farmacias para asistirlo en la compra de medicamentos recetados (incluidos los descuentos/cupones para medicamentos recetados que entrega en las farmacias cuando surte una receta) no contarán para su gasto máximo anual en efectivo. Además, si tiene cobertura del Plan Saver, dichos cargos no se tienen en cuenta para su deducible anual.

Presentación de una reclamación de un beneficio de farmacia

Cuando surte una receta en una farmacia de la red elegible, no es necesario que presente una reclamación. No obstante, si no puede utilizar su tarjeta en una farmacia de la red o si no está de acuerdo con el monto que debe pagar, puede presentar una reclamación ante OptumRx. Su reclamación debe enviarse por escrito dentro de los 12 meses a partir de la fecha en la que se surte la receta (o de la fecha en la que intentó surtir la receta). Si la receta es una receta elegible, se pagará de acuerdo con los términos del beneficio de farmacia.

En los casos en que el Plan requiera una autorización previa, deberá presentar una reclamación previa al servicio ante OptumRx antes de que pueda surtir su receta.

Llame a OptumRx al **844-705-7493** para obtener un formulario de reclamación, o visite **One.Walmart.com**. Las reclamaciones se procesan según los términos establecidos en el capítulo **Reclamaciones y apelaciones**.

Si se rechaza su reclamación, tiene derecho a apelar. Las apelaciones se procesan según los términos establecidos en el capítulo **Reclamaciones y apelaciones** .

Privacidad y seguridad

Cuando compra medicamentos recetados a través de una farmacia de Walmart o Sam's Club, la farmacia de entrega a domicilio de Walmart, la farmacia especializada de Walmart, o si es elegible, una farmacia de la red de OptumRx, su información médica y personal se mantendrá en estricta confidencialidad. Todas las farmacias de la red están abarcadas por las regulaciones federales y estatales correspondientes, y cumplen con estas, incluida la Ley de Portabilidad y Responsabilidad de Seguros de Salud de 1996 (HIPAA), que protege la privacidad de la información personal de salud. Walmart valora la confianza que nuestros asociados depositan en nosotros. Ganar esa confianza va de la mano de nuestro principal valor: el respeto por las personas. Para obtener más información, consulte **Notificación sobre las prácticas de privacidad de la HIPAA** en el capítulo **Información legal**.

Cuenta de ahorro de salud (HSA)

Cuenta de ahorro de salud para participantes del Plan Saver

Si está inscrito en el Plan Saver y desea ahorrar en los gastos médicos calificados, la HSA es una excelente opción. Sus aportes a la HSA están libres de impuestos y Walmart las igualará dólar por dólar, hasta los límites establecidos. Las ganancias del saldo de su cuenta están exentas de impuestos y, a medida que la cantidad de dinero aumenta año tras año, usted puede utilizarlo para pagar sus gastos médicos actuales o futuros.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Establecer una cuenta o cambiar el monto de su aporte	Ingrese en **One.Walmart.com**	Llame a Servicios al Personal al **800-421-1362.**
Acceda a su HSA	Ingrese en **MyHealthEquity.com** Si ingresa por primera vez como miembro y aún no ha establecido un usuario y una contraseña, haga clic en el botón “Create username and password” (Crear nombre de usuario y contraseña)”.	Llame a HealthEquity al **866-296-2860.** HealthEquity es el administrador y custodio de la HSA.
Obtener una lista de los gastos médicos calificados, I.R.C.§ 213(d). Obtenga información sobre los límites de aporte, la elegibilidad, y las obligaciones de informes impositivos en relación con una HSA.	**irs.gov** **Publicación 502 del IRS**, *Gastos médicos y dentales* **Publicación 969 del IRS**, *Cuentas de ahorro para la salud y otros planes de salud con ventajas fiscales*	Llame a HealthEquity al **866-296-2860** o comuníquese con su asesor impositivo.

Lo que debe saber sobre la HSA

- Se debe inscribir en el Plan Saver a fin de abrir una HSA y hacer contribuciones a través de este programa.
- Walmart igualará el dinero antes de impuestos que usted aporte mediante deducción en nómina, dólar por dólar hasta el límite de aporte de contrapartida.
- La HSA le permite pagar los gastos médicos calificados (según lo define el IRS) con dólares libres de impuestos.
- La Cuenta de ahorro de salud (HSA) acepta aportes de transferencia desde otros planes de HSA elegibles.
- No es elegible para realizar aportes a una HSA durante los meses en los que esté de viaje fuera de los EE. UU. por negocios de la compañía y está cubierto por la póliza de seguro médico contra accidentes durante viajes de negocios internacionales de GeoBlue, la cual proporciona beneficios médicos para los asociados que viajan por negocios al exterior. Consulte con su asesor impositivo si tiene preguntas sobre el monto para reducir sus aportes en función de sus circunstancias individuales.
- La cuenta de ahorro de salud se ofrece a través de HealthEquity.

Ventajas del HSA: exenciones impositivas y aportes de Walmart

Si está inscrito en el Plan Saver, la HSA le ofrece lo siguiente:

- Aportes paralelos de la compañía a su HSA a sus aportes antes de impuestos, dólar por dólar, hasta el límite de los aportes paralelos.
- La posibilidad de realizar contribuciones con dólares antes de impuestos a su HSA a través de deducciones en el sueldo.
- La posibilidad de transferir fondos de HSA anteriores.
- La posibilidad de pagar los gastos médicos calificados con dinero exento de impuestos a través de la cuenta, incluido el acceso fácil al dinero de su cuenta mediante la tarjeta de débito que recibirá de HealthEquity. Usted también puede acceder a los fondos de su cuenta ingresando en **MyHealthEquity.com**.

HealthEquity es el administrador/custodio de la HSA con el que Walmart ha contratado la recepción de los aportes a la HSA que se realizan mediante deducciones en nómina y aportes paralelos de Walmart. Para recibir el aporte equivalente de la compañía a su HSA o para realizar aportes antes de impuestos a través de las deducciones del sueldo, usted debe mantener una cuenta abierta con HealthEquity y seguir estando inscrito en el Plan Saver. Si tiene una HSA con otro custodio, Walmart no le permitirá hacer aportes antes de impuestos mediante las deducciones de nómina para esa HSA ni hará aportes paralelos a tal HSA. Puede trasferir sus fondos a otro custodio de HSA en cualquier momento, pero Walmart mantendrá las deducciones de nómina en curso y proporcionará aportes paralelos de la compañía solamente para las HSA que se hayan establecido con HealthEquity.

Las ganancias por interés y de capital sobre el saldo de su cuenta no se gravan mientras los fondos permanezcan en su cuenta. Además, todos los fondos extraídos de la HSA para gastos médicos calificados están exentos de impuestos.

Podrá invertir el saldo de su cuenta una vez que el saldo alcanza un cierto monto. Las inversiones no están garantizadas ni aseguradas por la Corporación Federal de Seguros de Depósitos (FDIC).

El saldo de su HSA se transfiere de un año a otro, lo cual aumenta sus ahorros para gastos médicos futuros. Usted es el propietario del saldo en su cuenta y puede ahorrarlo, invertirlo en fondos ofrecidos a través de HealthEquity o gastarlo en gastos médicos calificados.

NOTA: Es posible que la legislación fiscal estatal con respecto a las HSA difiera de la legislación fiscal federal en ciertos estados, como California y Nueva Jersey, que no eximen los aportes a las HSA del impuesto sobre la renta estatal. Consulte a su asesor impositivo o a HealthEquity si tiene preguntas acerca de las consecuencias impositivas federales o estatales de una cuenta de ahorro de salud.

Elegibilidad para la HSA

Se debe inscribir en el Plan Saver a fin de hacer contribuciones a una HSA a través de este programa. El Plan Saver es un plan de salud de deducible alto calificado (HDHP), sujeto a la ley ERISA y a los requisitos de la ley federal que le permiten realizar contribuciones a una HSA. No obstante, Walmart no asegura la HSA que se describe en este capítulo. Walmart procura cumplir con las pautas del Departamento de Trabajo de los EE. UU. que especifican que una HSA no está sujeta a la ley ERISA cuando la participación del empleador con la HSA es limitada. En este sentido, ni Walmart ni el Plan se hacen cargo de establecer o administrar la HSA. En su lugar, usted establece la HSA durante el proceso de inscripción de beneficios y HealthEquity la administra.

Incluso si usted está inscrito en el Plan Saver, no puede aportar a una HSA en los siguientes casos:

- Tiene cobertura de cualquier otro plan de salud que no sea un plan de salud de deducible alto calificado, incluida una cuenta de gastos flexibles (FSA) de atención de la salud para todo propósito o una cuenta de reembolso para la salud (HRA). Esto incluye también una FSA o HRA de uso general de un cónyuge u otro miembro de la familia de quien tenga cobertura. Existen ciertas excepciones para las FSA/HRA de "propósito limitado", que pueden utilizarse solamente para la cobertura dental o de la visión o de cuidados preventivos; las FSA/HRA "después del deducible", que facilitan cobertura solamente después de satisfacer el deducible bajo un HDHP; ciertas coberturas específicas de enfermedades; cobertura dental, de la visión, de cuidados a largo plazo y de discapacidad; pólizas de seguro por accidentes como el seguro por enfermedad grave y el seguro por accidentes, entre otros. No obstante, si está inscrito en el Plan Saver y también en el seguro por enfermedad grave que ofrece el Plan, no es elegible para la cobertura adicional para trasplante de órganos principales del seguro de enfermedad grave debido a las pautas del IRS que establecen que dicha cobertura se consideraría una cobertura de plan de salud que no es de deducible alto. Para obtener más información, comuníquese con HealthEquity por teléfono al **866-296-2860** o en línea en **MyHealthEquity.com**.
- Está inscrito en Medicare.
- Está inscrito en Medicaid.
- Tiene cobertura de TRICARE.
- Ha recibido servicios médicos del Departamento de Asuntos de Veteranos de los EE. UU. durante los tres meses anteriores, que no fueran beneficios dentales, de la visión o de atención preventiva o por una discapacidad relacionada con su servicio. La mera elegibilidad para recibir los beneficios del Departamento de Asuntos de Veteranos no lo descalifican para contribuir a una HSA.
- Ha recibido servicios médicos en un centro de atención del Servicio de Salud para las Poblaciones Indígenas (IHS) durante los tres meses anteriores, salvo servicios dentales, de la visión o atención preventiva.
- Puede presentar una reclamación como dependiente en la declaración de impuestos de otra persona.

Asimismo, no es elegible para realizar aportes a una HSA durante los meses en los que esté de viaje fuera de los EE. UU. por negocios de la compañía y esté cubierto por la póliza de seguro médico contra accidentes durante viajes de negocios internacionales de GeoBlue, la cual proporciona cobertura médica para los asociados que viajan por negocios al exterior. Consulte con su asesor impositivo si tiene preguntas sobre el monto para reducir sus aportes en función de sus circunstancias individuales.

Pueden corresponder otras restricciones. Para obtener más información, llame a HealthEquity al **866-296-2860**. Usted debe determinar si es elegible para una HSA.

Su condición de dependiente no afecta que pueda realizar contribuciones a una HSA. Por ejemplo, la condición de cónyuge/pareja de Medicare no afecta la posibilidad de realizar contribuciones a una HSA.

Durante el año del Plan, es posible que usted deba confirmar la elegibilidad para la cuenta para continuar con los aportes (por ejemplo, si usted pasa a ser elegible para Medicare debido a su edad, es posible que se le pida que demuestre que no esté inscrito en Medicare). En ciertos casos, la inscripción en Medicare puede ser retroactiva (como cuando retrasa su inscripción hasta después de los 65 años) y, en ese caso, además perderá la elegibilidad para realizar aportes a la HSA de manera retroactiva. Si es elegible para Medicare o se inscribe en Medicare, debe evaluar con atención su participación en la HSA para evitar sanciones por aportes en exceso.

Si realiza o recibe un aporte no elegible a su HSA, se puede aplicar un régimen impositivo, a menos que retire el aporte dentro de ciertas fechas límites. Para obtener más información acerca de Medicare, la elegibilidad para la HSA o cómo corregir aportes no elegibles, comuníquese con su asesor impositivo o consulte la **Publicación 969 del IRS**, *Cuentas de ahorro de salud y otros planes de salud con beneficios impositivos*. También puede llamar al **800 Medicare** (**800-633-4227**) o visitar **medicare.gov**.

Cómo abrir su HSA

Cuando se inscribe en línea en el plan Saver, elige la cantidad que desea contribuir a su HSA a través de deducciones del sueldo. Puede cambiar su monto de aporte en cualquier momento. Consulte **Configuración o cambio del monto de su aporte** más adelante en este capítulo.

Recibirá un kit de bienvenida en el domicilio que figura en los registros de Walmart, directamente de HealthEquity, por lo general, dentro de los siguientes plazos:

- Antes de fines de diciembre si se inscribe durante el periodo de Inscripción Anual, o
- Dentro de las dos a tres semanas posteriores a la apertura de su HSA si se inscribe en cualquier otro momento

Se incluirá su tarjeta de débito en el kit de bienvenida. Active su tarjeta de débito en línea en **MyHealthEquity.com** o llamando a HealthEquity al **866-296-2860**.

No se depositarán aportes antes de impuestos ni aportes paralelos de la compañía en su HSA hasta que tal cuenta esté abierta y su cobertura del Plan Saver sea efectiva. Su cuenta no se considerará abierta hasta tanto complete con éxito el proceso de identificación de clientes obligatorio para la apertura de una HSA. Si HealthEquity necesita más información para completar este proceso, se pondrá en contacto con usted.

Una vez que HealthEquity confirme que su cuenta está abierta y usted ha completado la selección de la HSA en línea, comenzarán a ingresar sus aportes antes de impuestos y los aportes paralelos de Walmart a partir del siguiente periodo de pago. Si se realizan aportes antes de impuestos o aportes paralelos de la compañía antes de que se abra su HSA, HealthEquity retendrá tales aportes y las depositará en su HSA una vez que se abra. Si su cuenta no se abre dentro de un periodo razonable, se reembolsarán los fondos retenidos de su sueldo con su cheque de pago (menos los impuestos del sueldo aplicables) y aparecerán en su formulario W-2 como salarios. El aporte del empleador, si la hubiere, se devolverá a Walmart.

Su derecho a que los aportes paralelos de la compañía se depositen en su HSA está supeditado a que abra su HSA a tiempo, y los aportes paralelos de la compañía no se devengarán ni estarán disponibles a menos que haya abierto su HSA a tiempo. Si no abre su HSA antes del 1 de diciembre del año del Plan, perderá el derecho a los aportes paralelas de Walmart para ese año, incluso si está inscrito en el Plan Saver durante ese año.

Si tiene preguntas sobre el estado de su cuenta, el kit de bienvenida o la tarjeta de débito, llame a HealthEquity al **866-296-2860** o visite **MyHealthEquity.com**.

Para transferir fondos de una HSA anterior, póngase en contacto con HealthEquity llamando al **866-296-2860**.

GASTOS DE LA HSA

Walmart paga los gastos mensuales de mantenimiento de la HSA si usted está inscrito en el Plan Saver y el custodio de su HSA es HealthEquity. Sin embargo, si está inscrito en la ley COBRA, finaliza su relación laboral con Walmart, pierde de otro modo la elegibilidad para la cobertura del AMP o deja de estar inscrito en el Plan Saver, será responsable de todos los cargos relacionados con los cargos de mantenimiento mensuales. Si se produce alguno de tales eventos, estos gastos se deducirán automáticamente del saldo de su HSA. Llame a HealthEquity al **866-296-2860** para obtener más información sobre los gastos de los diversos servicios de su HSA. Es su responsabilidad verificar el saldo de su HSA antes de utilizar fondos para pagar los servicios. Los cronogramas de cargos y tasas actuales están disponibles en **MyHealthEquity.com**. El cronograma de cargos también se incluye en el kit de bienvenida.

Walmart no pagará los cargos por giros en descubierto, los cargos por aportes en exceso ni los cargos por la pérdida de la tarjeta. Asimismo, Walmart tampoco contribuye fondos ni paga ninguna tarifa asociada a una HSA para su cónyuge o pareja que estén inscritos en el Plan Saver a través de su cobertura familiar.

DECLARACIONES E INFORMACIÓN DE LA HSA

Su derecho a recibir un estado de cuenta del saldo de su HSA de HealthEquity y otra información relativa a su HSA de HealthEquity se rige por los términos del acuerdo de custodia de HealthEquity. Para consultar la información relativa a su HSA, que incluye el acuerdo de custodia de HealthEquity, visite **MyHealthEquity.com.**

Designar un beneficiario

Para asegurarse de que, en caso de fallecimiento, su HSA se distribuya de la manera que usted desea, puede designar uno o varios beneficiarios. Puede hacerlo a través del portal para miembros HealthEquity en la app HealthEquity o en **MyHealthEquity.com**. Para obtener información y asistencia, llame a HealthEquity al **866-296-2860**.

Si no designa a ningún beneficiario, su cónyuge que lo sobreviva se considerará ser el beneficiario (si tiene un cónyuge). Si su cónyuge es el beneficiario designado o considerado, el saldo de su cuenta HSA puede transferirse tras su fallecimiento a una nueva cuenta HSA a nombre de su cónyuge. Si no designa a un beneficiario y no tiene un cónyuge que lo sobreviva, su cuenta se distribuirá a su patrimonio, sucesor en interés u otra parte con autoridad para tomar decisiones sobre la cuenta.

Los requisitos de designación de beneficiarios varían dependiendo del estado. Por ejemplo, si está casado y vive en un estado de bienes gananciales y desea designar a un beneficiario principal que no sea su cónyuge, su cónyuge debe aceptar por escrito tal designación.

Las designaciones que se hayan completado debidamente entrarán en vigencia en el momento de ser recibidas por HealthEquity y anularán todas las designaciones de beneficiarios de HSA anteriores que consten en el expediente.

Al designar a un beneficiario, debe consultar a su asesor fiscal o legal ya que su designación puede tener consecuencias fiscales o legales.

Aportes a su HSA

Una vez que abra su HSA, los aportes a la misma se realizarán en los siguientes términos (siempre y cuando su cuenta esté abierta y usted esté inscrito en el Plan Saver):

- Usted realiza aportes antes de impuestos a su HSA a través de deducciones del sueldo por cualquier suma (de $5 o más cada periodo de pago) hasta el límite legal (considerando los aportes de Walmart). Los aportes suelen basarse en 26 periodos de pago.
- Walmart realizará aportes paralelos antes de impuestos a sus aportes, dólar por dólar, hasta el límite de los aportes paralelos que se indica en la tabla en la página siguiente.
- Los aportes antes de impuestos y los aportes paralelas de la compañía se depositan en su HSA poco después de que finalice cada periodo de deducción de nómina.
- Además de realizar aportes antes de impuestos con deducciones del sueldo, puede aportar directamente a su HSA enviando un cheque por correo postal a HealthEquity o realizando una transferencia electrónica de fondos una vez que haya vinculado su cuenta bancaria personal con el sitio web de HealthEquity. Cualquiera de dichos aportes se computa para el límite de aporte especificado en la en la tabla en la página siguiente. Estos aportes personales se hacen después de impuestos y no son elegibles para los aportes paralelos de Walmart. Si bien puede solicitar una deducción en el impuesto sobre la renta por los aportes realizados directamente a su HSA, no hay una deducción correspondiente por los impuestos del Seguro Social o Medicare que puedan haberse aplicado a los fondos utilizados para realizar los aportes directos. (Para fines comparativos, los aportes antes de impuestos que se realizan mediante deducciones de nómina están exentas de los impuestos del Seguro Social y Medicare, al igual que del impuesto federal sobre la renta y, en varios casos, del impuesto estatal sobre la renta). Walmart no lleva un seguimiento de sus aportes a la HSA después de impuestos; usted tiene la responsabilidad de asegurarse de no exceder el límite de aporte anual.
- Si el aporte solicitado para su HSA para un periodo de pago específico excede el monto de su cheque de pago después de las deducciones, no se realizarán aportes antes de impuestos ni aportes paralelos de la compañía a su HSA para dicho periodo.
- Con respecto a su cheque de pago final, es posible que los aportes antes de impuestos y el aporte paralelo de la compañía para su HSA se reduzcan debido a restricciones legales estatales sobre las deducciones del sueldo o debido a que el aporte solicitado para su HSA excede el monto neto de su cheque de pago después de las deducciones.

Si se produce un evento de cambio de elección y cambia de cobertura para asociado solo a cobertura familiar dentro del Plan Saver durante el año, Walmart aumentará el aporte paralelo para que corresponda con el límite de aporte paralelo para la cobertura familiar. Si cambia de cobertura familiar a cobertura para asociado solo durante el año, no se reducirán los aportes paralelos que Walmart realizó previamente. Si esto provoca que los aportes a su cuenta superen el límite de aporte anual, deben retirarse los aportes en exceso antes de la fecha límite de la declaración de impuestos para evitar el pago de impuestos adicionales.

LÍMITES ANUALES DE APORTE

Por ley, puede contribuir un monto máximo a su HSA durante el año. El aporte máximo anual es el aporte total proveniente de todas las fuentes (aportes antes y después de impuestos realizadas por usted y cualquier aporte paralelo hecha por la compañía). Para el 2025, el aporte anual máxima que se puede hacer a su HSA es:

- $4,300 para la cobertura individual, u
- $8,550 para la cobertura familiar.

El gobierno federal indexa estos montos anualmente y es posible que estén sujetos a cambios cada año. Puede consultar la Publicación 969 del IRS para saber detalles sobre los montos indexados aplicables a un año en particular.

SUS APORTES Y LOS APORTES DE WALMART A LA HSA		
El deducible anual de la red del Plan Saver	**Aporte equivalente de la compañía: $1 por $1 hasta**	**El aporte máximo anual para 2025 (aportes del asociado y de la compañía combinadas) ***
$3,000 (cobertura del asociado solo)	$350	$4,300
$6,000 (cobertura familiar)	$700	$8,550
* Si el 31 de diciembre de 2025 usted tiene 55 años o más, puede contribuir un monto adicional de $1,000 en 2025.		

Su aporte máximo anual a la HSA puede ser inferior al máximo establecido por la ley si durante el año hay meses en los que no tiene derecho a contribuir a la HSA. Es elegible para contribuir a la HSA durante un mes si el primer día del mes tiene una cobertura de la salud con deducible alto que cumpla los requisitos (como la cobertura a través del Plan Saver) y no tiene ninguna cobertura de salud que no cumpla los requisitos el primer día del mes (como la cobertura a través de Medicare o un plan de salud con "deducible bajo"). Si no es elegible para contribuir a la HSA durante uno o más meses al año, su aporte máximo anual a la HSA se prorrateará por la cantidad de meses que sea elegible para la HSA. Por ejemplo, si solamente es elegible para una HSA durante nueve meses al año, su aporte máximo anual para la HSA será de 9/12 (75 %) del máximo anual establecido por ley. Usted es responsable de determinar su aporte máximo anual para la HSA.

Es importante controlar los aportes que se realizan a su HSA, ya que se aplican sanciones impositivas si sus aportes exceden el límite anual. Los cambios en la cobertura durante el año o la inscripción después del comienzo del año pueden afectar los límites de sus aportes. Si, durante el año, se da cuenta de que los aportes combinadas a su HSA superan el límite anual, puede retirar los aportes en exceso y las ganancias por interés relacionadas antes de que venza el plazo de presentación de la declaración del impuesto a los ingresos para ese año (incluidas las prórrogas). Para obtener información y asistencia, llame a HealthEquity al **866-296-2860**.

SI TIENE MÁS DE 55 AÑOS

Si tiene 55 años o más en el 2025, puede hacer aportes para ponerse al corriente adicionales a su HSA mediante deducciones del sueldo, como con su aporte regular. Para el 2025, el límite de aporte para ponerse al corriente es de $1,000. Llame a HealthEquity al **866-296-2860** para obtener información.

SI TIENE COBERTURA FAMILIAR

Si también tiene cobertura para su cónyuge con el Plan Saver y están legalmente casados, ambos pueden contribuir a las HSA individuales, pero el límite de aporte para 2025 para ambas cuentas combinadas se basa en el monto máxima que se puede contribuir para una familia: $8,550. Este límite puede repartirse entre usted y su cónyuge de la forma que acuerden. Si usted o su cónyuge cumplirán 55 años o más en 2025, el aporte total combinado aumenta a razón de $1,000 por cada participante que tenga 55 años o más. No obstante, los $1,000 adicionales solamente pueden ser contribuidos por cada cónyuge a su propia HSA individual. Walmart no contribuye fondos ni paga los gastos relacionados con una HSA de su cónyuge.

Si usted tiene cobertura para una pareja elegible conforme al Plan Saver y no están legalmente casados, usted y su pareja son elegibles para contribuir a HSA individuales hasta el límite máximo de aporte familiar de $8,550 (siempre y cuando ni usted ni su pareja puedan declararse como dependiente en los impuestos en ninguna declaración de impuestos federal de la persona). Si usted o su pareja tienen 55 años o más en el 2025, el aporte máximo se incrementa $1,000 por cada participante de 55 años o más, pero estos $1,000 adicionales solamente los puede contribuir cada miembro de la pareja a su propia HSA individual. La compañía no contribuye fondos ni paga los gastos relacionados con una HSA de su pareja.

Llame a HealthEquity al **866-296-2860** para obtener información acerca de cómo abrir una HSA para su cónyuge/pareja elegible.

GANANCIAS POR INTERÉS EN SU CUENTA DE AHORRO DE SALUD

El saldo no invertido de su HSA devenga intereses. Para obtener información sobre la tasa de interés, llame a HealthEquity al **866-296-2860** o visite **MyHealthEquity.com/Enroll**. El interés actual devengado junto con el listado de las tasas de interés está disponible en los estados de cuenta mensuales.

CONFIGURACIÓN O CAMBIO DEL MONTO DE SU APORTE

Puede cambiar el monto de su aporte en línea en cualquier momento durante el año, sobre una base prospectiva.

Para establecer o cambiar su monto de aporte, inicie sesión en **One.Walmart.com/Enroll**. Llame a Servicios al Personal al **800-421-1362** si necesita ayuda para establecer sus deducciones del sueldo.

NOTA: Una vez que haga el aporte máximo anual (según se muestra en la tabla anterior), sus aportes del sueldo se interrumpen automáticamente. Es su responsabilidad tomar una nueva decisión sobre el aporte en la siguiente Inscripción Anual para el próximo año calendario.

Pago de los gastos médicos calificados con su HSA

Cuando tenga un gasto médico elegible, puede decidir pagar en efectivo o utilizar los fondos de su HSA. Algunas personas utilizan su HSA para los gastos actuales, mientras que otras prefieren utilizar la HSA como una cuenta para los gastos de atención médica en el futuro. Los gastos médicos elegibles incluyen los deducibles y el coseguro del plan de salud, la mayoría de la atención y los servicios médicos, la atención dental y de la visión, los medicamentos recetados y los medicamentos de venta libre. Además, los montos que se pagan por ciertos productos de cuidado menstrual, como tampones y toallitas femeninas, son gastos médicos elegibles. Estos gastos no deben estar ya cubiertos por su plan de seguro médico y, por lo general, las primas de seguro médico no califican. Solamente los gastos médicos incurridos después de haber establecido una HSA son elegibles para el pago o reembolso a través de una HSA. Consulte las Publicaciones 969 y 502 del IRS en **irs.gov** para obtener información sobre los gastos médicos calificados. También puede encontrar información sobre los gastos médicos calificados en **One.Walmart.com** y **MyHealthEquity.com**.

LA HSA Y LA DECLARACIÓN DEL IMPUESTO A LOS INGRESOS

Los fondos de su HSA le pertenecen, pero todo el dinero usado para gastos médicos no calificados estará sujeto al impuesto federal a los ingresos y a una multa del 20 % si tiene menos de 65 años. Guarde sus recibos y otros registros para demostrar que usó los fondos de la HSA para sus gastos médicos elegibles. Recuerde que usted es responsable de las consecuencias fiscales asociadas con los aportes y los retiros de su HSA. Consulte con su asesor impositivo si tiene preguntas sobre su HSA y los impuestos.

Cómo invertir en su HSA

Una vez que su HSA alcanza un saldo mínimo de $1,000, puede invertir el monto que exceda ese saldo en una selección de más de 20 fondos de inversión disponibles a través de HealthEquity. Revise los fondos y obtenga más información en **MyHealthEquity.com**, en la sección “Inversiones”. Usted es responsable de sus propias decisiones de inversión. Los montos que se invierten no están garantizados ni asegurados por la FDIC y pueden perder valor.

Si deja Walmart o deja de estar inscrito en el Plan Saver

Los fondos de su HSA le pertenecen como titular de la cuenta, incluso si se inscribe en la ley COBRA, cambia de plan de seguro médico, cambia de empleo o se va de Walmart. En estos casos, usted es responsable de todos los gastos relacionados con la cuenta.

Cómo cerrar su HSA

Todos los fondos en su HSA le pertenecen y puede usarlos para gastos médicos calificados libres de impuestos, ahora y en el futuro. Si no desea mantener la cuenta, llame a HealthEquity al **866-296-2860** para obtener información sobre su cierre. Si retira fondos de su HSA al cerrarla, puede estar sujeto a impuestos sobre los montos retirados.

Plan dental

La información de este capítulo describe los beneficios dentales a los que puede acceder si:

- Usted es conductor de camión por hora, temporal, a tiempo parcial, o asociado asalariado (de la gerencia) elegible
- Ha cumplido todos los requisitos para que la cobertura tenga vigencia, incluidos los requisitos de trabajo activo, y
- Se ha inscrito debida y oportunamente.

Si tiene preguntas sobre los requisitos de elegibilidad, los requisitos para que la cobertura sea efectiva y la repercusión en sus beneficios de un cambio en su clasificación laboral, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Plan dental

El plan dental cubre varios servicios sin deducible para los servicios de atención preventiva y de ortodoncia. Además, cuando utiliza odontólogos de la red, ahorrará dinero mientras protege uno de sus bienes más valiosos: su sonrisa.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Obtener una lista de odontólogos de la red de Delta Dental	Visite **One.Walmart.com** o **deltadentalar.com**	Llame a Delta Dental al **800-462-5410** o a Servicios al Personal al **800-421-1362**
Obtenga respuestas a sus preguntas con respecto a las reclamaciones dentales y comuníquese con el Servicio de Atención al Cliente de Delta Dental	Visite **deltadentalar.com** y seleccione "Login/Register" (Iniciar sesión/Registrarse) para crear una cuenta.	Llame a Delta Dental al **800-462-5410**
Obtenga un formulario de reclamación si utiliza un odontólogo que no forma parte de la red.	Visite **One.Walmart.com** o **deltadentalar.com**	

Lo que debe saber sobre el plan dental

- Si es un asociado elegible, puede adquirir cobertura dental para pagar los gastos de atención dental preventiva, básica y compleja, además de los gastos de ortodoncia. Para obtener información sobre la elegibilidad, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.
- Delta Dental of Arkansas administra el beneficio del plan dental.
- Una vez que alcanza el deducible anual del plan dental, el plan dental paga los beneficios de hasta $2,500 por persona cubierta por año calendario y un beneficio máximo de ortodoncia de por vida de $1,500 por persona cubierta. El deducible anual no se aplica a los servicios de atención preventiva y de diagnóstico ni de ortodoncia.
- La cobertura del plan dental debe permanecer vigente durante dos años calendario consecutivos.
- Los servicios de ortodoncia se cubren después de un periodo de espera de 12 meses.
- Si tiene cobertura médica del Plan Médico para Asociados (AMP), la información odontológica y médica se encuentra en la tarjeta de identificación del plan. Si está inscrito en una HMO o si solo tiene cobertura dental, recibirá una tarjeta de identificación de Delta Dental. Las tarjetas de identificación se enviarán por correo al domicilio que figura en los registros de Walmart.

Su plan dental

El plan dental está disponible para usted si es un asociado pagado por hora o gerencial. La cobertura también está disponible para sus dependientes elegibles, excepto los cónyuges/parejas de los asociados pagados por hora a tiempo parcial, los asociados temporales y los conductores de camión a tiempo parcial. El plan dental está administrado a través de Delta Dental.

El beneficio del plan dental es autoasegurado, lo que significa que los beneficios no son pagados por una compañía aseguradora.

Delta Dental administra el plan dental y tiene la autoridad fiduciaria para tomar decisiones con respecto a las reclamaciones de beneficios y la apelación de primer nivel de una reclamación que ha sido denegada.

Una vez inscrito en el plan dental, su cobertura debe permanecer vigente durante dos años calendario consecutivos. Puede agregar o quitar a un dependiente durante la Inscripción anual o debido a un evento de cambio de elección, pero debe mantener un mínimo de cobertura para asociado solo, durante dos años calendario consecutivos.

SELECCIÓN DE UN NIVEL DE COBERTURA

Cuando se inscribe al plan dental, además selecciona los dependientes elegibles que desea cubrir:

- Asociado solo
- Asociado + cónyuge/pareja (excepto para asociados a tiempo parcial pagados por hora, asociados temporales o conductores de camión a tiempo parcial)
- Asociado + hijos o
- Asociado + familia (excepto para asociados a tiempo parcial pagados por hora, asociados temporales o conductores de camión a tiempo parcial)

Para obtener información sobre la elegibilidad de los dependientes y sobre cuándo se los puede inscribir, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Cómo funciona el plan dental

El plan dental cubre cuatro tipos de servicios odontológicos:

- **La cobertura de los servicios de atención preventiva y de diagnóstico** incluye exámenes bucales y limpiezas, y servicios relacionados. No es necesario que alcance el deducible anual para que el plan dental cubra estos servicios. Los gastos que pague para la atención preventiva y de diagnóstico, si los hubiere, no se aplicarán al deducible.
- **La cobertura de atención básica** incluye empastes, periodoncia no quirúrgica y tratamientos de conducto, y comienza una vez que alcanza el deducible anual.
- **La cobertura de atención compleja** incluye periodoncia quirúrgica, coronas y dentaduras postizas, y comienza una vez que alcanza el deducible anual.
- **La cobertura de ortodoncia** comienza una vez que la persona que recibe servicios de ortodoncia haya tenido cobertura del plan dental durante 12 meses; no es necesario que alcance el deducible anual antes de recibir los beneficios de atención de ortodoncia. Los cargos que pague por la atención de ortodoncia no se aplicarán al deducible anual.

NOTA: El periodo de espera de 12 meses para la cobertura de ortodoncia se anula para los siguientes miembros:

- asociados y dependientes cubiertos localizados; y
- participantes inscritos que han cumplido previamente su periodo de espera completo.

Una vez que alcanza el deducible anual (si corresponde) y completa el periodo de espera correspondiente, el plan dental paga un porcentaje del gasto máximo permitido del plan (MPA) para los gastos cubiertos.

COBERTURA SEGÚN EL PLAN DENTAL			
Deducible anual Exento para atención preventiva y de diagnóstico, y ortodoncia	$75 por persona/$225 por familia		
Beneficio máximo No se aplica a la atención de ortodoncia	$2,500 por persona cubierta por año calendario.		
	Odontólogos de Delta Dental PPO	**Odontólogos de Delta Dental Premier**	**Dentistas que no son parte de la red**
Atención preventiva y de diagnóstico Los costos (si hubiera) no se cuentan para el deducible anual	100 % de cobertura; no se aplica el deducible anual	80 % de cobertura;* no se aplica el deducible anual	80 % del gasto máximo permitido; sin deducible anual
	* En las áreas donde la cantidad de odontólogos PPO no es suficiente, tal como lo determina la ubicación del centro de atención, los servicios están cubiertos al 100 %. Visite **One.Walmart.com** para obtener información.		
Atención básica incluye empastes, periodoncia no quirúrgica y tratamiento de conducto	80 % del gasto máximo permitido del plan después de alcanzar el deducible anual		
Atención compleja incluye periodoncia quirúrgica, coronas y dentaduras postizas	50 % del gasto máximo permitido del plan después de alcanzar el deducible anual		
Asistencia de ortodoncia (espera de 12 meses) los costos no se cuentan para el deducible anual o el beneficio máximo	80 % del gasto máximo permitido del plan hasta $1,500 de beneficio de ortodoncia máximo de por vida por persona; no se aplica el deducible anual		

GASTO MÁXIMO PERMITIDO DEL PLAN (MPA)

El MPA es el monto máximo que el plan dental paga por los servicios odontológicos cubiertos. El MPA se aplica a los servicios dentales dentro y fuera de la red para atención preventiva y diagnósticos, atención básica y atención principal.

Para los servicios cubiertos dentro de la red, el MPA es la parte de los cargos cobrados por un proveedor que cubre el plan dental, según lo establece el contrato del proveedor con Delta Dental of Arkansas. Los proveedores de la red acuerdan aceptar un monto negociado por Delta Dental para los servicios cubiertos como pago completo, sujeto al deducible y el coseguro aplicables.

En el caso de los servicios cubiertos fuera de la red, el MPA puede diferir según el estado y se deriva de una serie de factores, entre ellos, los datos de las tarifas de las reclamaciones y las declaraciones de honorarios presentadas por el odontólogo. Si consulta a un proveedor dentista que no es parte de la red de la red, el plan dental paga un porcentaje basado en el MPA o los cargos reales facturados por el proveedor para un procedimiento cubierto, lo que sea menor. Si los cargos facturados del proveedor superan el MPA del Plan, usted es responsable de pagar el 100 % de la diferencia. Para obtener más información, llame a Delta Dental al **800-462-5410**.

SEPA QUÉ ADEUDARÁ: OBTENGA UN CÁLCULO APROXIMADO ANTES DEL TRATAMIENTO

No es obligatorio que obtenga una aprobación previa para los tratamientos odontológicos. Sin embargo, al solicitar a su odontólogo que envíe una propuesta de plan de tratamiento, usted puede saber cuánto podría pagar el plan dental por un procedimiento o tratamiento antes de que se lleven a cabo. Se recomienda enviar una propuesta de plan de tratamiento para los tratamientos que podrían costar $800 o más. Delta Dental le ofrecerá un cálculo aproximado previo al tratamiento de la cantidad que se cubrirá y le puede recomendar un plan de tratamiento alternativo si parte del plan de tratamiento de su odontólogo no es elegible para la cobertura.

Para obtener un cálculo aproximado antes del tratamiento, pídale a su odontólogo que complete un formulario de reclamación odontológica regular y marque la casilla “determinación previa”. El formulario debe enviarse por correo a la siguiente dirección:

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, Arkansas 72231-5965

El cálculo aproximado de Delta Dental previo al tratamiento no constituye garantía de pago. Debe presentar una reclamación por los servicios prestados, según lo establecido en el capítulo **Reclamaciones y apelaciones**.

AHORRE DINERO UTILIZANDO ODONTÓLOGOS DE LA RED

Como participante del plan dental, puede utilizar cualquier odontólogo y recibir beneficios para los gastos cubiertos conforme al Plan. Sin embargo, ahorrará dinero cuando utilice odontólogos de Delta Dental PPO y Premier. Los proveedores contratados con Delta Dental acuerdan aceptar el gasto permitido máximo del plan dental como pago completo para un procedimiento cubierto, por lo que usted no paga más del porcentaje de coseguro aplicable al plan dental (después de alcanzar el deducible anual aplicable).

Además, puede ahorrar tiempo si recurre a los odontólogos de Delta Dental PPO o Premier porque ellos se encargan de la presentación de reclamaciones.

La red PPO de Delta Dental es una amplia red nacional de odontólogos, pero no está ampliamente disponible como la red Delta Dental Premier. Consulte el cuadro titulado **Cobertura según el plan dental** anteriormente en este capítulo para obtener detalles sobre cómo los términos de la cobertura para atención preventiva y de diagnóstico pueden diferir en cuanto a la disponibilidad de odontólogos PPO en su área. Para buscar un odontólogo de Delta Dental PPO o de Delta Dental Premier, consulte la tabla de **Recursos** que aparece al comienzo de este capítulo.

VALE LA PENA UTILIZAR LOS ODONTÓLOGOS DE LA RED

	Odontólogos de Delta Dental Premier y Delta Dental PPO	Dentistas que no son parte de la red
El odontólogo presenta las reclamaciones en su nombre	Sí	No
El odontólogo acepta el gasto máximo permitido como pago total, sujeto al deducible anual y al coseguro	Sí	No
El odontólogo ofrece precios reducidos en los servicios cubiertos por el plan dental para los participantes de Delta Dental.	Sí	No

Presentación de una reclamación dental

Si utiliza un odontólogo de Delta Dental PPO o Premier, su odontólogo se encargará de la presentación de su reclamación. Si utiliza un dentista que no es parte de la red, es posible que usted deba presentar la reclamación. Si el odontólogo pertenece a Delta Dental PPO o Premier, el plan dental puede pagarle directamente al odontólogo. Si utiliza un dentista que no es parte de la red, el pago se le realizará a usted.

Envíe su reclamación a la siguiente dirección:

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, Arkansas 72231-5965

Usted o su proveedor odontológico deben presentar una reclamación según los procedimientos de reclamaciones dentro de los 12 meses a partir de la fecha del servicio para que su reclamación no se rechace. Si no se sigue el procedimiento de reclamaciones descrito en el capítulo **Reclamaciones y apelaciones**, por ejemplo, si no envía su reclamación a la dirección correcta, su reclamación puede ser rechazada.

Las reclamaciones se determinan dentro de los plazos y requisitos establecidos en el capítulo **Reclamaciones y apelaciones**. Tiene derecho a apelar una reclamación rechazada.

SI CUENTA CON COBERTURA CONFORME A MÁS DE UN PLAN DENTAL

Si usted o un dependiente elegible tiene cobertura del plan odontológico y también tiene cobertura de otro plan odontológico (por ejemplo, un plan de la compañía de su cónyuge/pareja), se puede aplicar la coordinación de beneficios. El plan dental tiene el derecho de coordinar con los otros planes que le dan cobertura a fin de que los beneficios dentales totales que se deben pagar no excedan el nivel de beneficios que se deben pagar conforme al plan dental.

Cuando tiene la cobertura de más de un plan, se designa a uno de ellos como el plan principal. El plan principal paga primero e ignora los beneficios que se deben cubrir conforme a otros planes cuando se los determine. Se designa cualquier otro plan como el plan secundario que paga los beneficios después del plan principal. Un plan secundario resta de sus beneficios el monto de beneficios que se deben cubrir conforme a "otros planes" y puede limitar los beneficios que paga.

Debe cumplir con las cláusulas del seguro principal a fin de que el plan dental pague como pagador secundario.

Estas reglas se aplican independientemente de que se presente o no una reclamación conforme al otro plan. Si no se presenta una reclamación, los beneficios conforme al plan dental quedarán pendientes o se rechazarán hasta que se reciba una explicación de los beneficios que demuestre que se presentó la reclamación ante el plan principal.

CÓMO EL PLAN DENTAL PUEDE COORDINARSE CON OTROS PLANES

	Ejemplo 1	Ejemplo 2	Ejemplo 3
Si otro plan paga como plan principal al:	80 %	80 %	0 %
Y el pago del plan dental es:	80 %	100 %	80 %
El beneficio total del plan dental es:	0 %	20 %	80 %

DETERMINAR CUÁL ES EL PLAN PRINCIPAL

Un plan sin una disposición de coordinación es siempre principal. El plan dental tiene una disposición de coordinación. Si todos los planes incluyen una disposición de coordinación, se aplicarán las siguientes disposiciones:

- El plan que cubre al participante para el que se realizó la reclamación, que no sea como dependiente, paga primero y el otro plan paga en segundo término.
- En lo que respecta a las reclamaciones de hijos dependientes, el plan del progenitor que primero cumple años en el año calendario es el primario.
- Cuando las fechas de cumpleaños de ambos progenitores coinciden en el mismo día, el plan que ha cubierto a la persona a cargo por un periodo de tiempo mayor es el primario.
- Cuando los progenitores de un hijo dependiente están divorciados o separados, o la pareja de hecho o relación legal se termina, y el progenitor que tiene la custodia no se ha casado de nuevo, el plan de ese progenitor es el principal.
- Cuando el progenitor que tenga custodia se haya vuelto a casar o haya establecido una relación de pareja de hecho con otra persona, el plan de ese progenitor pasa a ser el principal, el plan del padrastro o la madrastra paga de forma secundaria y el plan del progenitor sin custodia paga último.
- Cuando existe una sentencia del tribunal que establece la responsabilidad financiera de los gastos de atención de la salud del niño, el plan que cubre al progenitor con responsabilidad financiera es el principal.
- Si estas reglas no establecen un orden de determinación de beneficios, el plan que ha cubierto al afiliado para el que se realizó la reclamación durante el periodo más extenso será el principal.

Si tiene cobertura bajo un derecho de continuación de la cobertura en virtud de la ley federal o estatal (tal como COBRA) y también tiene cobertura bajo otro plan que le cubre como empleado, afiliado o jubilado (o como dependiente de esa persona), este último plan es el principal y la continuación de la cobertura es secundaria. Si el otro plan no tiene esta norma, y los planes no llegan a un acuerdo con respecto al orden de los beneficios, esta norma no se aplica.

Qué está cubierto conforme al plan dental

El plan dental cubre los servicios enumerados en esta sección, sujeto a ciertas limitaciones. Si tiene preguntas sobre qué está cubierto con el plan dental, llame a Delta Dental al **800-462-5410**.

ATENCIÓN PREVENTIVA Y DE DIAGNÓSTICO

La atención preventiva y de diagnóstico tiene cobertura sin necesidad de alcanzar el deducible anual.

Radiografías de aleta de mordida: Se cubre cada año según lo exija el dentista. Se combina con la radiografía panorámica si la realiza el mismo proveedor el mismo día y se procesa como una serie de boca completa. Limitadas a dos películas por visita para menores de 10 años.

Limpieza (profilaxis dental): Se cubre una profilaxis, que incluye limpieza, raspado y pulido de los dientes, dos veces durante un año calendario. Se permiten dos limpiezas adicionales durante el embarazo y hasta tres meses después del parto. Se permiten dos limpiezas adicionales en caso de enfermedades cardíacas, diabetes y enfermedad periodontal. Mantenimiento periodontal adicional (hasta cuatro por año calendario) permitido para la enfermedad periodontal. El beneficio adicional no puede combinarse para un paciente con más de una de las afecciones mencionadas.

Tratamientos con flúor: Cubierto una vez cada año natural para los afiliados menores de 19 años. Se cubre una aplicación adicional por año calendario para los dependientes menores de 19 años elegibles y con riesgo moderado o alto (según la definición de los Códigos de procedimientos dentales de la asociación dental americana) de desarrollar caries. Se ofrece cobertura para la aplicación de fluoruro diamino de plata dos veces por año calendario, por diente. No se cubren las restauraciones realizadas en los dos meses siguientes a una aplicación de fluoruro diamino de plata. Los selladores y las restauraciones preventivas no están cubiertos si se ha aplicado fluoruro diamino de plata al diente. El fluoruro diamino de plata no está cubierto el mismo día que una restauración del mismo diente.

Desbridamiento bucal completo: Limitado a una vez en la vida.

Serie de radiografías panorámicas o de la boca entera: Limitada a un procedimiento en un periodo consecutivo de 60 meses. Una serie de la boca entera es cualquier combinación de 14 o más radiografías periapicales y/o interproximales que se toman en la misma fecha. Si la combinación de imágenes intraorales facturadas por separado (es decir, radiografías interproximales y periapicales) iguala o supera la cantidad de películas permitida para una serie de la boca entera, los cargos por las imágenes se combinarán y se considerará que comprenden una serie de la boca entera. Solo se paga un beneficio si no se pagaron otras radiografías panorámicas o serie de boca completa durante los 60 meses consecutivos anteriores.

Evaluaciones orales: Los beneficios se abonan de la siguiente manera:

- **Evaluación oral rutinaria:** Dos evaluaciones cubiertas durante un año calendario.
- **Evaluación oral exhaustiva y detallada o evaluación periodontal:** Las evaluaciones orales exhaustivas iniciales se pagan sujetas a las limitaciones de tiempo de las evaluaciones orales rutinarias. Los exámenes bucales integrales posteriores presentados por el mismo proveedor en el plazo de tres años se procesan como exámenes bucales de rutina.

Los exámenes de emergencias realizados por odontólogos no están sujetos a las restricciones del año calendario.

Radiografías periapicales: Cubierto según sea necesario.

Restauración preventiva con resina: Cobertura para los primeros y segundos molares permanentes con superficie oclusal no restaurada para los participantes menores de 19 años. Limitados a un tratamiento por pieza dentaria cada cinco años.

Pruebas de vitalidad de la pulpa: Cubiertas si el mismo proveedor no realiza otro procedimiento definitivo el mismo día.

Evaluaciones de riesgo: Cubiertas una vez cada tres años para niños de 3 a 18 años.

Reparación de selladores: Cobertura para los primeros y segundos molares permanentes con superficie oclusal no restaurada para los participantes menores de 16 años. No se cubren durante los primeros 24 meses de la colocación inicial del sellador. Limitados a un tratamiento por pieza dentaria cada 24 meses. No se cubren cuando la pieza dentaria tiene una restauración preventiva con resina previa.

Selladores: Cobertura para los primeros y segundos molares permanentes con superficie oclusal no restaurada para los participantes menores de 16 años. Limitados a un tratamiento por pieza dentaria de por vida. No se cubren cuando la pieza dentaria tiene una restauración preventiva con resina previa.

Mantenedores de espacio: Cubiertos para participantes de 13 años o menores. Se limitan a una aplicación por zona de extracción de espacio (cuadrante/arco) en cualquier periodo de 60 meses consecutivos. La reparación de un mantenedor de espacio no está cubierta.

ATENCIÓN BÁSICA

Luego de alcanzar el deducible anual, el Plan paga el 80 % del gasto máximo permitido del plan para los tratamientos básicos.

Empastes de amalgama y resina compuesta: Los beneficios se abonarán una vez por superficie dental en cualquier periodo consecutivo de 24 meses.

Endodoncia: Incluye terapia pulpar y endodoncia. Consulte **Tratamiento de conducto** en **Cuidado general** a continuación.

Extracciones: Las extracciones no quirúrgicas están cubiertas una vez por diente.

Periodoncia no quirúrgica: Se proporciona una vez por cuadrante en cualquier periodo consecutivo de 24 meses.

Dispositivo ortésico oclusal (aparato para la articulación temporomandibular): Los beneficios se abonan una vez cada cinco años. No se cubren los ajustes dentro de los seis meses. Unajuste cubierto por año posteriormente.

Mantenimiento periodontal: Solamente está cubierto si se realiza 30 días o más después de la finalización del tratamiento periodontal quirúrgico o no quirúrgico. Posteriormente, se permite el mantenimiento periodontal hasta cuatro veces por año calendario. Este beneficio se combina con cualquier limpieza de rutina que se lleve a cabo durante el mismo año calendario con una limitación combinada de cuatro para ese año.

CUIDADO GENERAL

Luego de alcanzar el deducible anual, el Plan paga el 50 % del gasto máximo permitido del plan para la atención compleja.

Anestesia/anestesia general y sedación intravenosa: Cubierta solamente cuando se facilita bajo las siguientes circunstancias:

- El paciente padece una afección médica que le impide quedarse quieto (incluidas, entre otras, distonía, enfermedad de Parkinson, autismo).
- El paciente tiene menos de 4 años, o
- Se relaciona con ciertos procedimientos quirúrgicos bucales cubiertos.

Prótesis removibles completas y parciales y puentes fijos parciales: Cubiertos cuando la prótesis o el puente es el tratamiento estándar aceptado profesionalmente.

- Incluye la sustitución o adición de dientes a prótesis dentales, parciales o puentes fijos.
- Cuando estén disponibles planes de tratamientos alternativos, el plan dental cubre el tratamiento profesionalmente aceptado estándar. Por ejemplo, se permite un puente bucal solo cuando una dentadura postiza parcial no sea suficiente. Consulte la sección **Planes de tratamientos alternativos** en **Beneficios limitados** que aparece más adelante en este capítulo.

- Las dentaduras postizas desmontables completas y parciales, o los puentes fijos no se pagan para pacientes menores de 16 años.
- Una dentadura postiza que sustituya a otra dentadura postiza o a un puente fijo, o un puente fijo que sustituya a otro puente fijo se cubre únicamente si la dentadura postiza existente, la dentadura postiza parcial o el puente fijo tiene, al menos, cinco años y no se puede reparar.

Coronas, restauración con molde dentario, incrustaciones y recubrimientos y carillas: Cubiertos solamente cuando el diente no puede restaurarse con amalgama o empaste de resina compuesta.

- La sustitución no se cubre, salvo que la corona existente, la restauración de colados, las incrustaciones o las fundas tengan más de cinco años y no puedan repararse.

NOTA: Los accidentes que se deban por morder o masticar no son una excepción a la espera de cinco años para el reemplazo de coronas.

- Para los participantes menores de 12 años, los beneficios de coronas para piezas dentarias vitales se limitan a coronas de resina o de acero inoxidable, a menos que existan antecedentes de tratamiento de conducto o recesión de la pulpa.
- Se determina el tratamiento de acuerdo con el límite del plan de tratamiento alternativo. Consulte la sección **Planes de tratamientos alternativos** en **Beneficios limitados** que aparece más adelante en este capítulo.

Implantes: La colocación quirúrgica de un implante tiene cobertura una vez cada cinco años consecutivos.

- El pilar para sostener una corona tiene cobertura una vez cada cinco años consecutivos.
- Un retenedor sostenido por pilar o implante tiene cobertura una vez cada cinco años consecutivos.
- Un procedimiento de mantenimiento de los implantes tiene cobertura una vez cada 12 meses consecutivos.
- Las extracciones de los implantes tienen cobertura una vez de por vida por cada pieza dentaria. Los implantes no son pagaderos para pacientes menores de 16 años.

Ajustes Oclusales (limitados): Cubiertos solamente si se realizan seis meses o más después de la finalización de los procedimientos de restauración inicial, prostodónticos y de implantes que incluyen superficie oclusal.

Cirugía bucal: Extracciones quirúrgicas y de muelas del juicio, incluso la atención pre y posquirúrgica, excepto en el caso de los servicios cubiertos conforme al Plan Médico para Asociados. No tiene cobertura ni la anestesia bucal ni el óxido nitroso (analgesia). Si se realiza una cirugía bucal en un hospital, el plan dental cubre los honorarios de cirujanos bucales para dichos servicios para las personas cubiertas que no estén inscritas en el Plan Médico para Asociados.

Gastos hospitalarios ambulatorios o de hospitalización y tarifas adicionales que cobre el dentista por el tratamiento hospitalario: Consulte **Costos hospitalarios** bajo **Qué no está cubierto conforme al plan dental** más adelante en este capítulo.

Tratamiento de conducto: incluye cultivos bacteriológicos, exámenes de diagnóstico, anestesia local y atención de rutina de seguimiento. Se paga una vez por cada pieza dentaria.

- La pulpotomía terapéutica se paga una vez por pieza dentaria hasta la edad de 21 años.
- Un nuevo tratamiento de un conducto anterior se permite una vez en un periodo de 24 meses consecutivos.

Periodoncia quirúrgica: tratamiento de las encías: cirugía ósea/injerto de tejido blando, realizado en la misma sección una vez en cualquier periodo consecutivo de 36 meses.

ORTODONCIA

Para poder optar a la asistencia para ortodoncia, debe estar inscrito en el plan dental del AMP durante al menos 12 meses. El periodo de espera de 12 meses se aplica a usted y a cada uno de sus dependientes cubiertos por separado. El periodo de espera de 12 meses se omite para los asociados localizados y sus dependientes con cobertura. Si ya estaba inscrito en el plan dental y la cobertura finalizó por cualquier motivo después de que usted o su dependiente cubierto haya satisfecho el periodo de espera de 12 meses (por ejemplo, si dejó de trabajar y fue contratado de nuevo o si abandonó voluntariamente la cobertura), el periodo anterior de inscripción en el plan dental de usted o de su dependiente cubierto contará para el periodo de espera de 12 meses. No obstante, si usted o su dependiente cubierto no había satisfecho el periodo de espera de 12 meses antes de la finalización de la cobertura, el tiempo anterior de inscripción en el plan dental no contará para el periodo de espera de 12 meses y usted o su dependiente cubierto deberá satisfacer un nuevo periodo de espera de 12 meses tras su reinscripción.

Si el odontólogo remite una declaración a comienzos de un periodo de tratamiento de ortodoncia que demuestra un gasto único por el tratamiento completo, se pagan los beneficios de la siguiente manera:

- El odontólogo recibe un pago inicial de hasta $150.
- Una parte prorrateada del resto se paga mensualmente en función del periodo estimado para el tratamiento y de la elegibilidad continua.
- El monto y la cantidad de pagos están sujetos a cambio si el costo o el periodo de tratamiento cambia.

El plan dental solo cubre el tratamiento de ortodoncia que comience después de que la persona cubierta comience a ser elegible para la asistencia de ortodoncia. Se considera que el tratamiento de ortodoncia activo comienza en la fecha en que se colocan los dispositivos activos. El tratamiento de ortodoncia activo se considera finalizado en lo que ocurra primero de:

- La fecha en que se interrumpe el tratamiento por voluntad propia, o
- La fecha en que se extraen las bandas activas o los dispositivos.

La reparación o la sustitución de un aparato de ortodoncia no está cubierto.

Existen ciertos beneficios de asistencia de ortodoncia que no tienen cobertura. Consulte **Qué no está cubierto conforme al plan dental**adelante.

Beneficios limitados

Plan de tratamiento Alternativo: Cuando existen planes de tratamiento alternativos, el plan dental cubre el tratamiento estándar aceptado a nivel profesional.

Transferencia de tratamiento: Si, mientras se realiza el tratamiento, cambia de dentistas, o si más de un dentista presta servicios para un mismo procedimiento dental, el plan dental no paga más que el monto que habría abonado si los servicios hubiesen sido prestados solamente por un dentista.

Qué no está cubierto conforme al plan dental

El plan dental no paga los beneficios para todos los tipos de servicios. Para determinar si un servicio está cubierto, llame a Delta Dental o envíe un cálculo aproximado previo al tratamiento con el formulario de beneficios. Los servicios que no están cubiertos por el plan incluyen, entre otros, los siguientes:

Lesiones accidentales de dientes naturales sanos: es posible que los gastos de tratamiento de lesiones accidentales en dientes naturales sanos estén cubiertos por el plan médico. Esta exclusión no se aplica a lesiones accidentales causadas por mordeduras o masticaduras; estos costos pueden estar cubiertos conforme al plan dental.

Fuera del alcance de la concesión de la licencia o sin licencia: servicios prestados por un dentista fuera del ámbito de su licencia, o cualquier servicio prestado por un dentista sin licencia.

Puentes: reparación de puentes durante el primer periodo de seis meses tras haber sido entregados, y tales servicios recibidos con una frecuencia superior a una vez cada periodo de 60 meses consecutivos. Recementación de puentes durante el primer periodo de seis meses tras haber sido entregados, o tales servicios recibidos con una frecuencia superior a una vez cada periodo de 12 meses consecutivos.

Motivos estéticos: servicios realizados con fines cosméticos o para corregir malformaciones congénitas, hereditarias o del desarrollo. Esta exclusión no se aplica a servicios de ortodoncia para la corrección de piezas dentarias mal ubicadas.

Dentaduras postizas: reparación o rebase de las dentaduras postizas durante los primeros seis meses tras haber sido entregadas, y tales servicios recibidos con una frecuencia superior a una vez cada cinco años para las reparaciones y una vez cada tres años para los rebases. Rebase inmediata de la dentadura durante los tres primeros meses tras haber sido entregadas.

Servicios odontológicos optativos que no sean de emergencia fuera de los EE. UU.

Servicios electivos no necesarios: servicios que no sean necesarios desde el punto de vista odontológico o que no satisfagan las normas de atención generalmente aceptadas para el tratamiento de la afección odontológica en particular, que incluye la decoración, personalización o inscripción de cualquier diente, dispositivo, aparato, corona u otro trabajo odontológico.

Experimentales o en Investigación: costos por tratamientos o servicios, incluida la atención hospitalaria, que sean experimentales, estén en investigación o resulten inapropiados según los protocolos establecidos por Delta Dental.

Organismo gubernamental: servicios prestados o cubiertos por cualquier organismo gubernamental o conforme a cualquier programa o ley gubernamental, excepto en el caso de costos por beneficios por derechos legales según las leyes federales correspondientes.

Costos hospitalarios: los servicios prestados en un hospital o en un centro para pacientes ambulatorios, que incluyen, entre otros, cargos de proveedores e instalaciones. Esta exclusión no se aplica a los honorarios de cirujanos bucales para participantes que no estén inscritos en el Plan Médico para Asociados, conforme a los términos del plan dental.

Protección oclusal: dispositivos que se utilicen para reducir los efectos del bruxismo (apretar los dientes) u otros factores de oclusión. Esta exclusión no se aplica a los dispositivos ortóticos oclusales para tratar trastornos de la articulación temporomandibular (TMJ).

Sedación bucal: sedación bucal y óxido nitroso (analgesia).

Atención de ortodoncia: servicios relacionados con el tratamiento para la corrección de piezas dentarias mal ubicadas durante los primeros 12 meses consecutivos en los que un participante tiene cobertura conforme al plan dental.

Ferulización periodontal: costos de ajustes oclusales completos o estabilización de las piezas dentarias mediante el uso de ferulización periodontal.

Restauraciones permanentes: costos de bases, revestimientos y anestésicos utilizados en forma conjunta con restauraciones permanentes (empastado).

Medicamentos recetados: recetas indicadas para fines dentales.

Prótesis, duplicados: dispositivos o aparatos protésicos duplicados.

Retenedores: costos separados de retenedores (dispositivos para retener la relación de ortodoncia) o de dispositivos para corregir hábitos dañinos, como la succión del pulgar o la protrusión lingual.

Servicios prestados antes de la fecha de entrada en vigencia o durante el periodo de espera de los servicios de ortodoncia: Cargos por sesiones de tratamiento, que incluyen prótesis y ortodoncia, que comiencen antes de la fecha de entrada en vigencia de la cobertura o antes de que satisfaga los requisitos para recibir beneficios por servicios de ortodoncia.

Correcciones quirúrgicas: costos por servicios relacionados con la corrección quirúrgica de:

- disfunción de la articulación temporomandibular (TMJ);
- deformidades orofaciales; y
- procedimientos quirúrgicos bucales específicos cubiertos por el Plan médico para asociados.

Estructura dental: los servicios para la restauración de la estructura dental perdida por desgaste, para la reconstrucción o el mantenimiento de las superficies de masticación debido a piezas dentarias desalineadas o a oclusión, o para la estabilización de piezas dentarias.

OTROS COSTOS NO CUBIERTOS

- Cualquier procedimiento realizado por un propósito temporal
- Cargos que excedan el gasto máximo permitido
- Injertos extrabucales
- Hipnosis o acupuntura
- Instrucción para la higiene bucal e instrucción nutricional
- Programas de control de placas
- Servicios cubiertos por el Plan Médico para Asociados
- Servicios que no tienen costo
- Teleodontología
- Cualquier otro servicio no mencionado de forma específica como cubierto
- Costos cubiertos por las leyes de compensación de los trabajadores o de responsabilidad de los empleadores
- Servicios prestados por un miembro de la familia del participante
- Costos pagados como resultado de una guerra.

Interrupción de la cobertura

En ocasiones, debe tomar medidas especiales para pagar sus primas del plan dental a fin de evitar la suspensión de la cobertura. Estas situaciones se producen con más frecuencia si se encuentra con una licencia de ausencia o si su cheque de pago de Walmart no es suficiente para pagar toda la parte que le corresponde del costo de cobertura (por ejemplo, después de una reducción de horas). El incumplimiento del pago de las primas antes de la fecha de vencimiento puede interrumpir el pago de cualquier reclamación de beneficio o suspender la cobertura.

Consulte **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información detallada sobre cómo realizar los pagos de las primas para que no haya un lapso en su cobertura.

SI SE TOMA UNA LICENCIA DE AUSENCIA

Puede continuar su cobertura hasta el último día de una licencia de ausencia aprobada, solo si paga sus primas antes de que comience la licencia de ausencia o durante esta. Para obtener información sobre cómo realizar los pagos durante una licencia, consulte la sección **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** .

En qué momento finaliza su cobertura dental

Su cobertura finaliza el último día de trabajo o cuando deja de ser elegible conforme a los términos del Plan. La cobertura para los dependientes finaliza cuando su cobertura termina o cuando un dependiente deja de ser un dependiente que reúne los requisitos (como se define en el capítulo **Elegibilidad, inscripción y fechas de vigencia**). Todos los beneficios cesan el día en que finaliza la cobertura, excepto cuando la culminación de los procedimientos operativos está en proceso en dicha fecha. Los “procedimientos operativos” se limitan a coronas individuales, dentaduras postizas y puentes bucales e implantes, y se consideran “en proceso” si todos los procedimientos para el comienzo de los análisis de laboratorio y todos los procedimientos operativos se completan dentro de los 45 días del cese de empleo. El plan dental no paga los beneficios si usted o sus dependientes cubiertos reciben beneficios de otro plan para estos gastos posteriores a la finalización. Usted y/o sus dependientes inscritos pueden ser elegibles para la continuación de la cobertura a través de la Ley Ómnibus Consolidada de Reconciliación Presupuestaria de 1985 y sus enmiendas (COBRA). Consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** para obtener información sobre la continuación de la cobertura según la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA).

Si su cobertura se cancela por falta de pago de las primas, la cobertura finaliza en la fecha de cancelación. Consulte **Pago de los beneficios** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información.

Si su clasificación de empleo cambia, consulte la tabla correspondiente en la sección **Cambio de una clasificación laboral a otra** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información sobre cualquier repercusión en su cobertura.

Si cancela voluntariamente la cobertura después de un evento de cambio de elección o en la Inscripción anual (después de completar dos años calendario consecutivos de cobertura), la cobertura finaliza de la siguiente manera:

- **Tras un evento de cambio de elección:** la cobertura finaliza en la fecha efectiva del evento. Para obtener más información, consulte **Cambios de elección permitidos fuera del periodo de Inscripción anual** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.
- **En la Inscripción anual: la cobertura** finaliza el 31 de diciembre del año en curso.

Si deja Walmart y lo contratan nuevamente

Si es usted un asociado pagado por hora a tiempo parcial o temporal que está sujeto a las verificaciones de elegibilidad de 60 días, una sola vez y anualmente para los beneficios médicos, consulte la sección **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener detalles sobre cómo el hecho de terminar el empleo con Walmart y luego volver a trabajar afecta sus beneficios. Consulte a continuación para obtener información adicional sobre las repercusiones en el periodo mínimo de inscripción, el deducible y el periodo de espera exigidos para la asistencia ortodóncica.

Si es un asociado a tiempo completo pagado por hora, un miembro de la gerencia o conductor de camión, consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para saber cómo el hecho de dejar de trabajar en Walmart y volver a hacerlo afecta sus beneficios. Abajo encontrará información detallada sobre las repercusiones en el periodo mínimo de inscripción, el deducible y el periodo de elegibilidad exigidos para la asistencia ortodóncica.

Repercusiones del periodo mínimo de inscripción, el deducible y el periodo de espera exigidos para la asistencia ortodóncica:

- Si deja de trabajar y vuelve a incorporarse al trabajo dentro de los 30 días siguientes a la fecha de haber dejado de trabajar, el deducible no se restablecerá a menos que haya dejado de trabajar en un año calendario y vuelva a incorporarse al trabajo en el año calendario siguiente. El periodo de espera para la asistencia de ortodoncia tampoco se reiniciará.
- Si deja de trabajar y vuelve a trabajar más de 30 días pero menos de 13 semanas desde la fecha cuando dejó de trabajar, su deducible no se restablecerá cuando vuelva a trabajar en el mismo año calendario cuando dejó de trabajar. Su deducible se restablecerá cuando deje de trabajar en un año calendario y vuelva a trabajar en el año calendario siguiente. El periodo de espera para usted o para de su dependiente cubierto para la asistencia ortodóncica se restablecerá a menos que ya se haya satisfecho el periodo de espera de 12 meses. Si ya ha mantenido el periodo mínimo de inscripción exigido de dos años, puede darse de baja de la cobertura dental en los 60 días siguientes a cuando vuelve a trabajar.
- Si deja de trabajar y vuelve a incorporarse al trabajo después de 13 semanas o más de la fecha en que deja de trabajar, se le considerará un nuevo asociado y deberá completar cualquier periodo de espera de elegibilidad u otros requisitos aplicables. El periodo de espera para usted o para de su dependiente cubierto para la asistencia ortodóncica se restablecerá a menos que ya se haya satisfecho el periodo de espera de 12 meses. Para obtener información, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Plan de la visión

La información de este capítulo describe los beneficios de la visión a los que puede acceder si:

- Usted es conductor de camión por hora, temporal, a tiempo parcial, o asociado asalariado (de la gerencia) elegible
- Ha cumplido todos los requisitos para que la cobertura tenga vigencia, incluidos los requisitos de trabajo activo, y
- Se ha inscrito debida y oportunamente.

Si tiene preguntas sobre los requisitos de elegibilidad, los requisitos para que la cobertura sea efectiva y la repercusión en sus beneficios de un cambio en su clasificación laboral, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Plan de la visión

El plan de la visión le ayuda a pagar los exámenes oculares de rutina, los lentes, los marcos y los lentes de contacto, para que pueda ver con claridad en los próximos años.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Ubique un Centro de la visión de Walmart o un proveedor de Sam's Club Optical	Visite **One.Walmart.com**	
Para obtener información detallada sobre la cobertura del plan de la visión o para ubicar a un proveedor de la red de VSP	Visite **Walmart.VSPforme.com** e ingrese el número de miembro	Llame a VSP al **866-240-8390**
Obtenga el costo de la cobertura del plan de la visión	Visite **One.Walmart.com**	Llame a Servicios al Personal al **800-421-1362**

Lo que debe saber sobre el plan de la vista

- La cobertura del plan de la visión es independiente del plan de seguro médico, el cual no suele cubrir los costos de la atención de la visión de rutina. Si le interesa obtener cobertura para servicios de la visión que no cubra el plan de seguro médico, debe inscribirse por separado en el plan de la visión.
- Puede consultar con cualquier proveedor del Centro de la visión de Walmart, Sam's Club Optical o con la red de VSP para recibir atención y obtener el mismo nivel de beneficios. No hay beneficios disponibles si usted consulta con un proveedor que no es parte de la red. **NOTA:** Puede haber casos inusuales en los que un proveedor de un Centro de la vista de Walmart o de una óptica de Sam's Club no sea un proveedor de VSP. Debe verificar que un proveedor es un proveedor de la red VSP antes de recibir los servicios.
- Puede comprar lentes de contacto en línea en **WalmartContacts.com** o **SamsClubContacts.com**, o a través del proveedor de la red de VSP. VSP coordina el monto de las compras que puede realizar conforme a la cobertura. Ingrese a **Walmart.VSPforme.com** o llame a VSP al **866-240-8390** para obtener información acerca del beneficio de lentes de contacto.
- Si cuenta con cobertura médica a través del Plan Médico para Asociados (AMP), el número de teléfono de VSP se encuentra en la tarjeta de identificación del plan. Si está inscrito en una HMO o si se inscribe para recibir únicamente cobertura de la visión, recibirá una tarjeta de identificación de VSP, la cual se enviará por correo a su domicilio.

Plan de la visión

Walmart ofrece el plan de la vista para ayudarlo a pagar la atención de la vista de rutina. El plan de la visión está administrado a través de VSP. Puede tener acceso a la atención conforme al plan de la vista a través de un Centro de Visión de Walmart o Sam's Club Optical, o a través de un proveedor de la red VSP de toda la nación. Puede obtener la cobertura del plan de la visión si es un asociado pagado por hora o un asociado gerencial. La cobertura también está disponible para sus dependientes, salvo para los cónyuges o las parejas de los asociados pagados por hora a tiempo parcial, los asociados temporales y los conductores de camiones a tiempo parcial.
NOTA: Puede haber casos inusuales en los que un proveedor de un Centro de la vista de Walmart o de una óptica de Sam's Club no sea un proveedor de VSP. Debe verificar que un proveedor es un proveedor de la red VSP antes de recibir los servicios.

SELECCIÓN DE UN NIVEL DE COBERTURA

Cuando se inscribe al plan de la visión, además selecciona los dependientes elegibles que desea cubrir:

- Asociado solo
- Asociado + cónyuge/pareja (excepto para asociados a tiempo parcial pagados por hora, asociados temporales o conductores de camión a tiempo parcial)
- Asociado + hijos o
- Asociado + familia (excepto para asociados a tiempo parcial pagados por hora, asociados temporales o conductores de camión a tiempo parcial)

Para obtener información sobre la elegibilidad de los dependientes y sobre cuándo se los puede inscribir, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Cómo funciona el plan de la visión

El plan de la visión cubre un examen de rutina de la visión por año calendario; lentes, una vez por año calendario; marcos, una vez por año calendario o lentes de contacto, una vez por año calendario. El plan de la visión cubre lentes de contacto y anteojos recetados. Si usted elige lentes de contacto, no será elegible para lentes ni marcos nuevamente hasta el año calendario siguiente. Los beneficios se pagan tal como se muestra en la tabla a continuación. Los proveedores de Walmart y los proveedores de la red de VSP aceptaron prestar sus servicios a los asociados con cobertura por un cargo previamente acordado; lo único que debe abonar es el copago correspondiente y el costo de los artículos no cubiertos u optativos. VSP le paga el resto directamente al proveedor.

BENEFICIOS DEL PLAN DE LA VISTA

	Centro de la visión de Walmart	Sam's Club Optical	Proveedores de la red de VSP
Copago para el examen de rutina Una vez por año calendario	$4 *Los servicios por visión parcial, como las pruebas y las ayudas complementarios para problemas visuales no corregibles con lentes normales, son un beneficio del plan cuando se satisfacen criterios específicos y cuando son recetados por un proveedor de la red VSP. Es posible que los servicios por visión parcial estén disponibles con menos frecuencia que una vez al año. Llame a VSP para obtener más información sobre los criterios de elegibilidad.*		
Copago para los materiales	$4 *Se aplica con la compra de marcos o lentes (pero no de lentes de contacto). El copago se cobra únicamente cuando los marcos y las lentes se compran juntos.*		
Copago para las lentes progresivas	$45		
Lentes • Visión unifocal • Lente bifocal con alineación • Lente trifocal con alineación • Lenticular	100 % de cobertura después del copago Las siguientes opciones también están 100 % cubiertas: • Revestimiento antirrayones • Lentes de policarbonato • Protección UV (ultravioleta) *Las lentes estándares están cubiertas luego del copago correspondiente. Consulte con su equipo óptico para saber qué lentes se ofrecen conforme al beneficio.*		
Marcos Una vez por año calendario	Gasto permitido de $130 *Los cargos que superen el gasto permitido del marco le corresponden a usted.*		
Lentes de contacto electivos Una vez cada año calendario en lugar de todos los demás beneficios de lentes y monturas	Gastos permitidos de $130 en lentes de contacto *Los cargos que superen el gasto permitido de lentes de contacto le corresponden a usted.* *Es posible que se le cobre una tarifa adicional de hasta $60 por la adaptación y la evaluación.*		
Lentes de contacto necesarios Una vez cada año calendario en lugar de todos los demás beneficios de lentes y monturas	100 % cubierto después del copago una vez cada año calendario. Incluye los honorarios profesionales y los materiales. *Los lentes de contacto no electivos son un beneficio del Plan cuando se satisfacen los criterios específicos y cuando son recetados por un proveedor de la red VSP. Llame a VSP para obtener más información sobre los criterios de elegibilidad.*		

NOTA: Pueden aplicarse impuestos sobre las ventas, los cuales reducirán el beneficio de la vista.

Los beneficios se pagarán solo por los servicios cubiertos proporcionados a través de cualquier Centro de la visión Walmart, Sam's Club Optical o proveedor de la red VSP. No hay beneficios disponibles si usted consulta a un proveedor que no es parte de la red. **NOTA:** Puede haber casos inusuales en los que un proveedor de un Centro de la vista de Walmart o de una óptica de Sam's Club no sea un proveedor de VSP. Debe verificar que un proveedor es un proveedor de la red VSP antes de recibir los servicios.

Cargos adicionales. Los siguientes cargos le corresponden pagar a usted. Para obtener más información, llame a VSP al **866-240-8390**.

- Lentes bifocales
- Lentes extragrandes
- Lentes fotocromáticas o polarizadas que no tengan asignación rosa 1 o 2
- Lentes laminadas
- Lentes de alto índice
- Revestimiento antirreflectivo
- Revestimiento de color
- Revestimiento espejado
- Procesos cosméticos opcionales
- Atención por visión parcial
- Lentes cosméticos, y
- Marcos o lentes de contacto que cuestan más que su gasto permitido

Cómo usar el plan

Para obtener atención de la visión, siga los pasos que se mencionan a continuación.

PASO 1	Para buscar un Centro de Visión de Walmart o un proveedor de Sam's Club Optical, ingrese a **One.Walmart.com**; para buscar un proveedor en la red de VSP, llame al **866-240-8390** o visite **Walmart.VSPforme.com** e ingrese su número de miembro. **NOTA:** Puede haber casos inusuales en los que un proveedor de un Centro de la vista de Walmart o de una óptica de Sam's Club no sea un proveedor de VSP. Debe verificar que un proveedor es un proveedor de la red VSP antes de recibir los servicios.
PASO 2	Cuando solicite una cita, identifíquese como miembro de VSP e informe al consultorio su nombre y fecha de nacimiento, y el nombre del paciente (si es diferente). El consultorio del proveedor se comunica con VSP para verificar su elegibilidad.
PASO 3	En la visita, pague el copago y cualquier otro monto requerido directamente al Centro de la visión de Walmart o Sam's Club Optical, o proveedor de la red de VSP. El consultorio del proveedor coordina el reembolso y se encarga de todas las demás tareas administrativas necesarias.

Qué no está cubierto

Algunos gastos no están cubiertos por el plan de la visión:

- Cargos por exámenes oculares, lentes o marcos que:
  - Usted no esté obligado por ley a pagar o para los cuales no se efectuará ningún cargo en ausencia de cobertura de la visión.
  - Excedan los máximos del plan.
  - No sean necesarios conforme a las normas aceptadas de práctica oftalmológica, o no estén pedidos o recetados por un médico u optometrista.
  - No cumplan con las normas aceptadas de práctica oftalmológica, incluidos cargos de servicios o suministros experimentales o de investigación.
  - Se reciban como resultado de una enfermedad, un defecto o una lesión ocular debido a un acto de guerra declarado o no declarado.
  - Sean para una afección, enfermedad, dolencia o lesión que surja del empleo compensable o en el transcurso de este, conforme a la Ley de Compensación de Trabajadores o la Ley de Responsabilidad del Empleador, cuando se pidan antes de que el paciente sea elegible para cobertura o después de que finaliza la cobertura.
  - Se reciban sin cargo de una agencia gubernamental en cumplimiento con las leyes o las normas promulgadas por cualquier cuerpo gubernamental federal, estatal, municipal o de otro tipo.
  - Se paguen a través de otro plan de seguro (consulte la sección **Si tiene cobertura en más de un plan de la vista** que figura más adelante en este capítulo), o
  - Deban pagarse conforme a un programa de atención médica respaldado en su totalidad o en parte por fondos federales o cualquier subdivisión estatal o política.
- Tratamiento o insumos médicos o quirúrgicos
- Servicios profesionales o anteojos relacionados con ortóptica, entrenamiento de la visión, ayudas de visión subnormal, lentes aniseicónicas y tonografía, y otros servicios/materiales cubiertos por el plan
- Reemplazo de lentes o marcos rotos después de un año de la compra
- Reemplazo de lentes o marcos perdidos, a menos que el paciente sea, de otro modo, elegible conforme a las disposiciones de frecuencia, tal como se detalla en la tabla **Beneficios del plan de la vista** en la página anterior
- Cargos del contrato de servicio
- Lentes sin aumento (lentes sin receta de menos de 0.50 de dioptría)
- Servicios de cualquier proveedor que no es parte de la red
- Dos pares de gafas en lugar de bifocales
- Modificación, pulido o limpieza de lentes de contacto
- Readaptación de lentes de contacto tras el periodo inicial de adaptación (90 días)
- Impuestos locales, estatales o federales, excepto cuando VSP esté obligado a pagarlos por ley.

Rotura y pérdida de anteojos

Si sus gafas se dañan dentro del plazo de un año desde su compra, puede optar por el reemplazo o la reparación. Consulte a su proveedor para conocer los detalles de la garantía. Las garantías pueden variar dependiendo del producto y del fabricante.

El plan de la visión no cubre los anteojos que se hayan perdido.

Presentación de una reclamación para la visión

Cuando utiliza el plan de la vista, por lo general, no es necesario presentar reclamaciones por los servicios; consulte la sección **Cómo usar el plan** para leer una descripción sobre la coordinación de los pagos. Si es necesario presentar una reclamación, por ejemplo, si se inscribió recientemente en el plan de la visión y realiza una consulta con un proveedor y su información personal todavía no figura en los registros de VSP, regrese al proveedor luego de que ingresen su información en el sistema y solicítele que presente una reclamación en su nombre. Las reclamaciones se procesan según los términos establecidos en el capítulo **Reclamaciones y apelaciones**.

SI TIENE COBERTURA EN MÁS DE UN PLAN DE LA VISTA

Si usted o un dependiente elegible cuentan con la cobertura del plan de la visión y también tienen cobertura de otro plan de la visión (por ejemplo, el plan de la visión de la compañía donde trabaja su cónyuge o pareja), se puede aplicar la coordinación de beneficios. El plan de la visión tiene el derecho de coordinar con otros planes con los cuales usted tiene cobertura, a fin de que los beneficios de la visión totales que se deben pagar no excedan el nivel de beneficios que se deben pagar conforme al plan de la visión. Conforme al plan de la visión, el término "otros planes" hace referencia únicamente a otros planes administrados por VSP. No hay disposición de coordinación de beneficios con proveedores de cobertura de la visión que no sea VSP. Los planes denominados "otros planes" se describen en **Si tiene cobertura conforme a más de un plan médico** en el capítulo **Plan médico**.

Interrupción de la cobertura

Es posible que en ocasiones deba hacer arreglos especiales para pagar sus primas médicas para evitar que se suspenda la cobertura. Estas situaciones se producen con más frecuencia si se encuentra con una licencia de ausencia o si su cheque de pago de Walmart no es suficiente para pagar toda la parte que le corresponde del costo de cobertura (por ejemplo, después de una reducción de horas). El incumplimiento del pago de las primas antes de la fecha de vencimiento puede interrumpir el pago de cualquier reclamación de beneficio o suspender la cobertura.

Consulte **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información detallada sobre cómo realizar los pagos de las primas para que no haya un lapso en su cobertura.

SI SE TOMA UNA LICENCIA DE AUSENCIA

Puede continuar su cobertura hasta el último día de una licencia de ausencia aprobado, solo si paga sus primas antes de que comience la licencia de ausencia o durante este. Para obtener información sobre cómo realizar los pagos durante una licencia, consulte la sección **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Si ha recibido servicios de la visión cubiertos antes de la licencia de ausencia, cualquier limitación de frecuencia de los beneficios aplicable conforme al plan de la visión (es decir, marcos de anteojos una vez por año calendario) continuará vigente a su regreso.

En qué momento finaliza su cobertura de la visión

Su cobertura finaliza el último día de trabajo o cuando deja de ser elegible conforme a los términos del Plan. La cobertura para los dependientes finaliza cuando su cobertura termina o cuando un dependiente deja de ser un dependiente que reúne los requisitos (como se define en el capítulo **Elegibilidad, inscripción y fechas de vigencia**). Usted y/o sus dependientes inscritos pueden ser elegibles para la continuación de la cobertura a través de la Ley Ómnibus Consolidada de Reconciliación Presupuestaria de 1985 y sus enmiendas (COBRA). Consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** para obtener información sobre la continuación de la cobertura según la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA).

Si su cobertura se cancela por falta de pago de las primas, la cobertura finaliza en la fecha de cancelación. Consulte **Pago de los beneficios** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información.

Si su clasificación de empleo cambia, consulte la tabla correspondiente en la sección **Cambio de una clasificación laboral a otra** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información sobre cualquier repercusión en su cobertura.

Si cancela voluntariamente la cobertura después de un evento de cambio de elección o en la Inscripción Anual, la cobertura finaliza de la siguiente manera:

- **Tras un evento de cambio de elección:** la cobertura finaliza en la fecha efectiva del evento. Para obtener más información, consulte **Cambios de elección permitidos fuera del periodo de Inscripción anual** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.
- **En la Inscripción anual: la cobertura** finaliza el 31 de diciembre del año en curso.

Si deja Walmart y lo contratan nuevamente

Si es usted un asociado pagado por hora a tiempo parcial o temporal que está sujeto a las verificaciones de elegibilidad de 60 días, una sola vez y anualmente para los beneficios médicos, consulte la sección **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener detalles sobre cómo el hecho de terminar el empleo con Walmart y luego volver a trabajar afecta sus beneficios.

Si es un asociado a tiempo completo pagado por hora, un miembro de la gerencia o conductor de camión, consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para saber cómo el hecho de dejar de trabajar en Walmart y volver a hacerlo afecta sus beneficios.

Recursos de asistencia para los asociados

Help Now no es un beneficio ofrecido en el marco del Plan de salud y bienestar para asociados (AHWP) de Walmart Inc. y no está sujeto a la Ley de Garantía de Ingresos por Jubilación para los Empleados de 1974 (ERISA).

Recursos de asistencia para los asociados

Walmart ofrece una variedad de servicios de asistencia para los asociados para ayudar a abordar una extensa gama de problemas que usted y sus dependientes elegibles pueden afrontar. Los servicios de **Help Now** los ofrece AiRCare y los servicios de **My Mental Health Resources** los ofrece Lyra.

RECURSOS: HELP NOW		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Acceso inmediato a un especialista en recursos de Help Now		Llame al **855-4HLPNOW (855-445-7669)**
Acceda a más información sobre cómo obtener el servicio de Help Now	Visite **One.Walmart.com/HelpNow**	
RECURSOS: MIS RECURSOS DE SALUD MENTAL		
Encuentre rápidamente un terapeuta o entrenador de salud mental para recibir hasta 20 sesiones al año sin costo alguno.	Comience en **Walmart.LyraHealth.com**	Llame al **800-825-3555**
Hable con un navegador de atención de Lyra para acceder a los recursos Lyra, encontrar un proveedor de salud mental, y obtener apoyo inmediato en tiempos de crisis o al tener pensamientos suicidas o de autolesionarse	Chatee con un navegador de atención en: **Walmart.LyraHealth.com**	Llame al **800-825-3555**
Aproveche Lyra Essentials para acceder a artículos, actividades, herramientas autoguiadas y recursos sobre una extensa gama de temas de salud mental	Visite **Walmart.LyraHealth.com**	
Explore los cursos disponibles inmediatamente sobre conocimientos de salud mental relacionados con el trabajo, los talleres mensuales en directo y los encuentros facilitados para grupos con pocos integrantes.	Visite **Walmart.LyraHealth.com**	

Lo que debe saber acerca de sus recursos de asistencia para asociados

Help Now

- Los servicios de Help Now los facilita AiRCare, cuyos especialistas en recursos están dispuestos a ayudarle con sus necesidades de bienestar.
- Los servicios de Help Now son confidenciales, excepto que lo exija la ley.
- Este servicio es opcional.
- Los servicios de Help Now no tienen ningún costo para usted ni su familia. Se lo inscribirá automáticamente en Help Now a partir de su fecha de contratación.

Mis recursos de salud mental

- Mis recursos de salud mental se encuentra disponible las 24 horas, los siete días de la semana, los 365 días del año.
- Usted y sus dependientes elegibles pueden encontrar terapia y asesoramiento en salud mental, herramientas de autoayuda y asistencia para la vida laboral y personal.
- Los beneficios de Mis recursos de salud mental son gratuitos. Usted y sus dependientes elegibles se inscriben automáticamente en el programa a partir de su fecha de contratación, independientemente de si se inscribe en un plan médico de Walmart. Los dependientes pueden utilizar los beneficios de Mis recursos de salud mental aunque usted esté inscrito en un plan médico de Walmart y sus dependientes no lo estén. Para acceder a los cursos disponibles inmediatamente o empezar a recibir servicios de parte de un proveedor, tendrá que crear una cuenta gratuita en Lyra.

¿Qué es Help Now?

Help Now ofrece a los asociados y a sus dependientes elegibles ayuda tras solicitarla para afrontar los distintos desafíos que les presente la vida. Si necesita ayuda para gestionar sus beneficios de Walmart, pagar facturas, encontrar comida o vivienda, o cuidar de un familiar enfermo, solo tiene que llamar (o enviar un correo electrónico). Los servicios de Help Now los facilita AiRCare, cuyos especialistas en recursos conocen los beneficios de bienestar y los recursos comunitarios de Walmart. Está disponible sin costo alguno para usted y sus dependientes elegibles a partir de la fecha de contratación.

Utilizar Help Now

Si usted es un asociado en los Estados Unidos o Puerto Rico, usted y sus dependientes elegibles están inscritos automáticamente en Help Now a través de AiRCare desde su primer día de trabajo. Los dependientes elegibles incluyen a su cónyuge/pareja e hijos hasta los 26 años. No es necesario que realice ningún trámite para inscribirse. Puede ponerse en contacto con AiRCare en cualquier momento llamando al **855-4HLPNOW** (**855-445-7669**) en horario de 7:00 a. m. CT a 7:00 p. m. CT o puede enviar un correo electrónico a **helpnowwalmart@aircarehealth.com**. Consulte **Elegibilidad de los dependientes** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Servicios de apoyo Help Now de AiRCare

AiRCare ofrece asistencia personalizada por teléfono.

AiRCare puede ayudarle a acceder a recursos de apoyo para los siguientes temas, que pueden actualizarse o modificarse de vez en cuando:

- Preocupaciones financieras*.
- Alimentos/comidas
- Ayuda para los veteranos
- Grupos de apoyo comunitario
- Recursos de prevención de ejecuciones hipotecarias y desalojos
- Servicios de reparación
- Viviendas
- Educación
- Transporte
- Cuidado de niños/ancianos
- Y otros servicios.

*Los servicios de AiRCare se limitan a ayudarle a encontrar y repasar los recursos disponibles. AiRCare no proporciona ayuda financiera directa, que incluye distribuciones monetarias o préstamos.

Los especialistas en recursos de Help Now le informarán sobre los programas de bienestar disponibles a través del Plan y le ayudarán a acceder a ellos. Si el Plan no tiene un programa de bienestar disponible para abordar su necesidad en particular, el especialista en recursos de Help Now investigará, identificará, examinará y lo pondrá en contacto con los recursos disponibles en su comunidad. El especialista en recursos le informará de las tarifas que cobran los recursos comunitarios, si cuenta con esta información.

Si desea más detalles sobre las categorías de asistencia, visite **One.Walmart.com/HelpNow**.

Si desea ayuda, puede llamar al **855-4HLPNOW** (**855-445-7669**). Las llamadas son confidenciales, excepto que lo exija la ley.

Cuando finalizan los beneficios de Help Now

Los beneficios finalizan el último día de trabajo o cuando deja de ser elegible conforme a los términos del Plan.

Help Now es un beneficio de orientación de recursos que no proporciona atención médica. Los servicios de asistencia de Help Now están exentos de ERISA y no satisfacen los requisitos de COBRA.

¿Qué es Mis recursos de salud mental?

El programa de asistencia a empleados de Walmart se denomina Mis recursos de salud mental. Este programa es proporcionado por Lyra y ofrece bienestar emocional confidencial y apoyo a la salud mental. Hay servicios de asesoramiento y terapia de salud mental y los recursos de aprendizaje disponibles sin costo alguno para usted y sus dependientes a partir de la fecha de contratación. Las consultas iniciales para los servicios para un balance entre la vida dentro y fuera del trabajo son gratuitas. Se ofrecen servicios para un balance entre la vida dentro y fuera del trabajo adicionales a un precio reducido. Puede llamar al equipo de orientación de la atención de Lyra o visitar la plataforma en línea de Lyra para conectarse con terapeutas y entrenadores de salud mental, acceder a herramientas digitales de bienestar para la gestión del estrés, el sueño y las relaciones, y aprovechar los servicios para mantener el equilibrio entre la vida y el trabajo.

Usar Mis recursos de salud mental

Si usted es un asociado en los Estados Unidos o Puerto Rico, usted y sus dependientes elegibles están inscritos automáticamente en Mis recursos de salud mental desde su primer día de trabajo. Para acceder a los recursos disponibles inmediatamente o empezar a recibir servicios de parte de un proveedor, tendrá que registrarse en Lyra. Los dependientes elegibles son su cónyuge/pareja y sus hijos, hijastros o niños en adopción temporal menores de 26 años. Consulte **Elegibilidad de los dependientes** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**. Usted y sus dependientes elegibles deben facilitar su WIN y fecha de nacimiento para confirmar que reúnen los requisitos para recibir los servicios. Todos los servicios facilitados son confidenciales, excepto que lo exija la ley.

Los asociados de cualquier edad (incluyendo a los menores) pueden crear sus propias cuentas en Lyra. Los dependientes pueden abrir cuentas a partir de los 13 años. No se necesita el consentimiento de los padres para crear una cuenta con Lyra.

Los asociados y dependientes de 13 a 17 años pueden necesitar el consentimiento de un padre para recibir cuidado, dependiendo de la legislación estatal. Para aquellos que sean parte del programa de Lyra para adolescentes, Lyra Care for Teens, se obtendrá verbalmente el consentimiento de los padres, cuando sea necesario, durante la primera sesión, junto con un formulario completo de "consentimiento para el cuidado" para las sesiones virtuales y la participación digital.

Los dependientes menores de 13 años pueden recibir servicios de cuidado a través de la cuenta de sus padres. Los padres pueden inscribirse y encontrar servicios de cuidado para sus hijos de 12 años y menores. Si un menor de edad que tiene 12 años vive en un estado que le permite buscar atención de salud mental sin el consentimiento de los padres, el menor puede ponerse en contacto con el equipo de orientación de la atención de Lyra para obtener asistencia en la búsqueda de un proveedor y la programación de una cita sin la participación de sus padres/tutores.

Puede acceder a Mis recursos de salud mental en cualquier momento visitando **Walmart.LyraHealth.com** o llamando a Lyra en cualquier momento al **800-825-3555** para encontrar herramientas para:

- Encontrar a un proveedor de salud mental
- Fortalecer la salud mental y la resiliencia
- Manejo del estrés
- Mejorar el sueño
- Fortalecer las relaciones en el hogar y en el trabajo

Puede acceder a muchos recursos de Lyra tanto en línea como por teléfono. Los servicios de asesoramiento de Lyra están disponibles tanto mediante sesiones en persona como por videollamada.

Servicios de coaching y terapia de salud mental

Usted y sus dependientes elegibles pueden recibir hasta 20 sesiones de coaching de salud mental o terapia, por persona, por año, sin costo alguno, siempre que se acceda a la terapia o coaching a través de un proveedor de Lyra. Usted puede encontrar su proveedor de Lyra visitando **Walmart.LyraHealth.com** o llamando al **800-825-3555**, donde un navegador de atención puede ayudarle a registrarse y buscar atención.

Puede trabajar con un entrenador a través de Lyra Coaching y programar sesiones regularmente para comprender mejor qué le resulta difícil, decidir en qué quiere hacer un mayor esfuerzo y planificar un camino a seguir. Elija entre conectarse con su entrenador mediante mensajes en directo a través de su dispositivo móvil o desde su computadora, o reunirse "individualmente" mediante video en directo de forma recurrente. También puede seleccionar una experiencia menos rigurosa mediante el programa Autocuidado guiado de Lyra.

Lyra Therapy ofrece acceso a proveedores de salud mental que solamente utilizan tratamientos basados en la evidencia con citas generalmente disponibles de dentro de dos semanas. Los terapeutas de Lyra pueden diagnosticar condiciones de salud mental e identificar pensamientos, conductas y emociones fuertes que pueden ser síntomas de depresión, ansiedad, TEPT, u otras condiciones. Durante las sesiones, el terapeuta le presentará nuevas habilidades y puede asignarle ejercicios que puede practicar entre sesiones. Las sesiones de terapia están disponibles a través de citas virtuales y en persona, dependiendo de la disponibilidad individual de cada proveedor.

Los temas que puede abordar con un proveedor de salud mental incluyen:

- Gestionar el estrés y el agotamiento
- Afrontar la depresión, la ansiedad o el consumo de sustancias
- Establecer relaciones sanas con la familia, los amigos y los compañeros de trabajo
- Conflicto padre-hijo
- Generar un equilibrio entre las demandas laborales y la vida familiar
- Duelo y pérdida
- Atravesar situaciones difíciles a nivel emocional

Servicios para un balance entre la vida dentro y fuera del trabajo

Lyra, a través de su socio externo, pone a disposición acceso a asistencia legal y contra el robo de identidad. Las consultas iniciales son gratuitas. Se ofrecen servicios adicionales a una tarifa con descuento.

Los servicios para un balance entre la vida dentro y fuera del trabajo incluyen ayudarle con lo siguiente:

- Explorar sus opciones relacionadas con cuestiones legales
- Acceder a una biblioteca de formularios y documentos legales para diversas necesidades
- Recuperarse de un robo de identidad

Puede participar sin cargo en una consulta de media hora por cuestiones legales, o en una consulta de una hora por cuestiones de robo de identidad. Tenga en cuenta que este servicio no brinda asistencia en situaciones que involucren el derecho laboral. Si necesita ayuda adicional legal o por robo de identidad, más allá de la consulta inicial, puede seguir por una tarifa adicional con descuento. Los recursos, documentos y herramientas de autoayuda están disponibles en línea las 24 horas del día, los 7 días de la semana visitando **Walmart.LyraHealth.com/Worklife**.

Recursos didácticos

Los recursos de aprendizaje de Lyra pueden ayudarle a desarrollar estrategias para ayudar a mejorar su bienestar en el trabajo y el hogar a través de cursos disponibles inmediatamente y eventos en vivo como seminarios web y grupos de debate creados y facilitados por Lyra.

CURSOS DISPONIBLES INMEDIATAMENTE

Explore cursos ilimitados a la carta impartidos por profesionales de la salud mental a su propio ritmo. Si bien algunos cursos cuentan con cinco a ocho capítulos de contenido en profundidad, otros toman menos de 15 minutos para completar.

Los temas incluyen:

- Liderar con conciencia y confianza
- Lucha contra el estigma de la salud mental
- Dormir mejor
- Control del estrés
- Raza, injusticia y salud mental
- Ser padres en el mundo real
- Desmitificar la salud mental
- Superar los contratiempos
- Y más. Además, se agregan nuevos temas regularmente

EVENTOS EN DIRECTO: SEMINARIOS WEB Y GRUPOS DE DEBATE

Lyra ofrece seminarios web y grupos de debate virtuales todos los meses sobre temas relacionados con la salud mental, dirigidos por un experto clínico. Los seminarios web dan a los participantes la oportunidad de ver, escuchar y aprender, mientras que los grupos de debate facilitan un espacio de apoyo para que los participantes compartan sus experiencias en grupos con menos integrantes. La inscripción previa es necesaria tanto para los seminarios web como para los grupos de debate.

Para explorar los cursos disponibles inmediatamente o inscribirse en un evento en vivo, visite **Walmart.LyraHealth.com** y navegue hasta la pestaña “Biblioteca” una vez que haya iniciado sesión en su cuenta de Lyra. Debe tener 18 años o más para inscribirse y asistir a los eventos en vivo, incluyendo los talleres y las sesiones de reunión.

Contactar a Mis recursos de salud mental

LYRA EN LA WEB

Visite **Walmart.LyraHealth.com** para comenzar a recibir atención de parte de un proveedor de atención de salud mental, y acceder a herramientas esenciales de salud mental autoguiadas. Asimismo, puede descargar la aplicación Lyra Health de la App Store o Google Play para acceder a muchos de los servicios de Lyra. Para registrarse como nuevo usuario debe utilizar su WIN y su fecha de nacimiento para confirmar su elegibilidad.

También puede acceder a más información en **One.Walmart.com/MyMentalHealthResources**.

LLAMAR A LYRA

Llame al **800-825-3555** para obtener asistencia personalizada en cualquier momento desde un navegador de atención. Los servicios están disponibles en inglés y español (puede solicitar previamente la asistencia en otros idiomas). Las llamadas son confidenciales, excepto que lo exija la ley.

Cuando los beneficios de Mis recursos de salud mental finalizan

Si usted experimenta un evento calificador y es elegible para los beneficios de COBRA, Mis recursos de salud mental permanecerá disponible para usted y sus dependientes elegibles durante 18 meses después de su último día de empleo (o el periodo máximo para el que sería elegible para la cobertura COBRA) sin costo alguno para usted. Si se inscribe en la cobertura COBRA bajo el plan médico, de visión o dental, el beneficio estará disponible durante todo el periodo COBRA. No obstante, no tiene que inscribirse en la cobertura COBRA del plan médico, de la visión o dental para continuar con sus beneficios de Mis recursos de salud mental.

Presentar una reclamación de beneficios de Mis recursos de salud mental

No es necesario que presente una reclamación de beneficios de Mis recursos de salud mental. Puede acceder al sitio web de Lyra o ponerse en contacto con Lyra por teléfono en cualquier momento mientras siga siendo elegible. Sin embargo, si tiene preguntas sobre sus beneficios o no está de acuerdo con los beneficios que le ofrecen, puede llamar a Servicios al Personal al **800-421-1362** o presentar una reclamación por escrito a la siguiente dirección:

Mail Stop 3610–Benefits Total Rewards Team
Attn: Custodian of Records
508 SW 8th Street
Mail Stop #3610
Bentonville, Arkansas 72716-3610

Las reclamaciones y las apelaciones se determinan según los plazos y los requisitos para los procedimientos de presentación de reclamaciones de beneficios médicos que se establecen en el capítulo **Reclamaciones y apelaciones**.

Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)

Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)

Si usted o sus dependientes con cobertura pierden la cobertura médica, dental o de la visión a causa de un evento calificador, la ley federal que se conoce como "COBRA" puede permitirle continuar teniendo esa cobertura durante un periodo determinado a su cargo.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Comuníquese con Servicios al Personal dentro de los 60 días calendario a partir de la fecha en que se divorcia, se separa legalmente, termina la relación con su pareja o sus dependientes pierden la elegibilidad.		Llame a Servicios al Personal al **800-421-1362** o facilite un aviso por escrito a: **Walmart People Services** **805 Moberly Lane** **Bentonville, Arkansas 72712-3501**
Comuníquese con WageWorks (una compañía de HealthEquity), el administrador de la ley COBRA, si tiene preguntas sobre la elegibilidad, la inscripción, las primas o la notificación de un segundo evento calificador.	Visite **mybenefits.wageworks.com**	Llame al **800-570-1863**

Lo que debe saber sobre COBRA

- "COBRA" significa Ley Ómnibus Consolidada de Reconciliación Presupuestaria (Consolidated Omnibus Budget Reconciliation Act) de 1985. Esta ley se puede aplicar si se produce un "evento calificador" que de otra manera provocaría que usted o un dependiente con cobertura pierda la cobertura médica, dental o de la visión. Los eventos calificadores se describen en este capítulo. A través del Plan, se extiende la continuación de la cobertura de COBRA para usted y todos los dependientes con cobertura.
- En el caso de los beneficios médicos, dentales o de la visión, la continuación de la cobertura de la ley COBRA puede seguir por hasta 18 o 36 meses, de acuerdo con el evento calificador. Estos 18 meses se pueden extender a 29 meses en determinadas circunstancias si se trata de una discapacidad.
- Si tiene un evento calificador y es elegible para recibir los beneficios de la ley COBRA, su acceso a Mis recursos de salud mental, provistos por Lyra, continuará de manera automática durante 18 meses a partir de la fecha del evento calificador (o por el tiempo máximo durante el cual sería elegible para recibir la cobertura de la ley COBRA). No es necesario que se inscriba en la cobertura COBRA para seguir teniendo acceso a Mis recursos de salud mental.
- El Plan tiene un contrato con WageWorks, un administrador subcontratado de los beneficios de la ley COBRA. Las referencias a COBRA de esta sección son hacia la continuación de la cobertura del Plan, la cual puede ser más favorable a los participantes y dependientes que la continuación de la cobertura que se requiere, legalmente, conforme a COBRA.
- Existen reglas de notificación y plazos estrictos para inscribirse en la continuación de la cobertura de COBRA, tal como se describe en este capítulo. Lea este capítulo detenidamente; si no cumple con estas reglas puede perder su derecho a elegir la continuación de la cobertura de COBRA. Si tiene alguna pregunta o necesita ayuda para inscribirse, llame al **800-570-1863**.

Continuación de la cobertura de COBRA

Si finaliza su cobertura médica, dental o de la visión o la de sus dependientes elegibles conforme al Plan, usted o ellos podrán continuar con la cobertura de acuerdo con las disposiciones de continuación del Plan, que cumplen con COBRA. La continuación de la cobertura de COBRA se aplica a la cobertura médica, dental o de la visión; no se aplica a otros beneficios que se describen en este *Libro de beneficios para asociados*.

Un evento calificador es cuando usted o sus dependientes elegibles son elegibles para recibir la continuación de la cobertura de la ley COBRA, tales como la finalización de la relación laboral o la pérdida de elegibilidad para obtener beneficios. De acuerdo con la ley COBRA, todas las personas que podrían perder la cobertura después de un evento calificador se consideran "beneficiarios calificados". Todos los beneficiarios calificados tienen el derecho independiente de elegir la continuación de la cobertura de COBRA.

Para recibir la cobertura de la ley COBRA, debe haber tenido la cobertura médica, dental o de la visión del Plan el día anterior a la fecha del evento calificador, salvo que la cobertura haya finalizado mientras se encontraba con una licencia de ausencia, tal como se describe en esta página. Puede elegir un nivel de cobertura inferior o seleccionar un plan de seguro médico alternativo, si corresponde.

Si cambia de plan de seguro médico cuando elige la cobertura de COBRA, se restablecerán el deducible anual y el desembolso máximo, y deberá alcanzar el deducible y el desembolso máximo nuevo en su totalidad.

Si cuenta con cobertura de la HMO al momento del evento calificador y el estado en el que vive dispone de reglas de continuación de cobertura más favorables que las de la ley federal COBRA, la HMO, por lo general, aplica las reglas estatales. En el caso de los participantes del Plan PPO, este plan también cumple con las reglas estatales. Para obtener información sobre los derechos de continuación del estado, comuníquese con su proveedor de la HMO o del Plan PPO, según corresponda.

SI SE TOMA UNA LICENCIA DE AUSENCIA

Por lo general, si su licencia de ausencia finaliza y no regresa al trabajo, a usted y a sus dependientes elegibles inscritos en la cobertura médica, dental o de la visión del Plan se les ofrecerá, durante la licencia de ausencia, la cobertura de COBRA, que entrará en vigencia a partir del día siguiente a la fecha de finalización del empleo.

Si usted y sus dependientes elegibles estaban inscritos en la cobertura médica, dental o de la visión del Plan el día anterior al comienzo de la licencia de ausencia, pero dio de baja la cobertura durante su licencia o la cobertura se canceló debido a la falta de pago de las primas durante la licencia, se le ofrecerá la cobertura de COBRA cuando finalice la relación laboral. Si elige la cobertura de COBRA, esta entrará en vigencia en la fecha posterior a la fecha de finalización de la relación laboral. Esto significa que, si usted o cualquier dependiente elegible optan por COBRA al final de una licencia de ausencia durante el cual se suspendió o se canceló la cobertura, la cobertura de COBRA seleccionada no estará vigente de manera retroactiva a la fecha en la que se suspendió o canceló la cobertura, sino que estará vigente en la fecha posterior a la fecha de finalización de la relación laboral.

Eventos calificadores de la ley COBRA

Usted es elegible para COBRA si su cobertura médica, dental o de la visión finaliza por los siguientes motivos:

- Su empleo con Walmart finaliza por cualquier motivo; o
- Ya no es elegible para la cobertura médica porque se redujo la cantidad de horas que usted trabaja regularmente para Walmart y pierde la elegibilidad para la cobertura conforme al Plan.

Su cónyuge o pareja es elegible para la cobertura de COBRA si la cobertura del cónyuge o la pareja finaliza por cualquiera de las siguientes razones:

- Su relación laboral con Walmart finaliza por cualquier motivo
- Su cónyuge o pareja ya no son elegibles para la cobertura médica, dental o de la visión porque se redujo la cantidad de horas que usted trabaja regularmente para Walmart y pierde la elegibilidad de la cobertura conforme al Plan;
- Usted y su cónyuge se divorcian o se separan legalmente;
- Usted o su cónyuge ya no reúnen los requisitos establecidos en la definición de "pareja" a los efectos del Plan (consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener la definición de "pareja");
- Se inscribe en los beneficios de Medicare Parte D y se cancela su cobertura médica (debe llamar a Servicios al Personal al **800-421-1362** en el plazo de 60 días de la inscripción en Medicare Parte D); o
- Usted fallece.

Su dependiente elegible que no sea su cónyuge ni pareja reúne los requisitos para los beneficios de la ley COBRA si la cobertura del dependiente finaliza por cualquiera de las siguientes razones:

- Su relación laboral con Walmart finaliza por cualquier motivo
- Sus dependientes elegibles dejan de ser elegibles para la cobertura médica, dental o de la visión porque se redujo la cantidad de horas que usted trabaja regularmente para Walmart y pierde la elegibilidad de la cobertura conforme al Plan
- Se inscribe en los beneficios de Medicare Parte D, por lo que se da por terminada su cobertura médica (usted o su dependiente elegible deben comunicarse con Servicios al Personal llamando al **800-421-1362** en el plazo de 60 días de la inscripción en Medicare Parte D);
- Sus hijos dependientes ya no cumplen los requisitos de elegibilidad como se describe en el capítulo **Elegibilidad, inscripción y fechas de vigencia** (por ejemplo, finaliza el mes en que un dependiente cumple 26 años); o
- Usted fallece.

NOTIFICACIÓN

En general, Walmart notificará a WageWorks, el administrador subcontratado del Plan para garantizar los beneficios de la ley COBRA, si usted o sus dependientes comienzan a ser elegibles para obtener la continuación de la cobertura de COBRA a causa de su fallecimiento, la finalización de la relación laboral o la reducción de las horas de trabajo que hacen que pierda la elegibilidad para recibir la cobertura del Plan, o si se inscribe en Medicare Parte D. Usted o sus dependientes deberán notificar a Servicios al Personal si se inscribe en Medicare Parte D. Por lo general, Walmart notificará al administrador de la ley COBRA dentro de los 30 días luego del evento calificador.

De acuerdo con la ley, usted o su dependiente elegible debe notificar a Servicios al Personal si se divorcia, se separa legalmente, finaliza la relación con su pareja o un hijo pierde la condición de dependiente. Tendrá que notificarle a Servicios al Personal, aun cuando haga cambios en línea para modificar su cobertura debido a uno de estos eventos de la vida. La notificación debe realizarse dentro de los 60 días después del evento calificador (o la fecha en la cual finalizaría la cobertura debido al evento calificador, si es posterior). Usted o su dependiente elegible puede avisar en su nombre o en nombre de cualquier dependiente elegible afectado por el evento calificador. Para informar el evento calificador, llame a Servicios al Personal al **800-421-1362** o escriba a:

Walmart People Services
805 Moberly Lane
Bentonville, Arkansas 72712-3501

El aviso debe incluir la siguiente información:

- Nombre y dirección del asociado con cobertura
- Tipo de evento calificador
- Fecha del evento calificador
- Nombre de los dependientes que pierden la cobertura, y
- Dirección de los dependientes que pierden la cobertura (en caso de que difiera del domicilio del asociado cubierto).

Si usted no se comunica con Servicios al Personal dentro del plazo de 60 días, su dependiente cubierto perderá el derecho a elegir la continuación de cobertura de COBRA. Con el fin de proteger los derechos de su dependiente cubierto, informe a Servicios al Personal sobre cualquier cambio que se produzca en las direcciones de los dependientes cubiertos. Debe guardar para su registro una copia de cualquier aviso que envíe a Servicios al Personal y/o a WageWorks.

De acuerdo con la ley federal, usted o su dependiente elegible debe notificar a Servicios al Personal en el plazo de 60 días calendario luego de un divorcio, una separación legal, la finalización de la relación con su pareja o el hecho de que un niño deje de ser elegible debido a la pérdida de la condición de dependiente, o la fecha en que se cancela la cobertura del Plan como resultado de alguno de estos eventos. Si usted o su dependiente elegible no notifica a Servicios al Personal en un plazo de 60 días, su dependiente no será elegible para recibir la cobertura de COBRA.

Usted o su dependiente elegible también debe notificar al administrador de COBRA por teléfono o por escrito si se produce un segundo evento calificador o una discapacidad que determine la Administración del Seguro Social con el fin de extender el periodo de cobertura de COBRA. Otras formas de notificación no obligarán legalmente al Plan. Si no avisa por teléfono o por escrito que ha ocurrido un segundo evento calificador o no solicita una extensión en un plazo de 60 días desde la fecha del segundo evento calificador o de la fecha en la que perdió (o perderá) la cobertura como resultado de un segundo evento calificador, los derechos de continuación de la cobertura de COBRA caducarán en la fecha en que termina la cobertura inicial de COBRA de usted o de sus dependientes elegibles.

INSCRIPCIÓN EN LA COBERTURA DE COBRA

Dentro de los 14 días luego de que el administrador de la ley COBRA reciba el aviso sobre un evento calificador, el administrador de la ley COBRA enviará, en nombre del Plan, un aviso de elección de COBRA a usted y sus dependientes elegibles a su última dirección conocida. El aviso de elección describe su derecho de continuar con la cobertura médica, dental o de la vista conforme a COBRA. (Si no recibe esta notificación, comuníquese con Servicios al Personal). Para recibir la cobertura de continuación de COBRA, debe elegirla a través del administrador de COBRA en un plazo de 60 días calendario desde la fecha en que pierde la cobertura o la fecha del aviso de elección, si es más tarde. Para inscribirse, debe diligenciar y enviar por correo su formulario de elección de COBRA a la dirección que figura en el formulario de elección o visitar **mybenefits.wageworks.com**. Si elige la cobertura de COBRA, notifique al administrador de COBRA sobre cualquier cambio de dirección. Consulte la sección **Pago de la cobertura de COBRA** en la página siguiente para obtener información sobre cómo realizar los pagos de COBRA. Si necesita ayuda, llame al **800-570-1863**.

NOTA: Se le puede pedir que presente documentación probatoria del evento calificador.

Usted y cada uno de los dependientes elegibles gozan de derechos de elección independientes. Puede optar por la cobertura de la ley COBRA para todos los dependientes que perdieron la cobertura debido al evento calificador. Uno de los progenitores o el tutor legal puede optar por la cobertura de COBRA en nombre de un dependiente elegible menor de edad. Un hijo que nace o que se le entrega en adopción mientras usted tiene la cobertura de COBRA también goza de los derechos de COBRA.

La ley COBRA se proporciona sujeta a los requisitos de elegibilidad para la continuación de la cobertura para usted y sus dependientes elegibles conforme a la ley y a los términos del Plan. En la medida en que la ley lo permita, el administrador del Plan finalizará la cobertura de COBRA de forma retroactiva si se determina con posterioridad que usted no es elegible.

En lugar de elegir la cobertura de COBRA, usted y su familia pueden disponer de otras opciones de cobertura a través del Mercado de Seguros Médicos (Health Insurance Marketplace), de Medicare o de Medicaid. También pueden ser elegibles para obtener un "periodo de inscripción especial" de 30 días en otro plan de salud grupal para el cual sean elegibles (por ejemplo, un plan que patrocine el empleador de su cónyuge). También pueden tener el mismo derecho de inscripción especial al final de su cobertura de COBRA si obtienen dicha cobertura por el plazo máximo disponible. Algunas de estas opciones pueden costar menos que la continuación de la cobertura de COBRA. Puede obtener más información sobre sus opciones en **healthcare.gov**.

EVENTOS DE CAMBIO DE ELECCIÓN MIENTRAS TIENE LA CONTINUACIÓN DE LA COBERTURA DE COBRA

Después del periodo de elección de la ley COBRA, usted o su dependiente elegible no pueden cambiar la cobertura de COBRA elegida fuera del periodo de Inscripción Anual, a menos que se produzca un evento de cambio de elección o un evento calificador posterior. Para obtener información sobre los eventos de cambio de elección, consulte **Cambios de elección permitidos fuera del periodo de Inscripción anual** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** . Si se produce un cambio de elección (como el nacimiento de un hijo), deberá informar al administrador de COBRA dentro de los 60 días calendario luego del evento. Se puede solicitar documentación de respaldo. Tendrá derecho a realizar cambios a la cobertura durante cualquier periodo de Inscripción Anual mientras tiene cobertura de COBRA.

A menos que el Plan indique lo contrario, si agrega a un cónyuge o pareja, u otro dependiente elegible debido a un evento de cambio de elección mientras tiene la cobertura de COBRA, cada persona debe cumplir de forma individual con el periodo de espera de los beneficios correspondientes (por ejemplo, para la cobertura de la cirugía para la pérdida de peso) y estará sujeto a todas las limitaciones aplicables del Plan. Si usted cambia de plan médico debido a un evento de cambio de elección, se restablecerán sus deducibles anuales y el desmbolso máximo,* y usted deberá alcanzar los nuevos deducibles y desembolso máximo nuevo en su totalidad. Si cambia de un Plan Contribution a otro plan, perderá el saldo de la cuenta HRA del Plan Contribution.

Si tiene cobertura como dependiente y se produce un evento calificador que afecte su estado como tal y lo hace elegible para su propia continuación de cobertura de la ley COBRA, recibirá un crédito para sus deducibles y el desembolso máximo conforme al Plan Médico para Asociados por los gastos que pagó como dependiente cubierto, a menos que cambie de plan como se describió arriba. También recibirá crédito para cualquier periodo de espera que corresponda.

En el caso de un evento de cambio de elección, usted o su dependiente elegible puede cambiar la cobertura de beneficios a otro nivel de beneficios conforme al Plan, únicamente, si el cambio de la cobertura es coherente con el evento de cambio de elección.

Si se muda a un nuevo lugar y esto afecta la cobertura médica (por ejemplo, se muda desde un área con una HMO a un área sin esa HMO), tendrá 60 días calendario desde la fecha en que notificó al administrador de COBRA acerca del cambio de dirección para seleccionar un plan diferente. Si no envía sus elecciones dentro de los 60 días, quedará registrado en un plan predeterminado de manera automática.

Pago de la cobertura de COBRA

La prima de COBRA es el monto que usted pagaba antes de que se produjera el hecho causante, más el monto que pagaba Walmart, más una tarifa administrativa del 2 % (tarifa administrativa del 50 % en los casos de prórroga de 11 meses por discapacidad, como se describe más adelante en este capítulo). La carta que se envió a usted y a los dependientes elegibles después de la notificación de un evento calificador incluirá el costo de la prima mensual de la cobertura de la ley COBRA.

Prima inicial de COBRA: El primer pago de la prima debe realizarse 45 días después de elegir COBRA y debe cubrir el periodo a partir del momento en que perdió la cobertura debido a un hecho causante y el final del mes en el que se realizó la elección. (Por ejemplo, supongamos que su empleo finaliza el 30 de septiembre y usted pierde la cobertura el 30 de septiembre. Elige la cobertura de COBRA el 15 de noviembre. El pago de la prima inicial equivale a las primas de octubre y noviembre, y vence antes del 30 de diciembre, 45 días después de la fecha en la que eligió la cobertura de COBRA. Las primas vigentes vencen el primer día de cada mes y tienen un periodo de gracia de 30 días. Por lo tanto, el pago que realice en diciembre se deberá recibir a más tardar el 31 de diciembre, es decir, el final del periodo de gracia de 30 días para el periodo de cobertura de diciembre).

Si el pago de la prima inicial no se realiza dentro del plazo permitido, no será elegible para la cobertura de COBRA.

Primas continuas: Las primas mensuales vencerán el primer día de cada mes después de la fecha de vencimiento de la prima inicial. Si realiza el pago antes o el primer día de cada mes, la cobertura de COBRA del Plan continuará durante ese mes. Se recomienda que pague sus primas entre 7 y 10 días antes de la fecha de vencimiento para eliminar cualquier posible retraso en la actualización de su información de elegibilidad.

Antes de cancelar la cobertura, se le otorgará un periodo de gracia de 30 días desde la fecha de vencimiento de la prima. Sin embargo, si realiza el pago el primer día del mes o después, se suspenderá la cobertura y no se pagará ninguna reclamación pagada, incluidos los beneficios farmacéuticos, hasta que la deuda de la cobertura sea saldada hasta el mes actual. Si no paga esta prima, usted será responsable de las reclamaciones incurridos. Si el día 30 cae en un día de fin de semana o un día festivo, tendrá hasta el primer día hábil siguiente para pagar o hacer sellar su pago por el correo.

Como cortesía, el administrador de COBRA le enviará una factura por el pago de la prima de COBRA, a menos que realice sus pagos mediante débito de la Cámara de Compensación Automatizada (Automated Clearing House, ACH), en cuyo caso no recibirá una factura. Se recomienda pagar las primas entre 7 y 10 días antes de la fecha de vencimiento para evitar la interrupción o anulación de la cobertura. Si utiliza el débito ACH a través del administrador de COBRA, pueden producirse retrasos en la elegibilidad, ya que estos débitos se tramitan el primer día hábil del mes. Los pagos de las primas vencen independientemente de si recibe o no la factura de pago. Si realiza el pago por correo postal, adjunte su pago a la factura y envíelo por correo a la siguiente dirección:

WageWorks
P.O. Box 660212
Dallas, Texas 75266-0212

Para pagar en línea, ingrese a **mybenefits.wageworks.com**. Para pagar por teléfono, llame al **800-570-1863**.

Si se cancela su cobertura de COBRA debido a la falta de pago de las primas, dicha cobertura finalizará el último día por el que pagó a tiempo su prima de COBRA completa, y no se restablecerá la cobertura.

COBRA es una cobertura mensual y si no desea continuar con la cobertura puede finalizarla de las siguientes maneras:

- Simplemente deje de pagar las primas y su cobertura COBRA se dará de baja por falta de pago.
- Presente una solicitud de asistencia en el centro de mensajes en línea de WageWorks.
- Envíe una carta a WageWorks para solicitar la baja de su cobertura de COBRA, por correo a:

  WageWorks
  P.O. Box 14390
  Lexington, Kentucky 40512-4390

Si opta por cancelar la cobertura, esta no podrá restablecerse. La cobertura se cancelará automáticamente si el pago no está sellado por el correo en la fecha de vencimiento de la prima o antes.

Cuánto puede durar la cobertura de COBRA

La duración máxima de la cobertura de COBRA depende del evento calificador por el cual usted es elegible para tener dicha cobertura, tal como se muestra en la tabla a continuación.

DURACIÓN MÁXIMA DE LA COBERTURA DE COBRA

Evento	Asociado	Dependientes
• Su relación laboral con Walmart finaliza por cualquier motivo • Ya no es elegible para obtener la cobertura conforme al Plan debido a una reducción de las horas de trabajo	18 meses desde la fecha del evento	18 meses desde la fecha del evento
• Su fallecimiento • Su estado civil (o de pareja) cambia • Sus dependientes ya no cumplen los requisitos de elegibilidad (p. ej., el dependiente cumple 26 años)	No se aplica	36 meses desde la fecha del evento
Usted se inscribe en Medicare menos de 18 meses antes de la finalización de su relación laboral o reducción de horas	18 meses desde el cese en el empleo o la reducción de horas	Hasta 36 meses desde la fecha en que usted se inscribió en Medicare
Usted se inscribe en Medicare Parte D	No se aplica	36 meses desde la fecha en que usted se inscribió en Medicare Parte D
Se obtiene una prórroga por discapacidad	29 meses desde la fecha del evento calificador original	29 meses desde la fecha del evento calificador original
Segundo evento calificador: debe notificar al administrador de COBRA dentro de los 60 días luego del segundo evento calificador o de la fecha de la pérdida de cobertura, si es posterior	No se aplica	Hasta 36 meses desde la fecha del evento calificador original

SI TIENE DERECHO A LA COBERTURA DE MEDICARE

En general, si usted es elegible para las Partes A y/o B de Medicare y deja de ser empleado de Walmart (o pierde la cobertura del Plan), tiene un periodo de inscripción especial de ocho meses para inscribirse en las Partes A y/o B de Medicare que comienza a partir de la fecha en que ya no es empleado de Walmart (o pierde la cobertura del Plan, lo que ocurra primero), incluso si elige la continuación de la cobertura COBRA. Debe tener en cuenta que si no se inscribe en las Partes A y/o B de Medicare durante el periodo de inscripción especial de Medicare, es posible que tenga que esperar para inscribirse en las Partes A y/o B de Medicare (hasta el siguiente periodo de inscripción anual de Medicare) y que tenga que pagar una prima de Medicare más alta al inscribirse. Para obtener más información, consulte el manual *Medicare & You* (Medicare y usted) de Medicare, que se publica cada año. El manual se consigue directamente en Medicare llamando al **800-633-4227** o se descarga del sitio web de Medicare **medicare.gov**.

Tener derecho a la cobertura de Medicare significa que es elegible para la cobertura de Medicare y para inscribirse en esta. Si pasa a tener derecho a Medicare menos de 18 meses antes de que se produzca un hecho causante debido al cese de la relación laboral o a la reducción de horas, sus dependientes cubiertos pueden optar a la ampliación de la cobertura COBRA hasta 36 meses a partir de la fecha en que usted adquirió el derecho a Medicare.

Si tiene derecho a la cobertura de Medicare antes de la fecha de elección de COBRA, usted y sus dependientes cubiertos deben informar al administrador de COBRA al **800-570-1863** sobre su fecha de derecho de Medicare para asegurarse de que la elegibilidad máxima de cobertura para sus dependientes se calcule correctamente.

SI USTED O UN DEPENDIENTE ELEGIBLE TIENEN UNA DISCAPACIDAD

Si es un beneficiario calificado con cobertura de COBRA debido a que finalizó la relación laboral o se redujeron las horas, usted y cada uno de sus dependientes cubiertos pueden tener derecho a recibir 11 meses adicionales de cobertura de COBRA si usted o alguno de sus dependientes cubiertos queda discapacitado (es decir, puede obtener hasta 29 meses en total de cobertura de COBRA). El periodo de cobertura de COBRA de 29 meses se inicia el día después de la finalización de su empleo o de la reducción de horas de trabajo que lo hacen perder elegibilidad para la cobertura del Plan. La prórroga por discapacidad solo se aplica si se reúnen todas las siguientes condiciones:

- La Administración de Seguridad Social determina que usted o sus dependientes elegibles tienen una discapacidad
- La discapacidad existe en cualquier momento dentro de los primeros 60 días calendario de la cobertura de COBRA y debe durar por lo menos hasta la finalización del periodo de 18 meses de la continuación de la cobertura de COBRA, y
- Usted y/o sus dependientes elegibles informan al administrador de COBRA que la Administración de Seguridad Social ha determinado la existencia de una discapacidad presentando una copia de la carta de reconocimiento de la discapacidad al administrador de COBRA durante el periodo inicial de cobertura de COBRA de 18 meses.

En ausencia de una carta de reconocimiento oficial de la Administración de Seguridad Social, el Plan podrá aceptar otro tipo de correspondencia de la misma entidad en tanto explícitamente incluya toda la información que el Plan necesita para garantizar la extensión y enviarla al administrador de COBRA en los plazos establecidos más arriba.

Si usted o su dependiente elegible reúne los requisitos para obtener la extensión por discapacidad, se le enviará a usted y/o a su dependiente elegible por correo postal una factura nueva, antes de que finalice el periodo inicial de cobertura de COBRA de 18 meses, a menos que realice los pagos a través del débito de la Cámara de Compensación Automatizada (ACH), en cuyo caso no recibirá ninguna factura. Comuníquese con el administrador de COBRA para obtener detalles sobre el pago de las primas durante un periodo de extensión por discapacidad.

Por lo general, la prima de COBRA para el periodo entre la cobertura de COBRA de 19 meses y 29 meses es la suma del monto que pagaba antes del evento calificador, el monto que Walmart pagaba y un cargo administrativo del 50 % o el 150 % del monto total de la prima.

Sin embargo, si se aplica la extensión por discapacidad, pero el dependiente beneficiario calificado y discapacitado no se afilia a la cobertura de COBRA, la prima de COBRA para los dependientes cubiertos durante el periodo de extensión se limita al 102 % del monto total de la prima. Usted o sus dependientes elegibles deben notificar al administrador de COBRA dentro de los 30 días luego de la fecha en que la Administración de Seguridad Social determina que usted o sus dependientes ya no tienen la discapacidad.

SI TIENE UN SEGUNDO EVENTO CALIFICADOR MIENTRAS TIENE LA COBERTURA DE COBRA

Si bien usted (el asociado) no puede recibir una extensión de la cobertura de COBRA debido a un segundo evento calificador, el dependiente elegible que tenga cobertura de COBRA debido al cese en el empleo o la reducción de horas puede recibir la cobertura de COBRA por hasta un total de 36 meses si se produce un segundo evento calificador durante el periodo de continuación de cobertura original de 18 meses (o durante el periodo de cobertura de 29 meses, en el caso de una extensión por discapacidad).

Los siguientes pueden considerarse segundos eventos calificadores:

- Su fallecimiento
- Su divorcio, separación legal o finalización de la relación con una pareja
- Su hijo ya no es elegible para la cobertura médica, dental o de la visión (por ejemplo, el dependiente cumple 26 años), o
- Su inscripción en Medicare Parte D

Si se produce un segundo evento calificador mientras su dependiente elegible tiene la cobertura de COBRA, dicha cobertura puede durar hasta 36 meses desde la fecha del primer evento calificador que hizo que usted (el asociado) es elegible para obtener la cobertura de COBRA.

Para recibir la extensión del periodo de cobertura de COBRA, usted o sus dependientes elegibles deben notificar al administrador de COBRA acerca del segundo evento calificador dentro de los 60 días calendario a partir de la fecha del evento o de la pérdida de cobertura luego del evento, si es posterior. Si no se notifica al administrador de COBRA acerca del segundo evento calificador durante el plazo de 60 días, sus dependientes elegibles no podrán obtener la prórroga de la cobertura de COBRA y la cobertura finalizará a partir de la fecha del periodo inicial de COBRA caducado.

Cuándo finaliza su cobertura de COBRA

Por lo general, la cobertura de COBRA finaliza después de un periodo máximo de cobertura de 18 meses, 29 meses o 36 meses. Consulte la sección **Cuánto puede durar la cobertura de COBRA** en este capítulo para averiguar cuál es el periodo de cobertura máximo de COBRA que se aplica a su caso.

La cobertura de COBRA puede culminar antes del final del periodo de 18 meses, 29 meses o de 36 meses en los siguientes casos:

- Walmart deja de proporcionar cobertura médica, dental o de la visión a cualquier asociado.
- Una vez que finalice el periodo de pago inicial de 45 días, no realiza un pago por la cobertura de COBRA dentro de los 30 días calendario posteriores a la fecha de vencimiento (si el día 30 cae durante un fin de semana o un día sin reparto de correo, tendrá tiempo hasta el siguiente día hábil para pagar o hacer sellar su pago por el correo).
- Usted o sus dependientes elegibles empiezan a tener cobertura de otro plan médico, dental o de la visión grupal luego de elegir la cobertura de COBRA.
- Durante un periodo de extensión por discapacidad, la Administración del Seguro Social determina que el beneficiario calificado ya no está discapacitado (finaliza la cobertura de COBRA para todos los beneficiarios calificados, no solo el beneficiario calificado discapacitado, a partir de (a) el primer día del mes en que se cumplen más de 30 días luego de la determinación final de la Administración del Seguro Social que el beneficiario calificado ya no está discapacitado o (b) el final del periodo de cobertura que se aplica independientemente de la extensión por discapacidad), o
- Usted o sus dependientes elegibles presentan al Plan una reclamación por fraude o información fraudulenta.

PRESENTACIÓN DE UNA APELACIÓN

Tiene derecho a apelar una decisión de estado de inscripción o elegibilidad relacionada con su cobertura de COBRA. Para obtener más información, consulte la sección **Cómo apelar una decisión sobre inscripciones o estados de elegibilidad** en el capítulo **Reclamaciones y apelaciones**.

Discapacidad a corto plazo para asociados a tiempo completo pagados por hora

La información de este capítulo describe los beneficios por discapacidad a corto plazo a los que puede acceder si:

- Usted es un asociado pagado por hora a tiempo completo elegible
- Ha cumplido todos los requisitos para que la cobertura tenga vigencia, incluidos los requisitos de trabajo activo, y
- Se ha inscrito debida y oportunamente (si corresponde).

Si tiene preguntas sobre los requisitos de elegibilidad, los requisitos para que la cobertura sea efectiva y la repercusión en sus beneficios de un cambio en su clasificación laboral, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Discapacidad a corto plazo para asociados a tiempo completo pagados por hora

Si no trabaja por un periodo prolongado debido a que está embarazada, se sometió a una cirugía programada, tiene una enfermedad o sufrió una lesión inesperada, este plan para asociados pagados por hora a tiempo completo puede reemplazar una parte de su pago. Las opciones incluyen el plan básico de discapacidad a corto plazo y el plan mejorado de discapacidad a corto plazo.

RECURSOS

Encuentre lo que necesita	En línea	Otros recursos
Para solicitar una licencia de ausencia o presentar una reclamación de beneficios básicos o mejorados o de beneficios de maternidad, o para obtener más información	Visite **One.Walmart.com/LOA > mySedgwick**	Llame a Sedgwick al **800-492-5678**
Si trabaja en uno de los estados indicados a continuación, presente una reclamación ante Sedgwick, que gestionará su licencia y notificará a Lincoln de la reclamación.	Visite **One.Walmart.com/LOA > mySedgwick**	Llame a Sedgwick/Lincoln al **800-492-5678**
Hawái		
Nueva Jersey		
Nueva York		
Si trabaja en uno de los estados o localidades que se mencionan a continuación, presente una reclamación ante Sedgwick además de hacerlo ante el estado o localidad. Consulte la sección **Beneficio de maternidad** más adelante en este capítulo para obtener información sobre el beneficio de maternidad.		
California	Visite **edd.ca.gov**	Llame al **800-480-3287**
Colorado	Visite **famli.colorado.gov**	Llame al **866-263-2654**
Connecticut	Visite **ctpaidleave.org**	Llame al **877-499-8606**
Massachusetts	Visite **paidleave.mass.gov**	Llame al **833-344-7365**
Oregon	Visite **paidleave.oregon.gov**	Llame al **833-854-0166**
Rhode Island	Visite **www.dlt.ri.gov/tdi**	Llame al **401-462-8420**
Washington D. C.	Visite **dcpaidfamilyleave.dc.gov**	Llame al **202-899-3700**
Estado de Washington	Visite **paidleave.wa.gov**	Llame al **833-717-2273**

Lo que debe saber sobre el plan de discapacidad a corto plazo para asociados a tiempo completo pagados por hora

- Este capítulo detalla los beneficios de discapacidad que puede recibir con dos opciones: el plan básico de discapacidad a corto plazo y el plan mejorado de discapacidad a corto plazo.
  - **Plan básico de discapacidad a corto plazo**
    - El *beneficio básico de discapacidad a corto plazo* reemplaza el 50 % de su salario semanal promedio por hasta 25 semanas después de un periodo de espera de siete días calendario, sin tope máximo por semana (sin embargo, si trabaja en Nueva York, el máximo es de $6,000 por semana).
    - El *beneficio por maternidad por discapacidad a corto plazo* sustituye el 100 % de su salario promedio semanal durante un máximo de nueve semanas tras un periodo de espera de siete días calendario.
  - **El plan mejorado de discapacidad a corto plazo** reemplaza el 60 % de su salario semanal promedio por hasta 25 semanas, después de un periodo de espera de siete días calendario, sin tope máximo por semana (sin embargo, el plan mejorado de discapacidad a corto plazo de Nueva York ofrece $6,000 por semana como máximo).
- Ciertos estados y localidades ofrecen beneficios obligatorios por ley. Las variaciones en las leyes y los procedimientos administrativos pueden afectar su derecho a participar en un plan de discapacidad a corto plazo de Walmart, al igual que el monto de cualquier beneficio por discapacidad.
  - Si trabaja en California, Hawái, Nueva Jersey o Rhode Island, no es elegible para el plan mejorado de discapacidad a corto plazo de Walmart ni para el beneficio básico del plan básico de discapacidad a corto plazo porque los estados en los que trabaja tienen beneficios obligatorios, de acuerdo con la ley. No obstante, tiene derecho al beneficio de maternidad en el marco del plan básico de discapacidad a corto plazo de Walmart para complementar los beneficios de maternidad legalmente establecidos por su estado.
  - Si trabaja en Colorado, Connecticut, Massachusetts, Nueva York, Oregon, Washington D.C. o el estado de Washington, es elegible para participar en uno de los planes de discapacidad a corto plazo de Walmart, pero solamente será un complemento de su beneficio estatal o local.
  - Los beneficios exigidos por la ley no se ofrecen conforme al Plan de salud y bienestar de los asociados, y los beneficios pagados en virtud de esos programas exigidos por la ley no se proporcionan conforme a un plan de discapacidad a corto plazo de Walmart. En este capítulo no se analizan en detalle los beneficios obligatorios por ley, excepto cuando son relevantes para ayudarle a entender los beneficios de un plan de discapacidad a corto plazo de Walmart.

Su beneficio por discapacidad a corto plazo

Si el plan de discapacidad a corto plazo está disponible en su ubicación y queda discapacitado según la definición en la sección **Cuándo se es elegible para recibir los beneficios** más adelante en este capítulo, el plan básico de discapacidad a corto plazo proporciona un beneficio semanal básico del 50 % de su salario semanal promedio por hasta 25 semanas para una discapacidad aprobada, después de un periodo de espera de siete días calendario, sin tope de beneficio semanal máximo (sin embargo, si trabaja en Nueva York, hay un beneficio semanal máximo de $6,000). Para obtener más información sobre su salario semanal promedio, consulte más **Cómo calcular su beneficio** adelante en este capítulo.

Si el plan de discapacidad a corto plazo está disponible en su ubicación y queda discapacitado según la definición en la sección **Cuándo se es elegible para recibir los beneficios** más adelante en este capítulo, el plan básico de discapacidad a corto plazo proporciona un beneficio semanal mejorado del 60 % de su salario semanal promedio por hasta 25 semanas para una discapacidad aprobada, después de un periodo de espera de siete días calendario, sin tope de beneficio semanal máximo (sin embargo, si trabaja en Nueva York, el plan mejorado de discapacidad a corto plazo de Nueva York ofrece un beneficio semanal máximo de $6,000).

Si su discapacidad se debe a un embarazo, el plan básico de discapacidad a corto plazo facilita un beneficio de maternidad del 100 % de su salario semanal promedio por hasta las primeras nueve semanas, luego de un periodo de espera inicial de siete días calendario. Si es elegible para recibir los beneficios de discapacidad a corto plazo exigidos por ley, el beneficio de maternidad complementa el beneficio del estado. El total combinado del beneficio de maternidad disponible para usted conforme al plan básico de discapacidad a corto plazo y al beneficio de maternidad disponible para usted conforme a cualquier programa obligatorio estatal o local no superará el 100 % de su salario semanal promedio durante nueve semanas. Si sigue estando discapacitada y es elegible para los beneficios después de las primeras nueve semanas de beneficios de maternidad, y los planes básico y mejorado de discapacidad a corto plazo de Walmart están disponibles en su lugar de trabajo, el plan de discapacidad a corto plazo pagará el beneficio básico o el beneficio correspondiente conforme al plan mejorado, según el plan en el que esté inscrita, hasta 16 semanas adicionales de pagos de beneficios (para un total de hasta 25 semanas de pagos de beneficios). Para obtener información, consulte **Beneficios de maternidad** más adelante en este capítulo.

Cómo se financian los beneficios de discapacidad a corto plazo

Walmart le proporciona sin cargo el plan básico de discapacidad a corto plazo. No obstante, si se inscribe en el plan mejorado de discapacidad a corto plazo, usted y Walmart comparten los gastos. Si participa en el plan mejorado de discapacidad a corto plazo, el costo depende de sus ingresos que reúnan los requisitos y de su edad. Si no tiene ingresos elegibles en un periodo de pago determinado, no se requieren aportes durante ese periodo de pago. Sus aportes están destinadas a cubrir los costos de los beneficios.

Excepto para los asociados que trabajan en Nueva York, los planes de discapacidad a corto plazo son autoasegurados. Esto significa que no hay una compañía aseguradora que cobre primas y pague los beneficios. No obstante, el beneficio de maternidad está autoasegurado para todas las asociadas, incluidas las que trabajan en Nueva York. Actualmente, Walmart financia los beneficios del plan de discapacidad a corto plazo autoasegurado con los bienes generales de Walmart.

Para los asociados que trabajan en Nueva York, los beneficios provistos conforme al plan básico de discapacidad a corto plazo y al plan mejorado de discapacidad a corto plazo de Nueva York están asegurados con Lincoln.

Cómo se administra el beneficio de discapacidad a corto plazo de Walmart

A menos que se disponga lo contrario, los planes de discapacidad a corto plazo son administrados por Sedgwick Claims Management Services, Inc. (Sedgwick). En cuanto a cualquier pago de beneficios realizado en virtud de un plan de discapacidad a corto plazo administrado por Sedgwick, el administrador del plan ha delegado a Sedgwick la autoridad fiduciaria para determinar las reclamaciones de beneficios y las apelaciones relacionadas.

Consulte la tabla **Beneficios exigidos por ley** de la siguiente página para obtener información detallada sobre la administración de la cobertura de discapacidad que no sea por maternidad disponible para los asociados en los estados y localidades con beneficios obligatorios por ley. Para obtener más información sobre la administración de los beneficios de maternidad del plan de discapacidad a corto plazo, consulte la sección **Beneficio de maternidad** más adelante en este capítulo.

Cuándo se es elegible para recibir los beneficios

A fin de ser elegible para recibir los beneficios por discapacidad a corto plazo conforme a cualquiera de los planes de discapacidad a corto plazo, deben cumplirse las siguientes condiciones:

- El plan de discapacidad a corto plazo debe estar disponible en su localidad.
- Su cobertura debe ser efectiva.
- Su discapacidad debe haberse producido en la fecha de entrada en vigencia de su cobertura o después.
- Debe estar en estado activo en la fecha que queda discapacitado, a menos que:
  - Está en licencia o cesantía como se describe más adelante en este capítulo en **Si está con licencia de ausencia o sujeto a cesantía temporal**, o
  - No puede trabajar activamente porque ha experimentado complicaciones médicas durante el embarazo o después del parto, y ha agotado el beneficio de maternidad de discapacidad a corto plazo de nueve semanas, como se describe más adelante en este capítulo, en **Beneficio de maternidad**.

BENEFICIOS EXIGIDOS POR LEY

Si trabaja en un estado o localidad con un beneficio exigido por ley, las diferencias en las leyes y los procedimientos administrativos afectan su elegibilidad para participar en los planes por discapacidad a corto plazo de Walmart y el monto de su beneficio por discapacidad. Consulte a continuación para obtener información general. Llame al número que figura en la tabla **Recursos** para obtener información sobre los beneficios que se ofrecen en estos estados o localidades. Consulte **Beneficio por maternidad** para obtener información sobre el beneficio por maternidad, que incluye información sobre la administración.

Beneficios exigidos por ley administrados por su estado	Si trabaja en **California** o **Rhode Island**, no puede participar en un plan de discapacidad a corto plazo de Walmart. El estado administra sus beneficios de discapacidad. Es posible que siga siendo elegible para el beneficio por maternidad* conforme al plan básico de discapacidad a corto plazo de Walmart.
Beneficios exigidos por ley administrados por Lincoln	Si trabaja en **Hawái** o **Nueva Jersey**, no puede participar en un plan de discapacidad a corto plazo de Walmart. Sus beneficios de discapacidad se proporcionan de acuerdo con el programa estatal y son asegurados y administrados por Lincoln. Es posible que siga siendo elegible para el beneficio por maternidad* conforme al plan básico de discapacidad a corto plazo de Walmart. Si trabaja en **Nueva York** reúnen los requisitos para participar en el plan básico de discapacidad a corto plazo de Walmart y en el plan mejorado de discapacidad a corto plazo de Nueva York para complementar su beneficio estatal. Sus beneficios bajo estos planes están asegurados y son administrados por Lincoln.
Beneficios exigidos por ley administrados por Sedgwick	Si trabaja en **Colorado, Connecticut, Massachusetts, Oregón, Washington, D.C.**, o el **estado de Washington**, puede participar en un plan de discapacidad a corto plazo de Walmart para complementar sus beneficios obligatorios por ley, los cuales son administrados por Sedgwick.*

*El monto de cualquier beneficio de maternidad o no de maternidad del plan de discapacidad a corto plazo de Walmart se reducirá según el monto del beneficio exigido por ley que Sedgwick estima que usted tiene derecho a recibir del estado o la localidad, independientemente de que solicite o no ese beneficio exigido por ley. Si el beneficio disponible para usted conforme a cualquier programa obligatorio estatal o local es menor que el beneficio disponible para usted conforme a un plan de discapacidad a corto plazo de Walmart, el total combinado del beneficio disponible para usted del plan de discapacidad a corto plazo de Walmart y el beneficio disponible para usted conforme a cualquier programa obligatorio estatal o local no excederá los beneficios que habrían estado disponibles mediante el plan de discapacidad a corto plazo de Walmart en el que está inscrito, si no hubiera trabajado en un estado con un programa obligatorio legal. Usted será responsable de proporcionar a Sedgwick la carta de determinación del estado o la localidad. Si Sedgwick sobrestimó lo que sería su beneficio exigido por ley, lo que significa que se le pagó un monto menor del que debía recibir en virtud del plan de discapacidad a corto plazo, se le pagará la diferencia en un pago único. Si Sedgwick subestimó lo que sería su beneficio exigido por ley, lo que significa que se le pagó un monto mayor del que debía recibir en virtud del plan de discapacidad a corto plazo de, deberá devolver dicho excedente. Consulte la sección **Derecho de recuperar un pago excesivo** más adelante en este capítulo.

- Excepto que se disponga lo contrario en la sección de **Beneficios de maternidad**, debe presentar evidencia médica provista por un médico calificado que certifique que usted se encuentra discapacitada según la definición a continuación (a los efectos de este capítulo, el término “médico” incluye todo médico y profesional de la salud con licencia vigente que no tiene parentesco con usted y presta servicios dentro del alcance de su licencia; esto incluye médicos [M.D.], osteópatas [D.O.], enfermeros, asistentes médicos, psicólogos u otros profesionales de la salud cuyos servicios serían elegibles para solicitar un reembolso si se envían para reembolso conforme al Plan médico de los asociados).
- Sedgwick o Lincoln (según corresponda) debe aprobar su reclamación.

Estas condiciones aplican ya sea que esté inscrito en el plan básico de discapacidad a corto plazo, el plan mejorado de discapacidad a corto plazo o el plan mejorado de discapacidad a corto plazo de Nueva York. Sedgwick o Lincoln puede exigir una prueba escrita de su discapacidad o información adicional antes de tomar una decisión sobre su reclamación. La declaración de su médico de que está discapacitado para trabajar no demuestra por sí misma que esté discapacitado. Asimismo, la aprobación de una licencia de ausencia no constituye la aprobación para recibir beneficios por discapacidad a corto plazo.

A menos que se estipule lo contrario en la sección de **Beneficios de maternidad**, para fines de los beneficios proporcionados por un plan de discapacidad a corto plazo, tal y como se describe en este capítulo, “discapacitado” o “discapacidad” significa que

(i) no puede realizar las tareas esenciales de su trabajo para su horario normal de trabajo, o que se le ha suspendido una licencia necesaria para sus tareas laborales debido a una enfermedad o lesión mental o física, o a un embarazo, y (ii) está bajo el cuidado continuo de un médico cualificado y está siguiendo el curso del tratamiento recetado por su médico.

Los beneficios por discapacidad se pagan durante el periodo en que haya perdido la licencia solo mientras dure su discapacidad y mientras se logra el restablecimiento oportuno de la licencia. "Restablecimiento oportuno de la licencia" significa que usted lo solicita cuando su estado cumple con los criterios correspondientes y proporciona la información y los formularios requeridos por la agencia que la otorga de manera oportuna hasta que la licencia se restablezca. Únicamente la pérdida de la licencia no es suficiente para adecuarse a la definición de discapacidad.

Si está empleado como piloto, copiloto o miembro de la tripulación de una aeronave, "discapacidad" o "discapacitado" significa que, como resultado de una lesión o enfermedad física o mental, no puede realizar las tareas materiales y sustanciales de su propia ocupación conforme a las normas de aptitud aplicables de la Administración Federal de Aviación.

Sedgwick (o Lincoln, si corresponde) determinará su discapacidad en función de evidencia médica objetiva, la cual consta de hechos y conclusiones, incluidos, entre otros, radiografías, informes de laboratorio, pruebas, informes realizados por el médico tratante, así como también informes y notas que realice su médico.

Si su discapacidad es causada por una enfermedad mental o abuso de sustancias, se le recomienda recibir tratamiento dentro de los 30 días de la primera fecha de ausencia por parte de un psicólogo, psiquiatra, consejero autorizado, consejero de drogas y alcohol, o trabajador social clínico que se especialice en salud mental y/o abuso de sustancias, y que tenga licencia conforme a la ley estatal. Consulte el capítulo **Recursos de asistencia para los asociados** para obtener información sobre los recursos que están disponibles si está experimentando los efectos de una enfermedad mental o abuso de sustancias.

Si Sedgwick o Lincoln solicita que lo examine un médico, debe asistir al examen para que pueda ser considerado para recibir los beneficios. Walmart pagará el costo de dicho examen.

La duración máxima de un periodo de discapacidad durante el cual se abonan los beneficios de discapacidad, incluso si la discapacidad es resultado de más de una causa, es de 25 semanas, tras el periodo de espera inicial de siete días calendario. Consulte también **Si regresa a trabajar y queda discapacitado nuevamente**.

Consulte la sección de **Beneficios de maternidad** para obtener más detalles sobre el beneficio de maternidad.

Cuándo no se pagan los beneficios

Los beneficios por discapacidad a corto plazo no se pagarán por una enfermedad o lesión en los siguientes casos:

- Si la enfermedad o lesión se produjo antes de que su cobertura entrara en vigencia
- Si a usted no lo atiende ni trata un médico calificado
- Si es causada por participar en una insurrección, rebelión, disturbio o desorden civil
- Si es ocasionada porque usted comete o intenta cometer un delito (p. ej., agresión, violencia, delitos mayores o cualquier ocupación o actividad ilegal) o
- Si es ocasionada por realizar cualquier trabajo remunerado o lucrativo (por ejemplo, una enfermedad o lesión relacionada con el trabajo fuera de Walmart o relacionada con su trabajo en Walmart por el que se pagan, o pueden pagarse, los beneficios de la compensación para trabajadores si se reclaman adecuadamente)

Cuándo comienzan los beneficios

Si se aprueba su reclamación por discapacidad a corto plazo, los beneficios comenzarán, después de un periodo de espera de siete días calendario, en el octavo día calendario después de que comience su discapacidad. Si su reclamación de beneficios por discapacidad a corto plazo se aprueba de manera retroactiva, cualquier pago de beneficios que de otro modo se le hubiera pagado mientras la decisión de su reclamación estaba pendiente se le hará en un pago único cuando se apruebe.

Para que su pago continúe durante el periodo de espera inicial de siete días calendario, puede utilizar tiempo libre pagado (PTO). No debe utilizar el PTO más allá del periodo de espera inicial de siete días mientras la decisión de la reclamación esté pendiente o durante cualquier periodo para el que se aprueben los beneficios por discapacidad a corto plazo, a menos que esté permitido por la ley. Si más tarde se verifica que no es elegible para los beneficios por discapacidad a corto plazo, puede volver a utilizar el PTO por el tiempo que no haya sido pagado, conforme a la política de PTO. Es posible que tenga que reembolsar el PTO utilizado durante los días en los que se aprobaron los beneficios por discapacidad. Tras el reembolso, se restablecerá cualquier saldo de PTO.

La política de PTO no es un beneficio ofrecido en virtud del Plan ni administrado como parte del Plan. Para obtener detalles específicos sobre la política de PTO, consulte **One.Walmart.com.**

Cómo calcular su beneficio

El monto de su beneficio semanal por discapacidad a corto plazo se basa en:

- Su salario semanal promedio, tal como se define a continuación
- La duración de su discapacidad, y
- Si está inscrito en el plan básico de discapacidad a corto plazo o en el plan mejorado

El monto de su beneficio semanal por discapacidad a corto plazo se basa en:

SALARIO SEMANAL PROMEDIO	
Duración del empleo	**Cómo se determina el salario semanal promedio**
Empleado durante 12 meses o más	Sus ingresos elegibles para los 26 periodos de pago inmediatamente anteriores a su último día de trabajo ÷ 52 semanas Por ejemplo, el salario promedio semanal de un asociado con ingresos elegibles de $36,400 durante los 26 periodos de pago anteriores es de $700 ($36,400 ÷ 52)
Empleado durante menos de 12 meses	Ingresos elegibles desde la fecha de contratación ÷ cantidad de semanas trabajadas Por ejemplo, el salario semanal promedio de un asociado con unos ingresos elegibles de $8,400 por 12 semanas de trabajo es de $700 ($8,400 ÷ 12).

*Cualquier periodo de pago en el que no registra ingresos elegibles queda excluido, lo que reduce la cantidad de periodos de pagos para el cálculo. En la medida en que sus ingresos elegibles hayan sido pagados semanalmente durante el periodo de 12 meses, la cantidad de periodos de pago utilizados para calcular su salario semanal promedio se ajustará en consecuencia.

Sus beneficios a corto plazo se abonan a través de la nómina de Walmart sobre la base de un periodo de pago.

Si su beneficio de discapacidad se paga por menos de una semana, su beneficio de discapacidad por cada día que esté discapacitado durante esa semana será 1/7 del beneficio semanal.

Los ingresos elegibles utilizados para determinar el salario promedio semanal incluyen:

- Los ingresos regulares de los 26 periodos de pago anteriores a su último día de trabajo
- Horas extras
- Bonos de incentivos programados periódicamente para los que usted y los asociados que tienen tipos de trabajo o niveles de trabajo similares son elegibles
- Tiempo libre remunerado y remuneraciones similares que sustituyen los ingresos habituales (por ejemplo: licencia por duelo, licencia de servicio de jurado y licencia por enfermedad)

Los ingresos elegibles utilizados para determinar el salario promedio semanal excluyen:

- Cualquier beneficio de discapacidad pagado anteriormente
- Las comisiones ni ninguna otra compensación adicional ni beneficios que no se hayan mencionado anteriormente

A continuación, se muestra un cálculo de beneficios hipotético que corresponde a un salario semanal promedio de $700.

SU BENEFICIO POR DISCAPACIDAD A CORTO PLAZO: UN EJEMPLO	
Si tiene	**Su beneficio es**
Cobertura del plan básico de discapacidad a corto plazo	50 % de su salario semanal promedio Salario semanal promedio: $700 50 % de $700: $350
Cobertura del plan mejorado de discapacidad a corto plazo	60 % de su salario semanal promedio Salario semanal promedio: $700 el 60 % de $700: beneficio semanal de $420 Los beneficios se abonan a través de la nómina de Walmart sobre la base de un periodo de pago.
NOTA: Si reúne los requisitos para recibir los beneficios exigidos por ley, así como los beneficios de los planes por discapacidad a corto plazo de Walmart, el monto del beneficio que se recibe conforme a los planes por discapacidad a corto plazo de Walmart se reducirá según el monto del beneficio exigido por ley que Sedgwick estima que recibirá. Consulte **Beneficios exigidos por ley** que se encuentra anteriormente en este capítulo.	

BENEFICIO DE MATERNIDAD

Consulte la sección **Cuándo se es elegible para recibir los beneficios** para ver los requisitos generales aplicables a todos los beneficios de discapacidad de un plan de discapacidad a corto plazo, incluyendo el beneficio de maternidad. Existen algunas excepciones a estas reglas generales que se aplican al beneficio por maternidad. Tales excepciones se analizan en esta sección. Consulte la tabla **Beneficios exigidos por ley** anteriormente en esta sección.

El beneficio de maternidad es del 100 % del salario promedio semanal hasta las nueve primeras semanas de licencia, tras un periodo de espera inicial de siete días calendario. Los beneficios por discapacidad comienzan el octavo día calendario luego del inicio de la discapacidad.

Si su discapacidad se debe a un embarazo, la fecha de su discapacidad suele ser el día del parto o hasta dos semanas antes. Si comienza su licencia por discapacidad a corto plazo durante este plazo, se considerará que cumple la definición de discapacidad para fines del beneficio de maternidad. Si comienza la licencia con más de dos semanas de antelación a la fecha prevista de parto, deberá aportar un comprobante médico objetivo que demuestre su discapacidad, tal y como se define en la sección **Cuándo se es elegible para recibir los beneficios**. Si está discapacitada, tal y como se define en tal sección, comenzará a recibir el beneficio de maternidad por discapacidad a corto plazo en la fecha en que se determine su discapacidad. El beneficio de maternidad no superará las nueve semanas en ningún caso.

Si no comienza su licencia por discapacidad a corto plazo en la fecha de parto, debe cumplir la definición de discapacidad del plan, tal y como se define en la sección **Cuándo se es elegible para recibir los beneficios**. En ese caso, cualquier beneficio por discapacidad estará sujeto a las reglas aplicables a los beneficios

por discapacidad no relacionados con la maternidad y dependerá de si es elegible para un beneficio de discapacidad a corto plazo básico o mejorado. No tendrá derecho al beneficio de maternidad que se describe en esta sección.

Si se reincorpora al trabajo antes de recibir la totalidad del beneficio por maternidad y, posteriormente, vuelve a irse de licencia, no podrá reanudar el beneficio por maternidad a menos que aporte evidencia médica objetiva a Sedgwick que avale la determinación de que cumple la definición de discapacidad. Si no se aporta ninguna evidencia médica, perderá el resto del beneficio por maternidad.

El beneficio de maternidad se resume a continuación. Consulte la tabla **Beneficios exigidos por ley** para más información sobre los beneficios obligatorios.

BENEFICIO DE MATERNIDAD		
Su lugar de trabajo (estado o localidad)*	**Hasta 9 semanas****	**Más de 9 semanas** (hasta 25 semanas en total)**
Si trabaja en un estado o localidad que no cuenta con beneficios exigidos por ley	100 % de su salario semanal promedio luego de un periodo de espera inicial de 7 días calendario.	Si presenta complicaciones médicas durante el embarazo o después del parto, los beneficios se pueden pagar conforme al plan básico o al plan mejorado de discapacidad a corto plazo para las asociadas, como se describe anteriormente.
Si (i) trabaja en un estado o localidad que cuenta con un plan exigido por ley, (ii) *es elegible para recibir* el beneficio estatal debido a su embarazo, y (iii) trabaja en un lugar elegible para el plan básico o el plan mejorado a corto plazo de Walmart	100 % de su salario semanal promedio, reducido por cualquier beneficio exigido por ley que se paga a la tasa aplicable del gobierno local o estatal, después de un periodo de espera inicial de 7 días calendario.	Es posible que haya beneficios adicionales disponibles a través de su gobierno estatal o local y los beneficios se pueden pagar conforme al plan básico o al plan mejorado de discapacidad a corto plazo para las asociadas, como se describe anteriormente.
Si (i) trabaja en un estado o localidad con un beneficio obligatorio por ley, (ii) *no reúne los requisitos* para recibir el beneficio estatal debido a su embarazo, y (iii) no trabaja en una localidad elegible para el plan básico o mejorado de discapacidad a corto plazo de Walmart.	100 % de su salario semanal promedio, reducido por cualquier beneficio exigido por ley que se paga a la tasa aplicable del gobierno local o estatal, después de un periodo de espera inicial de 7 días calendario.	Es posible que haya beneficios adicionales disponibles a través de su gobierno estatal o local.
Si (i) trabaja en un estado o localidad que cuenta con un beneficio exigido por ley, (ii) *no es elegible* para recibir el beneficio del gobierno estatal o local debido a su embarazo, y (iii) trabaja en un lugar elegible para el plan básico o el plan mejorado de discapacidad a corto plazo de Walmart	100 % de su salario semanal promedio luego de un periodo de espera inicial de 7 días calendario.	Si presenta complicaciones médicas durante el embarazo o después del parto, los beneficios se pueden pagar conforme al plan básico o al plan mejorado de discapacidad a corto plazo para las asociadas, como se describe anteriormente.
Si (i) trabaja en un estado o localidad con un beneficio obligatorio por ley, (ii) *no reúne los requisitos* para recibir el beneficio del gobierno estatal o local debido a su embarazo, y (iii) no trabaja en una localidad elegible para el plan básico o mejorado de discapacidad a corto plazo de Walmart.	100 % de su salario semanal promedio luego de un periodo de espera inicial de 7 días calendario.	Los planes básicos y mejorados de discapacidad a corto plazo de Walmart no están disponibles; los beneficios de maternidad finalizan después de las primeras 9 semanas de pagos de beneficios.
Los beneficios suelen pagarse a través de la nómina de Walmart por periodos de pago. No obstante, puede haber algunos casos durante el proceso de reclamación en los que los pagos podrían emitirse fuera del ciclo normal de nóminas.		

*Si trabaja en California, Colorado, Connecticut, Hawái, Massachusetts, Nueva Jersey, Nueva York, Oregón, Rhode Island, Washington D.C. o el estado de Washington, Sedgwick calculará el beneficio legalmente obligatorio disponible para usted bajo tales programas, independientemente de si ha solicitado o no los beneficios legalmente obligatorios.

Puede ser elegible para la paga parental igual al 100 % de su salario semanal promedio conforme a la póliza de pago parental de Walmart. No puede recibir el pago parental mientras recibe los beneficios de maternidad de discapacidad a corto plazo. La política de pago parental no es un beneficio ofrecido en virtud del Plan ni administrado como parte de este. Para obtener información específica sobre la política de pago parental, consulte **One.Walmart.com.

LOS IMPUESTOS Y SU BENEFICIO POR DISCAPACIDAD A CORTO PLAZO

El pago de impuestos sobre los beneficios que recibe dependerá de si está inscrito en el plan básico o en el plan mejorado por discapacidad a corto plazo. Si está inscrito en un plan básico por discapacidad a corto plazo, los beneficios que recibe están sujetos a impuestos. Esto se debe a que no realiza ningún aporte al plan básico de discapacidad a corto plazo y no paga ningún impuesto sobre la cobertura que brinda Walmart. Si está inscrito en un plan mejorado por discapacidad a corto plazo, solo se pagarán impuestos sobre una parte de sus beneficios, ya que Walmart y usted pagan el costo de la cobertura a través de una combinación de aportes de Walmart y un monto por parte del asociado después de impuestos. Por lo general, Walmart retiene todo impuesto local, estatal, federal y de seguridad social de la parte de beneficios sujeta a impuestos.

Si trabaja en Nueva York, comuníquese con Lincoln para obtener información sobre los impuestos de los beneficios básicos de su plan básico o mejorado de discapacidad a corto plazo. Los asociados que trabajan en otros estados o localidades con beneficios exigidos por ley que no son elegibles para participar en los planes básicos o mejorados de discapacidad a corto plazo deben comunicarse con Lincoln (si trabaja en Hawái o Nueva Jersey) o con el estado o la localidad donde se encuentra para obtener información sobre el estado fiscal de los beneficios estatales o locales.

El administrador del plan no puede garantizar las consecuencias fiscales específicas que surgirán cuando usted reciba los beneficios conforme al plan de discapacidad a corto plazo de Walmart. El administrador del plan no brinda asesoramiento legal o fiscal. Si necesita una respuesta en la que pueda confiar, puede consultar a un asesor fiscal.

DERECHO DE RECUPERAR UN PAGO EXCESIVO

El Plan tiene el derecho de cobrarle y usted debe pagar cualquier monto que se le haya pagado de más por beneficios de discapacidad a corto plazo como parte de un plan de discapacidad a corto plazo de Walmart. Consulte **El derecho del Plan a recuperar el exceso de pago** y **Derecho del Plan a descontar del sueldo o del salario** en el capítulo **Reclamaciones y apelaciones**. Si no devuelve los montos pagados en exceso en el plazo previsto, Walmart deducirá primero estas cantidades de los pagos futuros por discapacidad (si los hay). Si se debe algún monto restante después de cualquier deducción de los futuros pagos por discapacidad, entonces Walmart puede, a su discreción, (i) tratar los montos pagados en exceso como salarios imponibles para usted (declarables en su formulario W-2), o (ii) deducir los montos pagados en exceso de su pago quincenal, en la medida permitida por la ley.

Cómo presentar una reclamación por discapacidad a corto plazo

Si queda discapacitado, debe presentar de manera oportuna su reclamación para recibir los beneficios. Un retraso en la presentación podría dar lugar al pago retrasado del beneficio, a la interrupción de su salario o al rechazo de su reclamación. El momento y el proceso que debe seguir para presentar una reclamación de beneficios por discapacidad a corto plazo dependen de si el plan de discapacidad a corto plazo está disponible en su localidad (es decir, si se encuentra en un estado o localidad que ofrezca beneficios obligatorios por ley). Consulte **Instrucciones para presentar reclamaciones** en la siguiente página para obtener información sobre cómo presentar su reclamación.

PASO 1: Póngase en contacto con Sedgwick para solicitar una licencia. Independientemente del proceso que siga para presentar una reclamación de discapacidad a corto plazo ante el Plan, deberá ponerse en contacto con Sedgwick a través de **One.Walmart.com/LOA > mySedgwick** o llamando al **800-492-5678** para solicitar una licencia de ausencia en cuanto sepa que va a faltar al empleo debido a una enfermedad, lesión o embarazo. Sedgwick le enviará un paquete inicial en el que se encontrará la información que necesita y se describirán las medidas que debe tomar.

La política de licencia de ausencia no es un beneficio que se ofrece conforme al Plan ni es administrado como parte del Plan, por lo que no se aborda aquí detalladamente. Consulte **One.Walmart.com** para obtener información específica sobre la política de licencias de ausencia.

La aprobación de una licencia conforme a la política de licencias de Walmart no significa que se apruebe automáticamente su reclamación de discapacidad a corto plazo. Para obtener información, consulte **Cuándo comienzan los beneficios**.

PASO 2: Presentar una reclamación de discapacidad a corto plazo o de beneficios obligatorios por ley. Su reclamación de beneficios por discapacidad a corto plazo no puede procesarse completamente hasta que haya dejado de trabajar. Notifique a su gerente si su enfermedad o lesión está relacionada con su trabajo en Walmart a fin de iniciar una reclamación por la compensación para trabajadores.

NOTA: La fecha de presentación de su reclamación es la fecha en la que presenta su reclamación de discapacidad a Sedgwick. Para que Sedgwick comience a revisar su reclamación, debe haber dejado de trabajar por completo. Si presenta su reclamación antes del primer día de ausencia, Sedgwick comenzará a procesar su reclamación a partir del primer día de ausencia. Si presenta su reclamación el primer día de licencia o posteriormente, Sedgwick iniciará la revisión a partir de la fecha comunicada.

Consulte la tabla de la siguiente página para saber dónde y cuándo presentar su reclamación.

INSTRUCCIONES PARA PRESENTAR RECLAMACIONES

Su estado o localidad puede tener periodos de presentación únicos, lo que podría excluir los beneficios correspondientes a periodos anteriores a la fecha de su solicitud de beneficios. Le recomendamos encarecidamente que solicite los beneficios requerido por ley en su estado o localidad sin demora.

Estado o localidad	Elegibilidad	Administración de reclamaciones	Instrucciones de presentación
CA, RI	No tiene derecho a la cobertura de discapacidad a corto plazo básica o mejorada de Walmart Derecho a la maternidad, como complemento de los beneficios obligatorios por ley	Estado donde se ofrece el beneficio obligatorio por ley Sedgwick para maternidad	**CA:** Visite **edd.ca.gov** o llame al **800-480-3287** para obtener instrucciones **RI:** Visite **www.dlt.ri.gov/tdi** o llame al **401-462-8420** para obtener instrucciones Para obtener beneficios de maternidad, presente una reclamación ante Sedgwick dentro de los 90 días posteriores a la fecha en que su discapacidad haya comenzado; deberá facilitar la carta de determinación del estado que incluya los detalles de los beneficios. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.
HI, NJ	No tiene derecho a la cobertura de discapacidad a corto plazo básica o mejorada de Walmart Derecho a la maternidad, como complemento de los beneficios obligatorios por ley	Lincoln Sedgwick para maternidad	**HI:** Presente una reclamación a Sedgwick en un plazo de 90 días a partir de la fecha de inicio de su discapacidad y Sedgwick la remitirá a Lincoln. **NJ:** Presente una reclamación a Sedgwick en un plazo de 30 días a partir de la fecha de inicio de su discapacidad y Sedgwick la remitirá a Lincoln. Para el beneficio de maternidad, presente una reclamación con Sedgwick dentro de los 90 días de la fecha en que comienza la discapacidad. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.
CO, CT, MA, OR, WA **Washington D. C.**	Si es elegible para el plan de discapacidad a corto plazo de Walmart como complemento a los beneficios obligatorios por ley	Estado o distrito de beneficios obligatorios por ley Sedgwick para beneficios complementarios y de maternidad	**CO:** Visite **famli.colorado.gov** o llame al **866-263-2654** para obtener instrucciones **CT:** Visite **ctpaidleave.org** o llame al **877-499-8606** para obtener instrucciones **MA:** Visite **paidleave.mass.gov** llame al **833-344-7365** para obtener instrucciones **OR:** Visite **paidleave.oregon.gov** o llame al **833-854-0166** para obtener instrucciones **WA:** Visite **paidleave.wa.gov** o llame al **833-717-2273** para obtener instrucciones **D.C.:** Visite **dcpaidfamilyleave.dc.gov** o llame al **202-899-3700** para obtener instrucciones **Sedgwick:** Presente una reclamación ante Sedgwick dentro de los 90 días posteriores a la fecha en que su discapacidad haya comenzado; deberá facilitar la carta de determinación del estado o distrito que incluya los detalles de los beneficios estatales o del distrito. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.
NY	Si es elegible para el plan de discapacidad a corto plazo de Walmart como complemento a los beneficios obligatorios por ley	Lincoln Sedgwick para beneficios complementarios y de maternidad	Presente una reclamación a Sedgwick en un plazo de 30 días a partir de la fecha de inicio de su discapacidad y Sedgwick la remitirá a Lincoln. Para el beneficio de maternidad, presente una reclamación con Sedgwick dentro de los 90 días de la fecha en que comienza la discapacidad. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.
Todos los demás	Si es elegible para el plan de discapacidad a corto plazo de Walmart	Sedgwick	Presente una reclamación con Sedgwick dentro de los 90 días de la fecha en que comienza la discapacidad. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.

PASO 3: Informe al consultorio de su médico que se pondrá en contacto para solicitar información. Infórmele a su médico que se comunicarán con él para que complete un certificado médico y para pedirle que proporcione información médica objetiva, incluida la siguiente:

- Diagnóstico
- Fecha y duración prevista de la discapacidad
- Restricciones y limitaciones
- Conclusiones de exámenes cognitivos y/o físicos y resultados de pruebas
- Plan de tratamiento, y
- Notas de las consultas médicas.

Debe firmar un formulario que autorice a su médico a divulgar esta información. (Este formulario se incluirá en el paquete inicial que reciba de Sedgwick. Sin embargo, si presenta su reclamación en línea, se acepta una firma electrónica).

PASO 4: Realice un seguimiento con su médico para asegurarse de que la información solicitada se envíe a Sedgwick. Cualquier retraso en el envío de la información a Sedgwick podría tener como resultado un retraso, o rechazo, en el procesamiento de su reclamación y el pago de los beneficios.

Las reclamaciones se determinan dentro de los plazos y requisitos establecidos en el capítulo **Reclamaciones y apelaciones**. Tiene derecho a apelar una reclamación rechazada. Para obtener información, consulte el capítulo **Reclamaciones y apelaciones**.

Es posible que se le exija una prueba por escrito de su discapacidad o información médica adicional antes de que se apruebe su reclamación.

Cuándo finalizan los beneficios por discapacidad a corto plazo

Si está recibiendo beneficios por discapacidad a corto plazo en virtud de un plan de discapacidad a corto plazo de Walmart, sus pagos de beneficios finalizarán en la fecha más temprana de:

- Cuando deje de coincidir con la definición de discapacidad del plan para la discapacidad a corto plazo.
- Cuando no presente las pruebas necesarias de discapacidad cuando lo soliciten Sedgwick o Lincoln.
- Cuando usted ya no esté bajo la atención y el tratamiento permanentes de un médico calificado.
- Cuando se niegue a someterse a examen, si Sedgwick o Lincoln así lo exigiera.
- El último día de su periodo máximo en el cual los beneficios son abonables
- Cuando esté médicamente apto y calificado para trabajar en un puesto a tiempo completo similar que Walmart le ofrezca, o
- La fecha de su fallecimiento.

Si sus beneficios por discapacidad a corto plazo finalizan y no regresa a trabajar por cualquier motivo, debe solicitar una extensión de su licencia de ausencia (consulte la tabla **Recursos** al comienzo del capítulo para obtener información de contacto). Si no lo hace, es posible que se le despida.

Los beneficios proporcionados bajo un programa obligatorio estatal o local pueden tener fechas de finalización diferentes a las del plan de discapacidad a corto plazo de Walmart.

Volver al trabajo tras una licencia

Sedgwick se pondrá en contacto con usted antes de la fecha de regreso al trabajo prevista y le informará los pasos que deberá seguir, incluso cómo obtener un certificado médico para regresar a trabajar. En algunos casos, es posible que su médico le dé el alta para regresar a trabajar con ciertas restricciones médicas; dichas restricciones deben estar explícitamente establecidas en el certificado para regresar a trabajar o en el alta por escrito. Si recibe un certificado para regresar a trabajar que incluye restricciones médicas, es posible que esté sujeto a una revisión para determinar si una modificación a su trabajo o una adaptación ayudará a que pueda regresar a trabajar.

Deberá ponerse en contacto con Sedgwick **hasta siete días antes de la fecha real de vuelta al trabajo** para garantizar una transición fluida para volver al trabajo y evitar una posible repercusión en su salario. Si su fecha de reincorporación al trabajo cambia, debe notificarlo inmediatamente a Sedgwick. Si sus beneficios de discapacidad a corto plazo terminaron y no regresó a trabajar ni comunicó sus intenciones, Sedgwick le notificará sus opciones, las cuales incluyen la solicitud de una extensión de su licencia o la renuncia voluntaria a su empleo. Si no solicita una extensión, es posible que su relación laboral finalice.

SI REGRESA A TRABAJAR Y QUEDA DISCAPACITADO NUEVAMENTE

Si regresa a trabajar por 30 días calendario o menos y está clasificado como asociado a tiempo completo en estado activo (con o sin restricciones médicas) y queda discapacitado nuevamente por la misma enfermedad u otra afección relacionada que había causado el primer periodo de discapacidad, tal como lo define Sedgwick o Lincoln como un “reclamación por recaída/recurrente”, sus beneficios por discapacidad a corto plazo continuarán a partir de donde habían quedado antes de que volviera a trabajar. No deberá cumplir un periodo de espera adicional de siete días calendario. La duración del beneficio combinado para ambos periodos de discapacidad no superará las 25 semanas.

Si ha vuelto a trabajar como asociado a tiempo completo y está en estado activo durante más de 30 días calendario y, posteriormente, queda discapacitado por la misma afección o por una afección relacionada, se considerará una nueva discapacidad y podrá recibir hasta 25 semanas de beneficios tras haber satisfecho un nuevo periodo de espera de siete días calendario.

Si regresa como asociado a tiempo completo y está en estado activo por cualquier cantidad de días calendario y luego queda discapacitado por una nueva condición no relacionada, se considerará una nueva discapacidad y podría tener hasta un máximo de 25 semanas de beneficios. Se aplicará un nuevo periodo de espera de beneficios de siete días calendario.

Si está con licencia de ausencia o sujeto a cesantía temporal

Si no está en estado activo debido a una licencia o a una cesantía temporal, su derecho a los beneficios por discapacidad a corto plazo continuará durante 90 días a partir del inicio de su licencia o cesantía temporal. Su derecho a recibir la cobertura por discapacidad a corto plazo finaliza a los 91 días del inicio de la licencia o de la cesantía temporal, pero se restablece si se reincorpora al trabajo en el plazo de un año con estado de trabajo activo (no se le pedirá que vuelva a cumplir con el periodo de espera de 12 meses). Para obtener más información, consulte **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**, que incluye detalles sobre el pago de los beneficios durante una licencia.

Cuándo finaliza la cobertura por discapacidad a corto plazo

La cobertura del plan básico y del plan mejorado de discapacidad a corto plazo finaliza en la fecha más temprana de:

- La fecha en que finaliza su relación laboral
- El último día del periodo de pago en que su estado laboral cambia de un estado laboral elegible
- La fecha de su fallecimiento
- El día 91 de una licencia o cesantía (a menos que se reincorpore al trabajo), o
- La fecha en la que Walmart deja de ofrecer el beneficio de discapacidad a corto plazo.

Además, la cobertura conforme al plan mejorado de discapacidad a corto plazo finalizaría cuando usted da de baja su cobertura voluntariamente. Para obtener más información, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Si deja Walmart y vuelve a ser contratado

Si es un asociado pagado por hora a tiempo completo, consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para saber cómo el hecho de dejar de trabajar en Walmart y volver a hacerlo afecta sus beneficios.

Discapacidad a corto plazo para asociados a tiempo completo pagados por hora

Plan de discapacidad a corto plazo para asociados asalariados

La información de este capítulo describe los beneficios por discapacidad a corto plazo a los que puede acceder si:

- Es un asociado asalariado (gerencia) (conductores de camión: véase el siguiente capítulo), y
- Ha cumplido todos los requisitos para que la cobertura sea efectiva, incluidos los requisitos de trabajo activo.

Si tiene preguntas sobre los requisitos de elegibilidad, los requisitos para que la cobertura sea efectiva y la repercusión en sus beneficios de un cambio en su clasificación laboral, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

El plan de discapacidad a corto plazo para asalariados no es un beneficio ofrecido en el marco del Plan de salud y bienestar para asociados (AHWP) de Walmart Inc. y no está sujeto a la Ley de Garantía de Ingresos por Jubilación para los Empleados de 1974 (ERISA).

Esta información no crea un contrato de trabajo explícito ni implícito, ni cualquier otro compromiso contractual. Walmart puede modificar esta información a su exclusivo criterio sin previo aviso y en cualquier momento, de conformidad con la ley correspondiente.

Plan de discapacidad a corto plazo para asociados asalariados

Si no trabaja por un periodo prolongado debido a que está embarazada, se sometió a una cirugía programada, tiene una enfermedad o sufrió una lesión inesperada, este plan para asociados asalariados puede sustituir una parte de su cheque de pago.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Para solicitar una licencia, presentar una reclamación de beneficios u obtener más información	Visite **One.Walmart.com/LOA > mySedgwick**	Llame a Sedgwick al **800-492-5678**
Si trabaja en uno de los estados o localidades que se mencionan a continuación, presente una reclamación ante Sedgwick además de hacerlo ante el estado o localidad. Consulte la sección **Beneficio de maternidad** más adelante en este capítulo para obtener información sobre el beneficio de maternidad.		
Colorado	Visite **famli.colorado.gov**	Llame al **866-263-2654**
Connecticut	Visite **ctpaidleave.org**	Llame al **877-499-8606**
Massachusetts	Visite **paidleave.mass.gov**	Llame al **833-344-7365**
Oregon	Visite **dcpaidfamilyleave.dc.gov**	Llame al **833-854-0166**
Washington D. C.	Visite **paidleave.oregon.gov**	Llame al **202-899-3700**
Estado de Washington	Visite **paidleave.wa.gov**	Llame al **833-717-2273**
Solicite una apelación de una reclamación por discapacidad a corto plazo rechazada	Visite **One.Walmart.com/LOA > mySedgwick**	Llame a Sedgwick al **800-492-5678**

Lo que debe saber sobre el plan de discapacidad a corto plazo para asociados asalariados

- En este capítulo se describen los beneficios de discapacidad que le ofrece el plan de discapacidad a corto plazo.
- El plan de discapacidad a corto plazo para asociados asalariados sustituye el 100 % de su salario base durante un máximo de seis semanas tras esperar un periodo de espera de siete días calendarios y el 75 % de su salario base durante un máximo de 19 semanas adicionales. (Las discapacidades que dan derecho a compensación para trabajadores a través de Walmart se tratan de forma diferente, como se describe en la tabla titulada **Su beneficio del plan de discapacidad a corto plazo para asociados asalariados**).
- Si su discapacidad se debe a un embarazo, el plan de discapacidad a corto plazo para asociados reemplaza el 100 % de su pago básico durante hasta nueve semanas, luego de un periodo de espera de siete días calendario. Es posible que se paguen beneficios adicionales después de las primeras nueve semanas de beneficios si experimenta complicaciones médicas durante el embarazo o después del parto. Para obtener más información, consulte **Beneficio de maternidad** más adelante en este capítulo.
- El plan de discapacidad a corto plazo para asociados asalariados no está sujeto a ERISA y no se ofrece conforme al Plan de salud y bienestar para asociados.
- Los procedimientos de reclamaciones y apelaciones descritos en este capítulo aplican al beneficio por discapacidad a corto plazo para asociados asalariados en lugar de los procedimientos establecidos en el capítulo **Reclamaciones y apelaciones**.

Su beneficio por discapacidad a corto plazo

Si queda discapacitado, tal y como se define en la sección **Cuándo se es elegible para recibir los beneficios** que aparece más adelante en este capítulo, y satisface los requisitos para recibir los beneficios por discapacidad a corto plazo, el plan de discapacidad a corto plazo suele pagar el 100 % de su salario base durante un máximo de seis semanas de discapacidad aprobado, tras un periodo de espera inicial de siete días calendario de discapacidad continua. (Las discapacidades que califican para la compensación de trabajador a través de Walmart se consideran de manera diferente, tal como se describe en la tabla **Su beneficio del plan de discapacidad a corto plazo para asociados asalariados**). Si permanece discapacitado y es elegible para los beneficios luego de las primeras seis semanas de pagos por discapacidad, el plan de discapacidad a corto plazo para asociados asalariados pagará el 75 % de su pago básico por hasta 19 semanas adicionales.

Si su discapacidad se debe a un embarazo, el plan de discapacidad a corto plazo para asociados asalariados paga un beneficio de maternidad del 100 % de su pago básico por hasta las primeras nueve semanas, luego de un periodo de espera inicial de siete días calendario. Si permanece discapacitado y es elegible para los beneficios después de las primeras nueve semanas de pagos por discapacidad, el plan de discapacidad a corto plazo para asociados asalariados pagará el 75 % de su pago básico por hasta 16 semanas adicionales.

Cómo se administra el plan de discapacidad a corto plazo para asociados asalariados

La cobertura por discapacidad a corto plazo para asociados asalariados es administrada por Sedgwick Claims Management Services, Inc. (Sedgwick) y es proporcionada por Walmart sin costo alguno.

BENEFICIOS EXIGIDOS POR LEY

Los beneficios por discapacidad a corto plazo proporcionados por los estados individuales y los gobiernos locales no suelen afectar su elegibilidad para el plan de beneficios por discapacidad a corto plazo para asociados asalariados de Walmart, a menos que trabaje en Colorado, Connecticut, Massachusetts, Oregón, Washington, D.C. o el estado de Washington. La siguiente tabla contiene las reglas aplicables a estos programas estatales y locales.

Cuándo se es elegible para recibir los beneficios

A fin de ser elegible para recibir los beneficios por discapacidad a corto plazo, deben cumplirse las siguientes condiciones:

- Su cobertura debe ser efectiva.
- Su discapacidad debe haberse producido en la fecha de entrada en vigencia de su cobertura o después.
- Debe estar en estado activo en la fecha que queda discapacitado, a menos que:
  - Está en licencia o cesantía, tal como se describe más adelante en este capítulo, en el párrafo **Si está de licencia de ausencia o está sujeto a cesantía temporal**, o
  - No se encuentre trabajando activamente porque experimenta complicaciones médicas durante el embarazo o después del parto, y ha agotado el periodo de beneficio de maternidad del plan de discapacidad a corto plazo de nueve semanas, como se describe más adelante en este capítulo, en **Beneficio de maternidad**.
- Excepto que se disponga lo contrario en la sección de **Beneficios de maternidad** en este capítulo, debe presentar evidencia médica provista por un médico calificado que dé fe de que usted se encuentra discapacitado según la definición que aparece en la siguiente página (a los efectos de este capítulo, el término "médico" incluye todo médico y profesional de la salud con licencia vigente que no tiene parentesco con usted y presta servicios dentro del alcance de su licencia; esto incluye médicos [M.D.], osteópatas [D.O.], enfermeros, asistentes médicos, psicólogos u otros profesionales de la salud cuyos servicios serían elegibles para solicitar un reembolso si se envían para reembolso conforme al Plan médico).
- Sedgwick debe aprobar su reclamación.

Sedgwick puede exigir una prueba escrita de su discapacidad, tal como se describe en la siguiente página, o información adicional antes de tomar una decisión sobre su reclamación. La declaración de su médico de que está discapacitado para trabajar no demuestra por sí misma que esté discapacitado.

BENEFICIOS EXIGIDOS POR LEY	
Si usted es un asociado asalariado que trabaja en Colorado, Connecticut, Massachusetts, Oregón, Washington, D.C. o el estado de Washington	Usted es elegible para participar en el plan de discapacidad a corto plazo para asociados asalariados de Walmart para complementar los beneficios estatales. El monto del beneficio del plan de discapacidad a corto plazo para asociados asalariados se reducirá según el monto del beneficio exigido por ley que Sedgwick estima que usted tiene derecho a recibir del estado o la localidad, independientemente de que solicite o no ese beneficio exigido por ley. Si el beneficio disponible para usted conforme a cualquier programa obligatorio estatal o local es menor que el beneficio disponible para usted conforme a un plan de discapacidad a corto plazo de Walmart, el total combinado del beneficio disponible para usted del programa de discapacidad a corto plazo de Walmart y el beneficio disponible para usted mediante cualquier plan obligatorio estatal o local no excederá los beneficios que habrían estado disponibles conforme al plan de discapacidad a corto plazo de Walmart, si no hubiera trabajado en un estado o una localidad con un plan obligatorio legal. Usted será responsable de proporcionar a Sedgwick la carta de determinación del estado o la localidad. Si Sedgwick sobrestimó lo que sería su beneficio exigido por ley, lo que significa que se le pagó un monto menor del que debía recibir en virtud del plan de discapacidad a corto plazo para asociados asalariados, se le pagará la diferencia en un pago único. Si Sedgwick subestimó lo que sería su beneficio exigido por ley, lo que significa que se le pagó un monto mayor del que debía recibir en virtud del plan de discapacidad a corto plazo para asociados asalariados, deberá devolver dicho excedente. Consulte la sección **Derecho de recuperar un pago excesivo** más adelante en este capítulo.

Asimismo, la aprobación de una licencia de ausencia no constituye la aprobación para recibir beneficios por discapacidad a corto plazo.

A menos que se estipule lo contrario en la sección de **Beneficios de maternidad**, para fines de los beneficios proporcionados por el plan de discapacidad a corto plazo, "discapacitado" o "discapacidad" significa que (i) no puede realizar las tareas esenciales de su trabajo para su horario normal de trabajo, o que se le ha suspendido una licencia necesaria para sus tareas laborales debido a una enfermedad o lesión mental o física, o a un embarazo, y (ii) está bajo el cuidado continuo de un médico calificado y está siguiendo el curso del tratamiento recetado por su médico.

Los beneficios por discapacidad se pagan durante el periodo en que haya perdido la licencia solo mientras dure su discapacidad y mientras se logra el restablecimiento oportuno de la licencia. "Restablecimiento oportuno de la licencia" significa que usted lo solicita cuando su estado cumple con los criterios correspondientes y proporciona la información y los formularios requeridos por la agencia que la otorga de manera oportuna hasta que la licencia se restablezca. Únicamente la pérdida de la licencia no es suficiente para adecuarse a la definición de discapacidad.

Si está empleado como piloto, copiloto o miembro de la tripulación de una aeronave, "discapacidad" o "discapacitado" significa que, como resultado de una lesión o enfermedad física o mental, no puede realizar las tareas materiales y sustanciales de su propia ocupación conforme a las normas de aptitud aplicables de la Administración Federal de Aviación.

Sedgwick determinará su discapacidad en función de evidencia médica objetiva, la cual consta de hechos y conclusiones, incluidos, entre otros, radiografías, informes de laboratorio, pruebas, informes realizados por el médico tratante, así como también informes y notas que realice su médico.

Si su discapacidad es causada por una enfermedad mental o abuso de sustancias, se le recomienda recibir tratamiento dentro de los 30 días de la primera fecha de ausencia por parte de un psicólogo, psiquiatra, consejero autorizado, consejero de drogas y alcohol, o trabajador social clínico que se especialice en salud mental y/o abuso de sustancias, y que tenga licencia conforme a la ley estatal. Consulte el capítulo **Recursos de asistencia para los asociados** para obtener información sobre los recursos que están disponibles si está experimentando los efectos de una enfermedad mental o abuso de sustancias.

Si Sedgwick solicita que lo examine un médico, debe asistir al examen para que pueda ser considerado para recibir los beneficios. Walmart pagará el costo de dicho examen.

La duración máxima de un periodo de discapacidad durante el cual se abonan los beneficios de discapacidad, incluso si la discapacidad es resultado de más de una causa, es de 25 semanas, tras el periodo de espera inicial de siete días calendario. Consulte también **Si regresa a trabajar y queda discapacitado nuevamente**.

Consulte la sección **Beneficios de maternidad** en este capítulo para obtener más detalles sobre el beneficio de maternidad.

Cuándo no se pagan los beneficios

Los beneficios por discapacidad a corto plazo no se pagarán por una enfermedad o lesión en los siguientes casos:

- Si la enfermedad o lesión se produjo antes de que su cobertura entrara en vigencia
- Si a usted no lo atiende ni trata un médico calificado
- Si es causada por participar en una insurrección, rebelión, disturbio o desorden civil
- Si es ocasionada porque usted comete o intenta cometer un delito (p. ej., agresión, violencia, delitos mayores o cualquier ocupación o actividad ilegal) o
- Resultante de la realización de cualquier trabajo remunerado o lucrativo relacionada con el trabajo fuera de Walmart.

Cuándo comienzan los beneficios

Si se aprueba su reclamación por discapacidad a corto plazo, los beneficios comenzarán, después de un periodo de espera de siete días calendario, en el octavo día calendario después de que comience su discapacidad. (No hay periodo de espera para las discapacidades relacionadas con el trabajo que califican para la compensación de trabajador a través de Walmart).

Para que su pago continúe durante el periodo de espera inicial de siete días calendario, puede utilizar tiempo libre pagado. Los beneficios por discapacidad a corto plazo para asociados asalariados comienzan el octavo día calendario luego del inicio de la discapacidad elegible. No debe utilizar el PTO más allá del periodo de espera inicial de siete días, a menos que lo permita la ley estatal, mientras la decisión de la reclamación esté pendiente o durante cualquier periodo para el que se aprueben los beneficios por discapacidad a corto plazo (consulte **Su pago después de presentar una reclamación** anteriormente en este capítulo para obtener información sobre el pago provisional que puede aplicarse después de su periodo de espera inicial de siete días calendario). Si más tarde se verifica que no es elegible para los beneficios por discapacidad a corto plazo, puede volver a utilizar el PTO por el tiempo que no haya sido pagado, conforme a la política de PTO. Es posible que tenga que reembolsar el PTO utilizado durante los días en los que se aprobaron los beneficios por discapacidad. Tras el reembolso, se restablecerá cualquier saldo de PTO.

Para obtener detalles específicos sobre la política de PTO, consulte **One.Walmart.com**.

Cómo calcular su beneficio

El monto de su beneficio por discapacidad a corto plazo se basa en:

- Su pago básico, tal como se define más abajo, a partir de su último día de trabajo, y
- La duración de su discapacidad.

A los fines del beneficio por discapacidad a corto plazo para asociados asalariados, el pago básico se define de la siguiente manera:

TIPO DE ASOCIADO	PAGO BÁSICO
Asociados exentos	Salario bruto
Asociados no exentos	Pago por hora multiplicado por las horas normales programadas para el periodo de pago

Si queda discapacitado y es elegible para recibir los beneficios por discapacidad a corto plazo, el plan de discapacidad a corto plazo para asociados asalariados paga los beneficios, tal como se describe aquí:

SU BENEFICIO DEL PLAN DE DISCAPACIDAD A CORTO PLAZO PARA ASOCIADOS ASALARIADOS		
Duración de su discapacidad	**Su beneficio es:**	
	Si su discapacidad no califica para la compensación para trabajadores a través de Walmart	**Si padece de una discapacidad relacionada con el trabajo que califica para la compensación para trabajadores a través de Walmart**
Hasta 7 semanas	Luego de un periodo de espera inicial de 7 días calendario, el 100 % de su pago básico por periodo de pago. Los beneficios de discapacidad comienzan el 8.° día calendario. Puede utilizar el PTO durante sus primeros 7 días calendario de discapacidad continua.	100 % de su pago básico por periodo de pago, sin periodo de espera inicial.
Más de 7 semanas, hasta 26 semanas	75 % de su salario base por periodo de pago. Por ejemplo, si su pago básico por periodo de pago (como se define arriba) es de $1,000, el 75 % de $1,000 es un beneficio de $750. Los beneficios a corto plazo se abonan a través de la nómina de Walmart sobre la base de un periodo de pago.	Los beneficios por la compensación para trabajadores se pagarán a la tarifa estatal correspondiente; los beneficios por discapacidad a corto plazo compensarán la diferencia de hasta el 75 % de su pago básico por periodo de pago. Por ejemplo, si su pago básico por periodo de pago es de $1,000 y la compensación para trabajadores paga el 66 % por su discapacidad, o $660, el plan de discapacidad a corto plazo pagará $90 adicionales por un beneficio total de $750. (Si la tarifa de compensación para trabajadores exigida por ley supera el 75 % de su pago básico, no recibirá beneficios por discapacidad a corto plazo).
Si se paga un beneficio por menos de una semana, su beneficio de discapacidad se basará en su pago básico dividido por su cronograma laboral regular por cada día en que se vio afectado por la discapacidad. Si está apto para regresar a trabajar después de un periodo de discapacidad a corto plazo y debe ausentarse del trabajo periódicamente por motivos relacionados con su discapacidad, notifique su situación a Sedgwick y su centro. Es posible que su tratamiento esté cubierto conforme a la reclamación por discapacidad a corto plazo previa por hasta 12 meses a partir de la fecha en que regresa a trabajar de su reclamación por discapacidad a corto plazo. Por lo general, el plan de discapacidad a corto plazo para asociados asalariados paga el 100 % de su pago básico por la duración de su licencia intermitente aprobada. No deberá utilizar el PTO para las ausencias.		
NOTA: En el caso de los asociados que son elegibles para recibir los beneficios exigidos por ley (según lo especificado en **Beneficios exigidos por ley** que aparece anteriormente en este capítulo), como así también los beneficios conforme al plan de discapacidad a corto plazo para asociados asalariados de Walmart, el monto del beneficio conforme al plan de discapacidad a corto plazo para asociados asalariados de Walmart se reducirá según el monto del beneficio exigido por ley que Sedgwick estima que recibirá.		

COMPENSACIÓN PARA TRABAJADORES Y BENEFICIOS DE DISCAPACIDAD A CORTO PLAZO

La compensación para trabajadores y los beneficios de discapacidad a corto plazo se realizan como pagos separados, excepto en los estados de Texas y Wyoming, donde el beneficio completo se incluye en el pago que recibe por parte de Walmart.

Si está recibiendo los beneficios de la compensación para trabajadores por una lesión o enfermedad no relacionada, cualquier beneficio de discapacidad a corto plazo para el que sea elegible se reducirá o compensará con los beneficios de compensación para trabajadores que pueda recibir.

Beneficio de maternidad

A continuación, se describen los beneficios por maternidad en virtud del plan de discapacidad a corto plazo para asociados asalariados:

BENEFICIO DE MATERNIDAD		
Duración del beneficio	**Su beneficio es:**	**Si es elegible para los beneficios exigidos por ley en Colorado; Connecticut; Massachusetts; Oregón; Washington D. C. y el estado de Washington:**
Hasta 9 semanas*	100 % de su pago básico luego de un periodo de espera inicial de 7 días calendario.	Los beneficios obligatorios por ley se abonan según la tarifa estatal o local aplicable; el beneficio de maternidad por discapacidad a corto plazo para asociados asalariados de Walmart se reducirá en función de los beneficios obligatorios por ley a las que tenga derecho.
	Los beneficios por maternidad conforme al plan de discapacidad a corto plazo para asociados asalariados comienzan el 8.° día calendario luego del inicio de la discapacidad elegible. Puede utilizar el PTO durante sus primeros 7 días calendario de discapacidad continua. Los beneficios se abonan a través de la nómina de Walmart sobre la base de un periodo de pago.	
*Puede ser elegible para recibir el pago por cuidado familiar y parental equivalente al 100 % de su pago básico. No puede recibir beneficios del pago por cuidado familiar y parental mientras recibe los beneficios por maternidad de discapacidad a corto plazo. Para obtener más información, consulte la póliza sobre la paga por cuidado familiar y parental en **One.Walmart.com**.		
NOTA: En el caso de los asociados que son elegibles para recibir los beneficios exigidos por ley (según lo especificado en **Beneficios exigidos por ley** que aparece anteriormente en este capítulo), como así también los beneficios conforme al plan de discapacidad a corto plazo para asociados asalariados, el monto del beneficio conforme al plan de discapacidad a corto plazo para asociados asalariados se reducirá según el monto del beneficio exigido por ley, independientemente de si ha solicitado los beneficios legalmente exigidos.		

Consulte la sección **Cuándo se es elegible para recibir los beneficios** para ver los requisitos generales aplicables a todos los beneficios de discapacidad de un plan de discapacidad a corto plazo, incluyendo el beneficio por maternidad. Existen algunas excepciones a estas reglas generales que se aplican al beneficio por maternidad. Tales excepciones se analizan en esta sección.

Si su discapacidad se debe a un embarazo, la fecha de su discapacidad suele ser el día del parto o hasta dos semanas antes. Si comienza su licencia por discapacidad a corto plazo durante este plazo, se considerará que cumple la definición de discapacidad para fines del beneficio de maternidad. Si comienza la licencia con más de dos semanas de antelación a la fecha prevista de parto, deberá aportar un comprobante médico objetivo que demuestre su discapacidad, tal y como se define en la sección **Cuándo se es elegible para recibir los beneficios**. Si está discapacitada, tal y como se define en tal sección, comenzará a recibir el beneficio de maternidad por discapacidad a corto plazo en la fecha en que se determine su discapacidad. El beneficio de maternidad no superará las nueve semanas en ningún caso.

Si no comienza su licencia por discapacidad a corto plazo en la fecha de parto, debe cumplir la definición de discapacidad del plan, tal y como se indica en la sección **Cuándo se es elegible para recibir los beneficios**. En tal caso, cualquier beneficio por discapacidad estará sujeto a las reglas aplicables a los beneficios por discapacidad no relacionados con la maternidad. En la medida en que tenga derecho a un beneficio de discapacidad, el mismo se determinaría de acuerdo con las reglas aplicables a la discapacidad a corto plazo no relacionada con la maternidad. No tendrá derecho al beneficio de maternidad que se describe en esta sección.

Si sufre complicaciones médicas durante el embarazo o el posparto y sigue satisfaciendo la definición de discapacitado después de las primeras nueve semanas de beneficios por maternidad, el plan de discapacidad a corto plazo le proporcionará beneficios por discapacidad del 75 % de su salario base a partir de la décima semana y hasta las 25 semanas de pago de beneficios.

Si se reincorpora al trabajo antes de recibir la totalidad del beneficio por maternidad y, posteriormente, vuelve a irse de licencia, no podrá reanudar el beneficio por maternidad a menos que aporte evidencia médica objetiva a Sedgwick que avale la determinación de que cumple la definición de discapacidad. Si no se aporta ninguna evidencia médica, perderá el resto del beneficio por maternidad.

NOTA: Para los asociados de los estados o localidades con beneficios obligatorios por ley, consulte la tabla **Beneficios exigidos por ley** anterior de este capítulo para la coordinación de los beneficios.

LOS IMPUESTOS Y SU BENEFICIO POR DISCAPACIDAD A CORTO PLAZO

La compañía proporciona los beneficios que se le pagan conforme al plan de discapacidad a corto plazo para asociados asalariados sin costo alguno. Dado que usted no realiza ningún aporte al plan de discapacidad a corto plazo para asociados asalariados y que no paga ningún impuesto por la cobertura que Walmart le proporciona, cualquier beneficio que se le abone está sujeto a impuestos; Walmart generalmente retiene impuestos federales, estatales, locales y del Seguro Social del importe de sus pagos de beneficios.

Walmart no puede garantizar las consecuencias fiscales específicas que surgirán cuando usted reciba los beneficios conforme al plan de discapacidad a corto plazo de Walmart. Walmart no brinda asesoramiento legal ni fiscal. Si necesita una respuesta en la que pueda confiar, puede consultar a un asesor fiscal.

DERECHO DE RECUPERAR UN PAGO EXCESIVO

Walmart tiene el derecho de cobrarle y usted debe pagar cualquier monto que se le haya pagado de más por beneficios de discapacidad a corto plazo como parte de este plan. Si no devuelve los montos pagados en exceso en el plazo previsto, Walmart deducirá primero estas cantidades de los pagos futuros por discapacidad (si los hay). Si se debe algún monto restante después de cualquier deducción de los futuros pagos por discapacidad, entonces Walmart puede, a su discreción, (i) tratar los montos pagados en exceso como salarios imponibles para usted (declarables en su formulario W-2), o (ii) deducir los montos pagados en exceso de su pago, en la medida permitida por la ley.

Cómo presentar una reclamación por discapacidad a corto plazo para un asociado asalariado

Si queda discapacitado, debe presentar de manera oportuna su reclamación para recibir los beneficios. Un retraso en la presentación podría dar lugar al pago retrasado del beneficio, a la interrupción de su salario o al rechazo de su reclamación. El momento y el proceso que debe seguir para presentar una reclamación de beneficios por discapacidad a corto plazo dependen de si el plan de discapacidad a corto plazo está disponible en su localidad (es decir, si se encuentra en un estado o localidad que ofrezca beneficios obligatorios por ley). Consulte las **Instrucciones para presentar** reclamaciones más abajo para obtener información sobre cómo presentar su reclamación.

PASO 1: Póngase en contacto con Sedgwick para solicitar una licencia. Independientemente del proceso que siga para presentar una reclamación de discapacidad a corto plazo ante el Plan, deberá ponerse en contacto con Sedgwick a través de **One.Walmart.com/LOA > mySedgwick** o llamando al **800-492-5678** para solicitar una licencia de ausencia en cuanto sepa que va a faltar al empleo debido a una enfermedad, lesión o embarazo. Sedgwick le enviará un paquete inicial en el que se encontrará la información que necesita y se describirán las medidas que debe tomar.

La política de licencia de ausencia no es un beneficio que se ofrece conforme al Plan ni es administrado como parte del beneficio de discapacidad a corto plazo para asociados asalariados, por lo que no se aborda aquí detalladamente. Consulte **One.Walmart.com** para obtener información específica sobre la política de licencias de ausencia.

NOTA: La aprobación de una licencia conforme a la política de licencias de Walmart no significa que se apruebe automáticamente su reclamación de discapacidad a corto plazo. Para obtener información, consulte **Cuándo comienzan los beneficios**.

PASO 2: Presentar una reclamación de discapacidad a corto plazo o de beneficios obligatorios por ley. Su reclamación de beneficios por discapacidad a corto plazo no puede procesarse completamente hasta que haya dejado de trabajar. Notifique a su gerente si su enfermedad o lesión está relacionada con su trabajo en Walmart a fin de iniciar una reclamación por la compensación para trabajadores.

NOTA: La fecha de presentación de su reclamación es la fecha en la que presenta su reclamación de incapacidad a Sedgwick. Para que Sedgwick inicie el examen de su reclamación, debe haber dejado de trabajar por completo. Si presenta su reclamación antes de la primera fecha de baja, Sedgwick comenzará a tramitarla a partir de la primera fecha de baja. Si presenta su solicitud a partir de la primera fecha de baja, Sedgwick comenzará a tramitarla a partir de la fecha comunicada.

Consulte el cuadro a continuación para obtener información detallada sobre dónde y cuándo presentar su reclamación

PASO 3: Informe al consultorio de su médico que se pondrá en contacto para solicitar información. Infórmele a su médico que se comunicarán con él para que complete un certificado médico y para pedirle que proporcione información médica objetiva, incluida la siguiente:

- Diagnóstico
- Fecha y duración prevista de la discapacidad
- Restricciones y limitaciones
- Conclusiones de exámenes cognitivos y/o físicos y resultados de pruebas
- Plan de tratamiento, y
- Notas de las consultas médicas.

Debe firmar un formulario que autorice a su médico a divulgar esta información. (Este formulario se incluirá en el paquete inicial que reciba de Sedgwick. Sin embargo, si presenta su reclamación en línea, se acepta una firma electrónica).

INSTRUCCIONES PARA PRESENTAR RECLAMACIONES

Su estado o localidad puede tener periodos de presentación únicos, lo que podría excluir los beneficios correspondientes a periodos anteriores a la fecha de su solicitud de beneficios. Le recomendamos encarecidamente que solicite los beneficios requerido por ley en su estado o localidad sin demora.

Estado o localidad	Elegibilidad	Administración de reclamaciones	Instrucciones de presentación
CO, CT, MA, OR, WA **Washington D. C.**	Si es elegible para el plan de discapacidad a corto plazo de Walmart como complemento a los beneficios obligatorios por ley	Estado o distrito de beneficios obligatorios por ley Sedgwick para beneficios complementarios y maternidad	**CO:** Visite **famli.colorado.gov** o llame al **866-263-2654** para obtener instrucciones **CT:** Visite **ctpaidleave.org** o llame al **877-499-8606** para obtener instrucciones **MA:** Visite **paidleave.mass.gov** llame al **833-344-7365** para obtener instrucciones **OR:** Visite **paidleave.oregon.gov** o llame al **833-854-0166** para obtener instrucciones **WA:** Visite **paidleave.wa.gov** o llame al **833-717-2273** para obtener instrucciones **D.C.:** Visite **dcpaidfamilyleave.dc.gov** o llame al **202-899-3700** para obtener instrucciones **Sedgwick:** Presente una reclamación ante Sedgwick dentro de los 90 días posteriores a la fecha en que su discapacidad haya comenzado; deberá facilitar la carta de determinación del estado o distrito que incluya los detalles de los beneficios estatales o del distrito. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.
Todos los demás	Si es elegible para el plan de discapacidad a corto plazo de Walmart	Sedgwick	Presente una reclamación con Sedgwick dentro de los 90 días de la fecha en que comienza la discapacidad. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.

PASO 4: Realice un seguimiento con su médico para asegurarse de que la información solicitada se envíe a Sedgwick. Cualquier retraso en el envío de la información a Sedgwick podría tener como resultado un retraso, o rechazo, en el procesamiento de su reclamación y el pago de los beneficios.

Es posible que se le exija una prueba por escrito de su discapacidad o información médica adicional antes de que comience el pago de sus beneficios.

Su pago después de presentar una reclamación

Sedgwick le enviará un paquete inicial cuando presente una reclamación. Tiene hasta la fecha médica de parto, especificada en su paquete inicial, para presentar la documentación médica necesaria. Para que su pago continúe durante el periodo de espera inicial de siete días calendario, puede utilizar tiempo libre pagado (PTO). Después de su periodo de espera inicial de siete días calendario, su pago continuará hasta la fecha de parto, este pago se conoce como "pago provisional". Si la documentación médica requerida no se aprobó, su pago se suspenderá después de su Fecha límite médica.

Si se aprueba su reclamación, la aprobación será efectiva a partir de la fecha de su discapacidad y el pago provisional que recibió después de su periodo de espera de siete días mientras su reclamación estaba pendiente contará para su beneficio de discapacidad.

Si se deniega su reclamación antes de la fecha de vencimiento del plazo de pago por motivos médicos porque no está discapacitado, según la definición del plan, se interrumpirá su pago provisional y Walmart iniciará las gestiones para recuperar el pago provisional que se le abonó mientras su reclamación estaba pendiente.

No recibirá pago provisional durante ningún periodo en el que se esté tomando una determinación sobre una reclamación por recaída/recurrente (consulte **Si regresa a trabajar y queda discapacitado nuevamente** más adelante en este capítulo).

Para obtener detalles específicos sobre la política de PTO, consulte **One.Walmart.com**.

Determinación de beneficios

Sedgwick tomará una decisión dentro de los 45 días posteriores a la recepción de la reclamación correctamente presentada. El tiempo para una decisión se puede extender por hasta dos periodos de 30 días adicionales. Se le notificará por escrito, antes de cualquier periodo de extensión, que se necesita una extensión debido a asuntos que están fuera del control de Sedgwick. Se deben identificar dichos asuntos y se le debe proporcionar la fecha en la que Sedgwick tomará una decisión. Si su reclamación se extiende debido a que usted no presenta la información que Sedgwick considera como necesaria para determinar su reclamación, el tiempo de decisión se suspenderá a partir de la fecha en la cual se le envía la notificación de la extensión hasta la fecha en que Sedgwick recibe su respuesta. Si Sedgwick aprueba su reclamación, la decisión contendrá información suficiente para informarle sobre esa decisión.

Si Sedgwick rechaza su reclamación, se le enviará una notificación por escrito sobre el rechazo, la cual incluirá lo siguiente:

- Razones específicas para la decisión
- Referencia específica a las disposiciones de la póliza en la cual se basa la decisión.
- Una descripción de cualquier material adicional o información necesaria para que usted sustente la reclamación y una explicación de por qué es necesario dicho material o información
- Una descripción de los procedimientos de revisión y límites de tiempo aplicables a tales procedimientos.
- Si la decisión se basó en una norma, una pauta, un protocolo interno u otro criterio similar para realizar el rechazo, ya sea:
  - La norma, la pauta, el protocolo u otros criterios similares particulares.
  - Una declaración de que la decisión se basó en dicha norma, pauta, protocolo o criterio similar para dictaminar el rechazo y que se le enviará una copia sin cargo cuando la solicite.

Para los asociados de estados o localidades con planes obligatorios por ley (Colorado, Connecticut, Massachusetts, Oregón, Washington D.C. y el estado de Washington), su estado o localidad especificará su proceso y plazos para tomar una decisión. Encontrará más información en el sitio web de su estado o distrito. Consulte la tabla **Recursos** al principio de este capítulo para ver la información de contacto.

CÓMO APELAR UNA RECLAMACIÓN DE DISCAPACIDAD QUE SE RECHAZÓ EN SU TOTALIDAD O EN PARTE

Si su reclamación de beneficios por discapacidad a corto plazo es denegada porque Sedgwick no ha recibido documentación médica objetiva que respalde su reclamación, o la documentación facilitada no respalda su reclamación, dispondrá de un periodo de gracia de 30 días calendario a partir de la fecha de la carta de denegación para presentar información médica a Sedgwick para su revisión sin necesidad de presentar una apelación. Una vez finalizado el periodo de gracia, si su reclamación sigue denegada y desea presentar una apelación, deberá seguir el procedimiento que se describe en esta sección.

Si se rechaza su reclamación para obtener los beneficios de discapacidad a corto plazo y desea apelar, debe enviar una apelación oral o por escrito a Sedgwick dentro de los 180 días posteriores al rechazo. Su reclamo deberá incluir comentarios, documentos, archivos o cualquier otra información que le gustaría que se considere.

Tiene derecho a solicitar copias, sin cargo, de todos los documentos, archivos u otra información relacionada con su reclamación. Independientemente de la determinación inicial, su apelación será revisada por una persona que no sea quien decidió sobre su reclamación inicial.

Sedgwick decidirá sobre su apelación dentro de los 45 días a partir de la recepción de su solicitud de apelación. Este periodo se puede extender hasta 45 días adicionales si se determina que circunstancias especiales requieren una prórroga. Si se requiere una prórroga, se lo notificarán antes de que finalice el periodo de 45 días. Si se le pide que suministre información adicional, tendrá 45 días a partir de la fecha en que se lo notifica para que proporcione la información y se suspenderá el

tiempo para tomar una determinación hasta que proporcione la información que se le solicitó (o la fecha límite para presentar la información, si es anterior).

Si se rechaza su apelación en su totalidad o en parte, recibirá una notificación por escrito sobre el rechazo que incluirá:

- Las razones específicas para la determinación desfavorable
- Referencia a las disposiciones específicas del plan en las cuales se basó la determinación
- Una declaración que establezca su derecho a solicitar copias, sin cargo, de todos los documentos, archivos u otra información relacionada con su reclamación
- Una declaración en la cual se establece que usted tiene derecho a obtener, cuando la solicite y sin cargo, una copia de las normas o pautas internas en las cuales se basaron para tomar la determinación y
- Una declaración que describa los procedimientos de apelación ofrecidos por el Plan.

SEGUNDA APELACIÓN VOLUNTARIA DE UNA RECLAMACIÓN POR DISCAPACIDAD A CORTO PLAZO PARA ASOCIADOS ASALARIADOS

Si se rechaza su apelación, puede realizar una segunda apelación voluntaria de su rechazo de manera oral o por escrito a Sedgwick. Debe presentar su segunda apelación dentro de los 180 días luego de recibir la notificación escrita del rechazo de su primera apelación. Puede presentar comentarios por escrito, documentos, archivos y cualquier otra información relacionada con su reclamación. Por lo general, los mismos criterios y tiempos de respuesta que se aplicaron a su primera apelación se aplican a esta segunda apelación voluntaria, tal como se describe anteriormente.

Todas las apelaciones de discapacidad a corto plazo para asociados asalariados (apelaciones iniciales y segundas apelaciones voluntarias) deben enviarse a:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

Para los asociados de estados o localidades con planes obligatorios por ley (Colorado, Connecticut, Massachusetts, Oregón, Washington D.C. y el estado de Washington), su estado o localidad especificará su proceso y plazos para tomar una decisión, si corresponde. Encontrará más información en el sitio web de su estado o distrito. Consulte la tabla de **Recursos** al principio de este capítulo para ver la información de contacto.

Cuándo finalizan los beneficios por discapacidad a corto plazo

Si está recibiendo pagos de beneficios por discapacidad a corto plazo del plan de discapacidad a corto plazo para asociados asalariados, los pagos de sus beneficios terminarán de acuerdo con lo que ocurra primero:

- Cuando deje de coincidir con la definición de discapacidad del plan para la discapacidad a corto plazo.
- Cuando no presente las pruebas necesarias de discapacidad cuando lo solicite Sedgwick.
- Cuando usted ya no esté bajo la atención y el tratamiento permanentes de un médico calificado.
- Cuando se niegue a someterse a examen, si Sedgwick así lo exigiera.
- El último día de su periodo máximo en el cual los beneficios son abonables
- El día en que esté médicamente apto y calificado para trabajar en un puesto a tiempo completo similar que Walmart le ofrezca
- La fecha en que finaliza su relación laboral, o
- La fecha de su fallecimiento.

Si sus beneficios por discapacidad a corto plazo finalizan y no regresa a trabajar por cualquier motivo, debe solicitar una extensión de su licencia (consulte la tabla **Recursos** al comienzo del capítulo para obtener información de contacto). Si no lo hace, es posible que se le despida.

Los beneficios proporcionados bajo un programa obligatorio estatal o local pueden tener fechas de finalización diferentes a las del plan de discapacidad a corto plazo de Walmart.

Volver al trabajo tras una licencia

Sedgwick se pondrá en contacto con usted antes de la fecha de regreso al trabajo prevista y le informará los pasos que deberá seguir, incluso cómo obtener un certificado médico para regresar a trabajar. En algunos casos, es posible que su médico le dé el alta para regresar a trabajar con ciertas restricciones médicas; dichas restricciones deben estar explícitamente establecidas en el certificado para regresar a trabajar o en el alta por escrito. Si recibe un certificado para regresar a trabajar que incluye restricciones médicas, es posible que esté sujeto a una revisión para determinar si una modificación a su trabajo o una adaptación ayudará a que pueda regresar a trabajar.

Deberá ponerse en contacto con Sedgwick **hasta siete días antes de la fecha real de vuelta al trabajo para garantizar una transición fluida para volver al trabajo y evitar una posible repercusión en su salario.** Si su fecha de reincorporación al trabajo cambia, debe notificarlo inmediatamente a Sedgwick. Si sus beneficios de discapacidad a corto plazo terminaron y no regresó a trabajar ni comunicó sus intenciones, Sedgwick le notificará sus opciones, las cuales incluyen la solicitud de una extensión de su licencia o la renuncia voluntaria a su empleo. Si no solicita una extensión, es posible que su relación laboral finalice.

SI REGRESA A TRABAJAR Y QUEDA DISCAPACITADO NUEVAMENTE

Si regresa a trabajar por 30 días calendario o menos y está clasificado como asociado de la gerencia en estado activo (con o sin restricciones médicas) y queda discapacitado nuevamente por la misma enfermedad u otra afección relacionada que había causado el primer periodo de discapacidad, tal como lo define Sedgwick como un "reclamación por recaída/recurrente", sus beneficios por discapacidad a corto plazo continuarán a partir de donde habían quedado antes de que volviera a trabajar. No deberá cumplir un periodo de espera adicional de siete días calendario. La duración del beneficio combinado para ambos periodos de discapacidad no superará las 25 semanas.

Si ha vuelto a trabajar como asociado gerencial y está en estado activo durante más de 30 días calendario y, posteriormente, queda discapacitado por la misma causa o por una causa relacionada, se considerará una nueva discapacidad y podrá recibir hasta 25 semanas de beneficios tras haber satisfecho un nuevo periodo de espera de siete días calendario.

Si regresa como asociado de la gerencia y está en estado activo por cualquier cantidad de días calendario y luego queda discapacitado por una nueva causa no relacionada, se considerará una nueva discapacidad y podría tener hasta un máximo de 25 semanas de beneficios. Se aplicará un nuevo periodo de espera de beneficios de siete días calendario.

Licencia intermitente. Si está apto para regresar a trabajar después de un periodo de discapacidad a corto plazo y debe ausentarse del trabajo periódicamente por motivos relacionados con su discapacidad, notifique su situación a Sedgwick y su centro. Es posible que su tratamiento esté cubierto conforme a la reclamación por discapacidad a corto plazo previa por hasta 12 meses a partir de la fecha en que regresa a trabajar de su reclamación por discapacidad a corto plazo. Por lo general, el plan de discapacidad a corto plazo para asociados asalariados paga el 100 % de su pago básico por la duración de su licencia intermitente aprobada. No deberá utilizar el PTO para las ausencias.

Si está con licencia de ausencia o sujeto a cesantía temporal

Si no está en estado activo debido a una licencia o a una cesantía temporal, su derecho a los beneficios por discapacidad a corto plazo continuará durante 90 días a partir del inicio de su licencia o cesantía temporal. Su elegibilidad para la cobertura por discapacidad a corto plazo finalizará el día 91 después del inicio de su licencia de ausencia o cesantía temporal, pero será restablecida si regresa a trabajar dentro del plazo de un año. Para obtener más información, consulte **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**, que incluye detalles sobre el pago de los beneficios durante una licencia.

Cuándo finaliza la cobertura por discapacidad a corto plazo para asociados asalariados

Su cobertura de discapacidad a corto plazo finaliza en la fecha más temprana de:

- La fecha en que finaliza su relación laboral
- El último día del periodo de pago en que su estado laboral cambia de un estado laboral elegible
- La fecha de su fallecimiento
- El día 91 de una licencia o cesantía (a menos que se reincorpore al trabajo), o
- La fecha en la que Walmart deja de ofrecer el beneficio.

Si deja Walmart y lo contratan nuevamente

Si deja Walmart y regresa a trabajar para esta como asociado asalariado, quedará automáticamente reinscrito en el plan de discapacidad a corto plazo para asociados asalariados.

Plan de discapacidad a corto plazo para conductores de camión

La información de este capítulo describe los beneficios por discapacidad a corto plazo a los que puede acceder si:

- Usted es un asociado conductor de camión a tiempo completo, y
- Ha cumplido todos los requisitos para que la cobertura sea efectiva, incluidos los requisitos de trabajo activo.

Si tiene preguntas sobre los requisitos de elegibilidad, los requisitos para que la cobertura sea efectiva y la repercusión en sus beneficios de un cambio en su clasificación laboral, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

El plan de discapacidad a corto plazo para conductores de camión no es un beneficio ofrecido en el marco del Plan de salud y bienestar para asociados (AHWP) de Walmart Inc. y no está sujeto a la Ley de Garantía de Ingresos por Jubilación para los Empleados de 1974 (ERISA).

Esta información no crea un contrato de trabajo explícito ni implícito, ni cualquier otro compromiso contractual. Walmart puede modificar esta información a su exclusivo criterio sin previo aviso y en cualquier momento, de conformidad con la ley correspondiente.

Plan de discapacidad a corto plazo para conductores de camión

Si no trabaja por un periodo prolongado debido a que está embarazada, se sometió a una cirugía programada, tiene una enfermedad o sufrió una lesión inesperada, este plan para conductores de camión puede sustituir una parte de su pago. Cuando no puede trabajar, el plan de discapacidad a corto plazo para conductores de camión de Walmart trabaja por usted.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Para solicitar una licencia, presentar una reclamación de beneficios u obtener más información	Visite **One.Walmart.com/LOA > mySedgwick**	Llame a Sedgwick al **800-492-5678**
Si trabaja en uno de los estados o localidades que se mencionan a continuación, presente una reclamación ante Sedgwick además de hacerlo ante el estado o localidad. Consulte la sección **Beneficio de maternidad** más adelante en este capítulo para obtener información sobre el beneficio de maternidad.		
Colorado	Visite **famli.colorado.gov**	Llame al **866-263-2654**
Connecticut	Visite **ctpaidleave.org**	Llame al **877-499-8606**
Massachusetts	Visite **paidleave.mass.gov**	Llame al **833-344-7365**
Oregon	Visite **paidleave.oregon.gov**	Llame al **833-854-0166**
Washington D. C.	Visite **dcpaidfamilyleave.dc.gov**	Llame al **202-899-3700**
Estado de Washington	Visite **paidleave.wa.gov**	Llame al **833-717-2273**
Solicite una apelación de una reclamación por discapacidad a corto plazo rechazada	Visite **One.Walmart.com/LOA > mySedgwick**	Llame a Sedgwick al **800-492-5678**

Lo que debe saber sobre el plan de discapacidad a corto plazo para conductores de camión

- En este capítulo se describen los beneficios de discapacidad que le ofrece el plan de discapacidad a corto plazo.
- El plan de discapacidad a corto plazo para conductores de camión sustituye el 75 % de su salario promedio diario durante un máximo de 25 semanas, tras un periodo de espera inicial de siete días calendario. (Las discapacidades que dan derecho a compensación para trabajadores a través de Walmart se tratan de forma diferente, como se describe en la tabla titulada **Su beneficio del plan de discapacidad a corto plazo para conductores de camión**).
- Si su discapacidad se debe a un embarazo, el plan de discapacidad a corto plazo sustituye el 100 % de su salario promedio diario por hasta nueve semanas. Es posible que se paguen beneficios adicionales después de las primeras nueve semanas de beneficios si experimenta complicaciones médicas durante el embarazo o después del parto. Para obtener más información, consulte **Beneficio de maternidad** más adelante en este capítulo.
- El plan de discapacidad a corto plazo para conductores de camión no está sujeto a ERISA y no se ofrece conforme al Plan de salud y bienestar para asociados.
- Los procedimientos de reclamaciones y apelaciones descritos en este capítulo aplican al beneficio de discapacidad a corto plazo para conductores de camión en lugar de los procedimientos establecidos en el capítulo **Reclamaciones y apelaciones**.

Su beneficio por discapacidad a corto plazo

Si queda discapacitado como se define en la sección **Cuándo se es elegible para recibir los beneficios** más adelante en este capítulo y es elegible para recibir los beneficios por discapacidad a corto plazo, el plan de discapacidad a corto plazo para conductores de camión, por lo general, paga el 75 % de su pago diario promedio por hasta 25 semanas de un reclamo por discapacidad aprobado, luego de un periodo de espera inicial de siete días calendario de discapacidad continua. El periodo de espera comienza en su próximo día de trabajo programado luego de que comienza su discapacidad. (Las discapacidades que califican para la compensación de trabajador a través de Walmart se consideran de manera diferente, tal como se describe en la tabla **Su beneficio del plan de discapacidad a corto plazo para conductores de camión**).

Si su discapacidad se debe a un embarazo, el plan de discapacidad a corto plazo para conductores de camión paga un beneficio de maternidad del 100 % de su pago diario promedio por hasta las primeras nueve semanas, luego de un periodo de espera inicial de siete días calendario. El periodo de espera comienza en su próximo día de trabajo programado luego de que comienza su discapacidad. Si permanece discapacitado y es elegible para los beneficios después de las primeras nueve semanas de pagos por discapacidad, el plan de discapacidad a corto plazo para conductores de camión pagará el 75 % de su pago básico por hasta 16 semanas adicionales.

Cómo se administra el plan por discapacidad a corto plazo para conductores de camión

La cobertura por discapacidad a corto plazo para conductores de camión es administrada por Sedgwick Claims Management Services, Inc. (Sedgwick) y es proporcionada por Walmart sin costo alguno.

BENEFICIOS EXIGIDOS POR LEY

Los beneficios por discapacidad a corto plazo proporcionados por los estados individuales y los gobiernos locales no suelen afectar su elegibilidad para el plan de beneficios por discapacidad a corto plazo para conductores de camión a través de Walmart, a menos que sea un asociado que trabaje en Colorado, Connecticut, Massachusetts, Oregón, Washington, D.C. o el estado de Washington. La siguiente tabla contiene las reglas aplicables a estos planes estatales y locales.

BENEFICIOS EXIGIDOS POR LEY	
Si usted es un asociado que trabaja en Colorado, Connecticut, Massachusetts, Oregón, Washington, D.C. o el estado de Washington	Usted es elegible para participar en el plan de discapacidad a corto plazo para conductores de camión para complementar los beneficios estatales. El monto del beneficio del plan de discapacidad a corto plazo para conductores de camión se reducirá según el monto del beneficio exigido por ley que Sedgwick estima que usted tiene derecho a recibir del estado o la localidad, independientemente de que solicite o no ese beneficio exigido por ley. Si el beneficio disponible para usted conforme a cualquier programa obligatorio estatal o local es menor que el beneficio disponible para usted conforme a un plan de discapacidad a corto plazo de Walmart, el total combinado del beneficio disponible para usted del programa de discapacidad a corto plazo de Walmart y el beneficio disponible para usted mediante cualquier plan obligatorio estatal o local no excederá los beneficios que habrían estado disponibles conforme al programa de discapacidad a corto plazo si no hubiera trabajado en un estado con un plan obligatorio legal. Usted es responsable de proporcionar a Sedgwick una carta de determinación del estado o la localidad. Si Sedgwick sobrestimó lo que sería su beneficio exigido por ley, lo que significa que se le pagó un monto menor del que debía recibir en virtud del plan de discapacidad a corto plazo para asociados asalariados, se le pagará la diferencia en un pago único. Si Sedgwick subestimó lo que sería su beneficio exigido por ley, lo que significa que se le pagó un monto mayor del que debía recibir en virtud del plan de discapacidad a corto plazo para conductores de camión, deberá devolver dicho excedente. Consulte la sección **Derecho de recuperar un pago excesivo** más adelante en este capítulo.

Cuándo se es elegible para recibir los beneficios

A fin de ser elegible para recibir los beneficios por discapacidad a corto plazo, deben cumplirse las siguientes condiciones:

- Su cobertura debe ser efectiva.
- Su discapacidad debe haberse producido en la fecha de entrada en vigencia de su cobertura o después.
- Debe estar en estado activo en la fecha que queda discapacitado, a menos que:
  - Está en licencia o cesantía como se describe más adelante en este capítulo en **Si está con licencia de ausencia o sujeto a cesantía temporal**, o
  - No se encuentre trabajando activamente porque experimenta complicaciones médicas durante el embarazo o después del parto, y ha agotado el periodo de beneficio de maternidad del plan de discapacidad a corto plazo de nueve semanas, como se describe más adelante en este capítulo, en **Beneficio de maternidad**.
- Excepto que se disponga lo contrario en la sección de **Beneficios de maternidad** debe presentar evidencia médica provista por un médico calificado que dé fe de que usted se encuentra discapacitado según la definición a continuación (a los efectos de este capítulo, el término "médico" incluye todo médico y profesional de la salud con licencia vigente que no tiene parentesco con usted y presta servicios dentro del alcance de su licencia; esto incluye médicos [M.D.], osteópatas [D.O.], enfermeros, asistentes médicos, psicólogos u otros profesionales de la salud cuyos servicios serían elegibles para solicitar un reembolso conforme al Plan médico).
- Sedgwick debe aprobar su reclamación.

Sedgwick puede exigir una prueba escrita de su discapacidad, tal como se define más adelante en este capítulo, o información adicional antes de tomar una decisión sobre su reclamación. La declaración de su médico de que está discapacitado para trabajar no demuestra por sí misma que esté discapacitado. Asimismo, la aprobación de una licencia de ausencia no constituye la aprobación para recibir beneficios por discapacidad a corto plazo.

A menos que se estipule lo contrario en la sección de **Beneficios de maternidad**, para fines de los beneficios proporcionados por el plan de discapacidad a corto plazo, "discapacitado" o "discapacidad" significa que (i) no puede realizar las tareas esenciales de su trabajo para su horario normal de trabajo, o que se le ha suspendido una licencia necesaria para sus tareas laborales debido a una enfermedad o lesión mental o física, de conformidad con las regulaciones de la Administración Federal de Seguridad de Autotransportistas, o a un embarazo, y (ii) está bajo el cuidado continuo de un médico calificado y está siguiendo el curso del tratamiento recetado por su médico. Consulte la sección **Beneficios de maternidad** para conocer las excepciones a este requisito general para fines del beneficio de maternidad.

> Los beneficios por discapacidad se pagan durante el periodo en que haya perdido la licencia solo mientras dure su discapacidad y mientras se logra el restablecimiento oportuno de la licencia. "Restablecimiento oportuno de la licencia" significa que usted lo solicita cuando su estado cumple con los criterios correspondientes y proporciona la información y los formularios requeridos por la agencia que la otorga de manera oportuna hasta que la licencia se restablezca. Únicamente la pérdida de la licencia no es suficiente para adecuarse a la definición de discapacidad. Sedgwick determinará su discapacidad en función de evidencia médica objetiva, la cual consta de hechos y conclusiones, incluidos, entre otros, radiografías, informes de laboratorio, pruebas, informes realizados por el médico tratante, así como también informes y notas que realice su médico.
>
> Si su discapacidad es causada por una enfermedad mental o abuso de sustancias, se le recomienda recibir tratamiento dentro de los 30 días de la primera fecha de ausencia por parte de un psicólogo, psiquiatra, consejero autorizado, consejero de drogas y alcohol, o trabajador social clínico que se especialice en salud mental y/o abuso de sustancias, y que tenga licencia conforme a la ley estatal. Consulte el capítulo **Recursos de asistencia para los asociados** para obtener información sobre los recursos que están disponibles si está experimentando los efectos de una enfermedad mental o abuso de sustancias.

Si Sedgwick solicita que lo examine un médico, debe asistir al examen para que pueda ser considerado para recibir los beneficios. Walmart pagará el costo de dicho examen.

La duración máxima de un periodo de discapacidad durante el cual se abonan los beneficios de discapacidad, incluso si la discapacidad es resultado de más de una causa, es de 25 semanas, tras el periodo de espera inicial de siete días calendario. Consulte también **Si regresa a trabajar y queda discapacitado nuevamente**.

Consulte la sección de **Beneficios de maternidad** para obtener más detalles sobre el beneficio de maternidad.

Cuándo no se pagan los beneficios

Los beneficios por discapacidad a corto plazo no se pagarán por una enfermedad o lesión en los siguientes casos:

- Si la enfermedad o lesión se produjo antes de que su cobertura entrara en vigencia
- Si a usted no lo atiende ni trata un médico calificado
- Si es causada por participar en una insurrección, rebelión, disturbio o desorden civil
- Si es ocasionada porque usted comete o intenta cometer un delito (p. ej., agresión, violencia, delitos mayores o cualquier ocupación o actividad ilegal) o
- Resultante de la realización de cualquier trabajo remunerado o lucrativo relacionada con el trabajo fuera de Walmart.

Cuándo comienzan los beneficios

Si se aprueba su reclamación de discapacidad a corto plazo, el beneficio comenzará tras un periodo de espera de siete días calendario. El periodo de espera comienza en su próximo día de trabajo programado luego de que comienza su discapacidad. (Las discapacidades relacionadas con el trabajo que califiquen para la compensación de trabajador a través de Walmart pueden tener periodos de espera diferentes conforme a la ley estatal).

Para que su pago continúe durante el periodo de espera inicial de siete días calendario, puede utilizar tiempo libre pagado. Los beneficios por discapacidad a corto plazo para asociados asalariados comienzan el octavo día calendario luego del inicio de la discapacidad elegible. No debe utilizar el PTO más allá del periodo de espera inicial de siete días mientras la decisión de la reclamación esté pendiente o durante cualquier periodo para el que se aprueben los beneficios por discapacidad a corto plazo, a menos que lo permita la ley estatal (consulte **Su pago después de presentar una reclamación** anteriormente en este capítulo para obtener información sobre el pago provisional que puede aplicarse después de su periodo de espera inicial de siete días calendario). Si más tarde se verifica que no es elegible para los beneficios por discapacidad a corto plazo, puede volver a utilizar el PTO por el tiempo que no haya sido pagado, conforme a la política de PTO. Es posible que tenga que reembolsar el PTO utilizado durante los días en los que se aprobaron los beneficios por discapacidad. Tras el reembolso, se restablecerá cualquier saldo de PTO.

Para obtener detalles específicos sobre la política de PTO, consulte **One.Walmart.com**.

Cómo calcular su beneficio

El monto de su beneficio por discapacidad a corto plazo se basa en:

- Su pago diario promedio a partir de su último día trabajado.
- La duración de su discapacidad.

Si queda discapacitado y es elegible para recibir los beneficios por discapacidad a corto plazo, el plan de discapacidad a corto plazo para conductores de camión reemplaza el 75 % de su pago diario promedio a partir del último día previo a su discapacidad por hasta 25 semanas, luego de un periodo de espera inicial de siete días calendario. No hay un beneficio semanal máximo conforme al plan de discapacidad a corto plazo para conductores de camión.

Si queda discapacitado y es elegible para recibir los beneficios por discapacidad a corto plazo, el plan de discapacidad a corto plazo para conductores de camión paga los beneficios, tal como se describe aquí.

SU BENEFICIO DEL PLAN DE DISCAPACIDAD A CORTO PLAZO PARA CONDUCTORES DE CAMIÓN

Duración de su discapacidad	Su beneficio es:	
	Si su discapacidad no califica para la compensación para trabajadores a través de Walmart	**Si padece de una discapacidad relacionada con el trabajo que califica para la compensación para trabajadores a través de Walmart**
Hasta 26 semanas	Luego de un periodo de espera inicial de 7 días calendario, 75 % de su pago diario promedio. El periodo de espera comienza en su próximo día de trabajo programado luego de que comience su discapacidad total. Puede utilizar el PTO durante sus primeros 7 días calendario de discapacidad continua. Por ejemplo, si su pago diario promedio durante la semana suma un total de $1,000, el 75 % de $1,000 es un beneficio semanal de $750. Los beneficios a corto plazo se abonan a través de la nómina de Walmart sobre la base de un periodo de pago.	75 % de su pago diario promedio. El beneficio de discapacidad a corto plazo pagará el 75 % durante el periodo de espera de compensación para trabajadores estatal; por lo tanto, la compensación para trabajadores pagará en función de la tarifa de compensación del estado. El beneficio de discapacidad a corto plazo "completará" este pago al 75 %. Si la tarifa de compensación del estado es mayor que el 75 %, no recibirá beneficios adicionales por parte de Sedgwick. Por ejemplo, si su beneficio por compensación para trabajadores o su beneficio anticipado es el 66 %, el beneficio por discapacidad a corto plazo proporcionará el 9 % de su salario. Los beneficios de discapacidad a corto plazo se pagan a través de la nómina de Walmart sobre una base del periodo de pago, mientras que la compensación de trabajador se paga a través de un cheque por separado, excepto en los estados de Texas y Wyoming, donde el beneficio completo se incluye en el pago que recibe por parte de Walmart.
Si se paga un beneficio por menos de una semana, su beneficio de discapacidad se basará en el 75 % de su pago diario promedio multiplicado por sus días laborales regulares programados por cada día en que se vio afectado por la discapacidad. Si está apto para regresar a trabajar después de un periodo de discapacidad a corto plazo y debe ausentarse del trabajo periódicamente por motivos relacionados con su discapacidad, notifique su situación a Sedgwick y su centro. Es posible que su tratamiento esté cubierto conforme a la reclamación por discapacidad a corto plazo previa por hasta 12 meses a partir de la fecha en que regresa a trabajar de su reclamación por discapacidad a corto plazo. Por lo general, el plan de discapacidad a corto plazo para conductores de camión paga el 100 % de su pago diario promedio por la duración de su licencia intermitente aprobada. No deberá utilizar el PTO para las ausencias.		
NOTA: En el caso de los asociados que reúnen los requisitos para recibir los beneficios exigidos por ley (según lo especificado en **Beneficios exigidos por ley** que aparece anteriormente en este capítulo), como así también los beneficios conforme al plan de discapacidad a corto plazo para conductores de camión, el monto del beneficio conforme al plan de discapacidad a corto plazo para conductores de camión se reducirá según el monto del beneficio exigido por ley.		

COMPENSACIÓN PARA TRABAJADORES Y BENEFICIOS DE DISCAPACIDAD A CORTO PLAZO

La compensación para trabajadores y los beneficios de discapacidad a corto plazo se realizan como pagos separados, excepto en los estados de Texas y Wyoming, donde el beneficio completo se incluye en el pago que recibe por parte de Walmart.

Si está recibiendo los beneficios de la compensación para trabajadores por una lesión o enfermedad no relacionada, cualquier beneficio de discapacidad a corto plazo para el que sea elegible se reducirá o compensará con los beneficios de compensación para trabajadores que pueda recibir.

BENEFICIO DE MATERNIDAD

Los beneficios por maternidad en virtud del plan de discapacidad a corto plazo para conductores de camión se otorgan de la siguiente manera:

<table>
<tr><th colspan="3">BENEFICIO DE MATERNIDAD</th></tr>
<tr><th>Duración del beneficio</th><th>Su beneficio es:</th><th>Si es elegible para los beneficios exigidos por ley en Colorado; Connecticut; Massachusetts; Oregón; Washington D. C. y el estado de Washington:</th></tr>
<tr><td rowspan="2">Hasta 9 semanas*</td><td>100 % de su pago diario promedio luego de un periodo de espera inicial de 7 días calendario.</td><td>Los beneficios obligatorios por ley se abonan según la tarifa estatal o local aplicable; el beneficio de maternidad por discapacidad a corto plazo para asociados que sean conductores de camión de Walmart se reducirá en función de los beneficios obligatorios por ley a las que tenga derecho.</td></tr>
<tr><td colspan="2">Los beneficios por maternidad conforme al plan de discapacidad a corto plazo para conductores de camión comienzan el 8.° día calendario luego del inicio de la discapacidad elegible. Puede utilizar el PTO durante sus primeros 7 días calendario de discapacidad continua. Los beneficios se abonan a través de la nómina de Walmart sobre la base de un periodo de pago.</td></tr>
<tr><td colspan="3">*También puede ser elegible para recibir un pago por cuidado familiar y parental adicional equivalente al 100 % de su pago diario promedio. No puede recibir beneficios del pago por cuidado familiar y parental mientras recibe los beneficios por maternidad de discapacidad a corto plazo. Para obtener más información, consulte la póliza sobre la paga por cuidado familiar y parental en One.Walmart.com.</td></tr>
<tr><td colspan="3">NOTA: En el caso de los asociados que son elegibles para recibir los beneficios exigidos por ley (según lo especificado en Beneficios exigidos por ley que aparece anteriormente en este capítulo), como así también los beneficios conforme al plan de discapacidad a corto plazo para conductores de camión, el monto del beneficio conforme al plan de discapacidad a corto plazo para conductores de camión se reducirá según el monto del beneficio exigido por ley, independientemente de si ha solicitado los beneficios legalmente exigidos.</td></tr>
</table>

Consulte la sección **Cuándo se es elegible para recibir los beneficios** para ver los requisitos generales aplicables a todos los beneficios de discapacidad de un plan de discapacidad a corto plazo, incluyendo el beneficio por maternidad. Existen algunas excepciones a estas reglas generales que se aplican al beneficio por maternidad. Tales excepciones se analizan en esta sección.

Si su discapacidad se debe a un embarazo, la fecha de su discapacidad suele ser el día del parto o hasta dos semanas antes. Si comienza su licencia por discapacidad a corto plazo durante este plazo, se considerará que cumple la definición de discapacidad para fines del beneficio de maternidad. Si comienza la licencia con más de dos semanas de antelación a la fecha prevista de parto, deberá aportar un comprobante médico objetivo que demuestre su discapacidad, tal y como se define en la sección **Cuándo se es elegible para recibir los beneficios**. Si está discapacitada, tal y como se define en tal sección, comenzará a recibir el beneficio de maternidad por discapacidad a corto plazo en la fecha en que se determine su discapacidad. El beneficio de maternidad no superará las nueve semanas en ningún caso.

Si no comienza su licencia por discapacidad a corto plazo en la fecha de parto, debe cumplir la definición de discapacidad del plan, tal y como se indica en la sección **Cuándo se es elegible para recibir los beneficios**. En tal caso, cualquier beneficio por discapacidad estará sujeto a las reglas aplicables a los beneficios por discapacidad no relacionados con la maternidad.

Si sufre complicaciones médicas durante el embarazo o el posparto y sigue satisfaciendo la definición de discapacidad después de las primeras nueve semanas de beneficios por maternidad, el plan de discapacidad a corto plazo le proporcionará beneficios por discapacidad del 75 % de su salario promedio diario a partir de la décima semana y hasta las 25 semanas de pago de beneficios.

Si se reincorpora al trabajo antes de recibir la totalidad del beneficio por maternidad y, posteriormente, vuelve a irse de licencia, no podrá reanudar el beneficio por maternidad a menos que aporte evidencia médica objetiva a Sedgwick que avale la determinación de que cumple la definición de discapacidad. Si no se aporta ninguna evidencia médica, perderá el resto del beneficio por maternidad.

NOTA: Para los asociados de los estados o localidades con beneficios obligatorios por ley, consulte la tabla **Beneficios exigidos por ley** anterior de este capítulo para la coordinación de los beneficios.

LOS IMPUESTOS Y SU BENEFICIO POR DISCAPACIDAD A CORTO PLAZO

La compañía proporciona sin cargo los beneficios que cobre conforme al plan de discapacidad a corto plazo para conductores de camión. Debido a que no realiza aportes al plan de discapacidad a corto plazo para conductores de camión, y no paga ningún impuesto sobre la cobertura que brinda Walmart, los beneficios que se le pagan están sujetos a impuestos. Por lo general, Walmart retiene los impuestos locales, estatales, federales, y de seguridad social del monto de los pagos de sus beneficios.

Walmart no puede garantizar las consecuencias fiscales específicas que surgirán cuando usted reciba los beneficios conforme al plan de discapacidad a corto plazo para conductores de camión. Walmart no brinda asesoramiento legal. Si necesita una respuesta en la que pueda confiar, puede consultar a un asesor fiscal.

DERECHO DE RECUPERAR UN PAGO EXCESIVO

Walmart tiene el derecho de cobrarle y usted debe pagar cualquier monto que se le haya pagado de más por beneficios de discapacidad a corto plazo como parte de este plan. Si no devuelve los montos pagados en exceso en el plazo previsto, Walmart deducirá primero estas cantidades de los pagos futuros por discapacidad (si los hay). Si se debe algún monto restante después de cualquier deducción de los futuros pagos por discapacidad, entonces Walmart puede, a su discreción, (i) tratar los montos pagados en exceso como salarios imponibles para usted (declarables en su formulario W-2), o (ii) deducir los montos pagados en exceso de su pago, en la medida permitida por la ley.

Cómo presentar una reclamación por discapacidad a corto plazo para conductores de camión

Si queda discapacitado, debe presentar de manera oportuna su reclamación para recibir los beneficios. Un retraso en la presentación podría dar lugar al pago retrasado del beneficio, a la interrupción de su salario o al rechazo de su reclamación. El momento y el proceso que debe seguir para presentar una reclamación de beneficios por discapacidad a corto plazo dependen de si el plan de discapacidad a corto plazo está disponible en su localidad (es decir, si se encuentra en un estado o localidad que ofrezca beneficios obligatorios por ley). Consulte **Instrucciones para presentar reclamaciones** más abajo para obtener información sobre cómo presentar su reclamación.

PASO 1: Póngase en contacto con Sedgwick para solicitar una licencia. Independientemente del proceso que siga para presentar una reclamación de discapacidad a corto plazo ante el Plan, deberá ponerse en contacto con Sedgwick a través de **One.Walmart.com/LOA > mySedgwick** o llamando al **800-492-5678** para solicitar una licencia de ausencia en cuanto sepa que va a faltar al empleo debido a una enfermedad, lesión o embarazo. Sedgwick le enviará un paquete inicial en el que se encontrará la información que necesita y se describirán las medidas que debe tomar.

La política de licencia de ausencia no es un beneficio que se ofrece conforme al Plan ni es administrado como parte del beneficio de discapacidad a corto plazo para conductores de camión, por lo que no se aborda aquí. Consulte **One.Walmart.com** para obtener información específica sobre la política de licencias de ausencia.

NOTA: La aprobación de una licencia conforme a la política de licencias de Walmart no significa que se apruebe automáticamente su reclamación de discapacidad a corto plazo. Para obtener información, consulte **Cuándo comienzan los beneficios**.

PASO 2: Presentar una reclamación de discapacidad a corto plazo o de beneficios obligatorios por ley. Su reclamación de beneficios por discapacidad a corto plazo no puede procesarse completamente hasta que haya dejado de trabajar. Notifique a su gerente si su enfermedad o lesión está relacionada con su trabajo en Walmart a fin de iniciar una reclamación por la compensación para trabajadores.

NOTA: La fecha de presentación de su reclamación es la fecha en la que presenta su reclamación de incapacidad a Sedgwick. Para que Sedgwick inicie el examen de su reclamación, debe haber dejado de trabajar por completo. Si presenta su reclamación antes de la primera fecha de baja, Sedgwick comenzará a tramitarla a partir de la primera fecha de baja. Si presenta su solicitud a partir de la primera fecha de baja, Sedgwick comenzará a tramitarla a partir de la fecha comunicada.

Consulte el cuadro a continuación para obtener información detallada sobre dónde y cuándo presentar su reclamación.

INSTRUCCIONES PARA PRESENTAR RECLAMACIONES

Su estado o localidad puede tener periodos de presentación únicos, lo que podría excluir los beneficios correspondientes a periodos anteriores a la fecha de su solicitud de beneficios. Le recomendamos encarecidamente que solicite los beneficios requerido por ley en su estado o localidad sin demora.

Estado o localidad	Elegibilidad	Administración de reclamaciones	Instrucciones de presentación
CO, CT, MA, OR, WA **Washington D. C.**	Si es elegible para el plan de discapacidad a corto plazo de Walmart como complemento a los beneficios obligatorios por ley	Estado o distrito de beneficios obligatorios por ley Sedgwick para beneficios complementarios y maternidad	**CO:** Visite **famli.colorado.gov** o llame al **866-263-2654** para obtener instrucciones **CT:** Visite **ctpaidleave.org** o llame al **877-499-8606** para obtener instrucciones **MA:** Visite **paidleave.mass.gov** o llame al **833-344-7365** para obtener instrucciones **OR:** Visite **paidleave.oregon.gov** o llame al **833-854-0166** para obtener instrucciones **WA:** Visite **paidleave.wa.gov** o llame al **833-717-2273** para obtener instrucciones **D.C.:** Visite **dcpaidfamilyleave.dc.gov** o llame al **202-899-3700** para obtener instrucciones **Sedgwick:** Presente una reclamación ante Sedgwick dentro de los 90 días posteriores a la fecha en que su discapacidad haya comenzado; deberá facilitar la carta de determinación del estado o distrito que incluya los detalles de los beneficios estatales o del distrito. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.

(Continúa en la próxima página)

INSTRUCCIONES PARA PRESENTAR RECLAMACIONES (CONTINUACIÓN)			
Su estado o localidad puede tener periodos de presentación únicos, lo que podría excluir los beneficios correspondientes a periodos anteriores a la fecha de su solicitud de beneficios. Le recomendamos encarecidamente que solicite los beneficios requerido por ley en su estado o localidad sin demora.			
Estado o localidad	**Elegibilidad**	**Administración de reclamaciones**	**Instrucciones de presentación**
Todos los demás	Si es elegible para el plan de discapacidad a corto plazo de Walmart	Sedgwick	Presente una reclamación con Sedgwick dentro de los 90 días de la fecha en que comienza la discapacidad. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.

PASO 3: Informe al consultorio de su médico que se pondrá en contacto para solicitar información. Infórmele a su médico que se comunicarán con él para que complete un certificado médico y para pedirle que proporcione información médica objetiva, incluida la siguiente:

- Diagnóstico
- Fecha y duración prevista de la discapacidad
- Restricciones y limitaciones
- Conclusiones de exámenes cognitivos y/o físicos y resultados de pruebas
- Plan de tratamiento, y
- Notas de las consultas médicas.

Debe firmar un formulario que autorice a su médico a divulgar esta información. Este formulario se incluirá en el paquete inicial que reciba de Sedgwick. Sin embargo, si presenta su reclamación en línea, se acepta una firma electrónica.

PASO 4: Realice un seguimiento con su médico para asegurarse de que la información solicitada se envíe a Sedgwick. Cualquier retraso en el envío de la información a Sedgwick podría tener como resultado un retraso, o rechazo, en el procesamiento de su reclamación y el pago de los beneficios.

Es posible que se le exija una prueba por escrito de su discapacidad o información médica adicional antes de que comience el pago de sus beneficios.

Su pago después de presentar una reclamación

Sedgwick le enviará un paquete inicial cuando presente una reclamación. Tiene hasta la fecha médica de parto, especificada en su paquete inicial, para presentar la documentación médica necesaria. Para que su pago continúe durante el periodo de espera inicial de siete días calendario, puede utilizar tiempo libre pagado (PTO). Después de su periodo de espera inicial de siete días calendario, su pago continuará hasta la fecha de parto, este pago se conoce como “pago provisional”. Si la documentación médica requerida no se aprobó, su pago se suspenderá después de su Fecha límite médica.

Si se aprueba su reclamación, la aprobación será efectiva a partir de la fecha de su discapacidad y el pago provisional que recibió después de su periodo de espera de siete días mientras su reclamación estaba pendiente contará para su beneficio de discapacidad.

Si se deniega su reclamación antes de la fecha de vencimiento del plazo de pago por motivos médicos porque no está discapacitado, según la definición del plan, se interrumpirá su pago provisional y Walmart iniciará las gestiones para recuperar el pago provisional que se le abonó mientras su reclamación estaba pendiente.

No recibirá pago provisional durante ningún periodo en el que se esté tomando una determinación sobre una reclamación por recaída/recurrente (consulte **Si regresa a trabajar y queda discapacitado nuevamente** más adelante en este capítulo).

Para obtener detalles específicos sobre la política de PTO, consulte **One.Walmart.com**.

Determinación de beneficios

Sedgwick tomará una decisión dentro de los 45 días posteriores a la recepción de la reclamación correctamente presentada. El tiempo para una decisión se puede extender por hasta dos periodos de 30 días adicionales. Se le notificará por escrito, antes de cualquier periodo de extensión, que se necesita una extensión debido a asuntos que están fuera del control de Sedgwick. Se deben identificar dichos asuntos y se le debe proporcionar la fecha en la que Sedgwick tomará una decisión. Si su reclamación se extiende debido a que usted no presenta la información que Sedgwick considera como necesaria para determinar su reclamación, el tiempo de decisión se suspenderá a partir de la fecha en la cual se le envía la notificación de la extensión hasta la fecha en que Sedgwick recibe su respuesta. Si Sedgwick aprueba su reclamación, la decisión contendrá información suficiente para informarle sobre esa decisión.

Si Sedgwick rechaza su reclamación, se le enviará una notificación por escrito sobre el rechazo, la cual incluirá lo siguiente:

- Razones específicas para la decisión
- Referencia específica a las disposiciones de la póliza en la cual se basa la decisión.
- Una descripción de cualquier material adicional o información necesaria para que usted sustente la reclamación y una explicación de por qué es necesario dicho material o información
- Una descripción de los procedimientos de revisión y límites de tiempo aplicables a tales procedimientos.
- Si la decisión se basó en una norma, una pauta, un protocolo interno u otro criterio similar para realizar el rechazo, ya sea:
  - La norma, la pauta, el protocolo u otros criterios similares particulares.
  - Una declaración de que la decisión se basó en dicha norma, pauta, protocolo o criterio similar para dictaminar el rechazo y que se le enviará una copia sin cargo cuando la solicite.

Para los asociados de estados o localidades con planes obligatorios por ley (Colorado, Connecticut, Massachusetts, Oregón, Washington D.C. y el estado de Washington), su estado o localidad especificará su proceso y plazos para tomar una decisión. Encontrará más información en el sitio web de su estado o distrito. Consulte la tabla **Recursos** al principio de este capítulo para ver la información de contacto.

CÓMO APELAR UNA RECLAMACIÓN DE DISCAPACIDAD QUE SE RECHAZÓ EN SU TOTALIDAD O EN PARTE

Si su reclamación de beneficios por discapacidad a corto plazo es denegada porque Sedgwick no ha recibido documentación médica objetiva que respalde su reclamación, o la documentación facilitada no respalda su reclamación, dispondrá de un periodo de gracia de 30 días calendario a partir de la fecha de la carta de denegación para presentar información médica a Sedgwick para su revisión sin necesidad de presentar una apelación. Una vez finalizado el periodo de gracia, si su reclamación sigue denegada y desea presentar una apelación, deberá seguir el procedimiento que se describe en esta sección.

Si se rechaza su reclamación para obtener los beneficios y desea apelar, debe enviar una apelación oral o por escrito a Sedgwick dentro de los 180 días posteriores al rechazo. Su reclamo deberá incluir comentarios, documentos, archivos o cualquier otra información que le gustaría que se considere.

Tiene derecho a solicitar copias, sin cargo, de todos los documentos, archivos u otra información relacionada con su reclamación. Independientemente de la determinación inicial, su apelación será revisada por una persona que no sea quien decidió sobre su reclamación inicial.

Sedgwick decidirá sobre su apelación dentro de los 45 días a partir de la recepción de su solicitud de apelación. Este periodo se puede extender hasta 45 días adicionales si se determina que circunstancias especiales requieren una prórroga. Si se requiere una prórroga, se lo notificarán antes de que finalice el periodo de 45 días. Si se le pide que suministre información adicional, tendrá 45 días a partir de la fecha en que se lo notifica para que proporcione la información y se suspenderá el tiempo para tomar una determinación hasta que proporcione la información que se le solicitó (o la fecha límite para presentar la información, si es anterior).

Si se rechaza su apelación en su totalidad o en parte, recibirá una notificación por escrito sobre el rechazo que incluirá:

- Las razones específicas para la determinación desfavorable
- Referencia a las disposiciones específicas del plan en las cuales se basó la determinación
- Una declaración que establezca su derecho a solicitar copias, sin cargo, de todos los documentos, archivos u otra información relacionada con su reclamación
- Una declaración en la cual se establece que usted tiene derecho a obtener, cuando la solicite y sin cargo, una copia de las normas o pautas internas en las cuales se basaron para tomar la determinación y
- Una declaración que describa los procedimientos de apelación ofrecidos por el Plan.

SEGUNDA APELACIÓN VOLUNTARIA DE UNA RECLAMACIÓN POR DISCAPACIDAD A CORTO PLAZO PARA CONDUCTORES DE CAMIÓN

Si se rechaza su apelación, puede realizar una segunda apelación voluntaria de su rechazo de manera oral o por escrito a Sedgwick. Debe presentar su segunda apelación dentro de los 180 días luego de recibir la notificación escrita del rechazo de su primera apelación. Puede presentar comentarios por escrito, documentos, archivos y cualquier otra información relacionada con su reclamación. Por lo general, los mismos criterios y tiempos de respuesta que se aplicaron a su primera apelación se aplican a esta segunda apelación voluntaria, tal como se describe anteriormente.

Todas las apelaciones de discapacidad a corto plazo para conductores de camión (apelaciones iniciales y segundas apelaciones voluntarias) deben enviarse a:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

Para los asociados de estados o localidades con planes obligatorios por ley (Colorado, Connecticut, Massachusetts, Oregón, Washington D.C. y el estado de Washington), su estado o localidad especificará su proceso y plazos para tomar una decisión, si corresponde. Encontrará más información en el sitio web de su estado o distrito. Consulte la tabla de **Recursos** al principio de este capítulo para ver la información de contacto.

Cuándo finalizan los beneficios por discapacidad a corto plazo

Si está recibiendo pagos de beneficios por discapacidad a corto plazo del plan de discapacidad a corto plazo para conductores de camión a causa de un reclamo por discapacidad aprobado, los pagos de sus beneficios del plan terminarán de acuerdo con lo que ocurra primero:

- Cuando deje de coincidir con la definición de discapacidad del plan para la discapacidad a corto plazo.
- Cuando no presente las pruebas necesarias de discapacidad cuando lo solicite Sedgwick.
- Cuando usted ya no esté bajo la atención y el tratamiento permanentes de un médico calificado.
- Cuando se niegue a someterse a examen, si Sedgwick así lo exigiera.
- El último día de su periodo máximo en el cual los beneficios son abonables
- El día en que esté médicamente apto y calificado para trabajar en un puesto a tiempo completo similar que Walmart le ofrezca
- La fecha en que finaliza su relación laboral, o
- La fecha de su fallecimiento.

Si sus beneficios por discapacidad a corto plazo finalizan y no regresa a trabajar por cualquier motivo, debe solicitar una extensión de su licencia (consulte la tabla **Recursos** al comienzo del capítulo para obtener información de contacto). Si no lo hace, es posible que se le despida.

Los beneficios proporcionados bajo un programa obligatorio estatal o local pueden tener fechas de finalización diferentes a las del plan de discapacidad a corto plazo de Walmart.

Volver al trabajo tras una licencia

Sedgwick se pondrá en contacto con usted antes de la fecha de regreso al trabajo prevista y le informará los pasos que deberá seguir, incluso cómo obtener un certificado médico para regresar a trabajar. En algunos casos, es posible que su médico le dé el alta para regresar a trabajar con ciertas restricciones médicas; dichas restricciones deben estar explícitamente establecidas en el certificado para regresar a trabajar o en el alta por escrito. Si recibe un certificado para regresar a trabajar que incluye restricciones médicas, es posible que esté sujeto a una revisión para determinar si una modificación a su trabajo o una adaptación ayudará a que pueda regresar a trabajar.

Deberá ponerse en contacto con Sedgwick **hasta siete días antes de la fecha real de vuelta al trabajo para garantizar una transición fluida para volver al trabajo y evitar una posible repercusión en su salario.** Si su fecha de reincorporación al trabajo cambia, debe notificarlo inmediatamente a Sedgwick. Si sus beneficios de discapacidad a corto plazo terminaron y no regresó a trabajar ni comunicó sus intenciones, Sedgwick le notificará sus opciones, las cuales incluyen la solicitud de una extensión de su licencia o la renuncia voluntaria a su empleo. Si no solicita una extensión, es posible que su relación laboral finalice.

SI REGRESA A TRABAJAR Y QUEDA DISCAPACITADO NUEVAMENTE

Si regresa a trabajar por 30 días calendario o menos y está clasificado como conductor de camión a tiempo completo (con o sin restricciones médicas) y queda discapacitado nuevamente por la misma enfermedad u otra afección relacionada que había causado el primer periodo de discapacidad, tal como lo define Sedgwick como un “reclamación por recaída/recurrente”, sus beneficios por discapacidad a corto plazo continuarán a partir de donde habían quedado antes de que volviera a trabajar. No deberá cumplir un periodo de espera adicional de siete días calendario. La duración del beneficio combinado para ambos periodos de discapacidad no superará las 25 semanas.

Si ha vuelto a trabajar como conductor de camión a tiempo completo y está en estado activo durante más de 30 días calendario y, posteriormente, queda discapacitado por la misma causa o por una causa relacionada, se considerará una nueva discapacidad y podrá recibir hasta 25 semanas de beneficios tras haber satisfecho un nuevo periodo de espera de siete días calendario.

Si regresa como conductor a tiempo completo y está en estado activo por cualquier cantidad de días calendario y luego queda discapacitado por una nueva causa no relacionada, se considerará una nueva discapacidad y podría tener hasta un máximo de 25 semanas de beneficios. Se aplicará un nuevo periodo de espera de beneficios de siete días calendario.

Licencia intermitente. Si está apto para regresar a trabajar después de un periodo de discapacidad a corto plazo y debe ausentarse del trabajo periódicamente por motivos relacionados con su discapacidad, notifique su situación a Sedgwick y su centro. Es posible que su tratamiento esté cubierto conforme a la reclamación por discapacidad a corto plazo previa por hasta 12 meses a partir de la fecha en que regresa a trabajar de su reclamación por discapacidad a corto plazo. Por lo general, el plan de discapacidad a corto plazo para conductores de camión paga el 100 % de su pago diario promedio por la duración de su licencia intermitente aprobada. No deberá utilizar el PTO para las ausencias.

Si está con licencia de ausencia o sujeto a cesantía temporal

Si no está en estado activo debido a una licencia o a una cesantía temporal, su derecho a los beneficios por discapacidad a corto plazo continuará durante 90 días a partir del inicio de su licencia o cesantía temporal. Su elegibilidad para la cobertura por discapacidad a corto plazo finalizará el día 91 después del inicio de su licencia de ausencia o cesantía temporal, pero será restablecida si regresa a trabajar dentro del plazo de un año. Para obtener más información, consulte **Mantener las primas al día en el capítulo Elegibilidad, inscripción y fechas de vigencia**, que incluye detalles sobre el pago de los beneficios durante una licencia.

Cuándo finaliza la cobertura por discapacidad a corto plazo para conductores de camión

Su cobertura de discapacidad a corto plazo finaliza en la fecha más temprana de:

- La fecha en que finaliza su relación laboral
- El último día del periodo de pago en que su estado laboral cambia de un estado laboral elegible
- La fecha de su fallecimiento
- El día 91 de una licencia o cesantía (a menos que se reincorpore al trabajo), o
- La fecha en la que Walmart deja de ofrecer el beneficio.

Si deja Walmart y lo contratan nuevamente

Si deja Walmart y regresa a trabajar para esta como un conductor de camión a tiempo completo, quedará automáticamente reinscrito en el plan de discapacidad a corto plazo para conductores de camión.

Discapacidad a largo plazo para asociados asalariados y a tiempo completo pagados por hora

La información de este capítulo describe los beneficios por discapacidad a largo plazo a los que puede acceder si:

- Es un asociado a tiempo completo pagado por horas o asalariado (gerencia) (conductores de camión: véase el siguiente capítulo)
- Ha cumplido todos los requisitos para que la cobertura tenga vigencia, incluidos los requisitos de trabajo activo, y
- Se ha inscrito debida y oportunamente.

Si tiene preguntas sobre los requisitos de elegibilidad, los requisitos para que la cobertura sea efectiva y la repercusión en sus beneficios de un cambio en su clasificación laboral, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Esta información pretende ser un resumen de sus beneficios y es posible que no incluya todas las condiciones de la póliza. Si existen diferencias entre este documento y la póliza emitida por The Lincoln National Life Insurance Company (Lincoln) respecto del cálculo de los beneficios y las limitaciones en virtud de la póliza, regirán los términos de la póliza. Puede obtener una copia de esta póliza si se comunica con el Plan.

Discapacidad a largo plazo para asociados asalariados y por hora a tiempo completo

Si queda discapacitado y no puede trabajar, el plan de discapacidad a largo plazo de Walmart puede ayudarlo. Cuando se inscribe, el plan trabaja con otros beneficios que recibe durante la discapacidad para reemplazar parte de su cheque de pago.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Obtenga más información o presente una reclamación	Visite **One.Walmart.com/LOA > mySedgwick**	Llame a Lincoln al **877-353-6404**

Lo que debe saber sobre el plan de discapacidad a largo plazo para asociados asalariados y por hora a tiempo completo

En este capítulo se describen los beneficios de discapacidad a largo plazo a los que puede acceder según una de las dos opciones del plan:

- **El plan de discapacidad a largo plazo** sustituye el 50 % de su salario promedio mensual.
- **El plan mejorado de discapacidad a largo plazo** sustituye el 60 % de su salario promedio mensual.

Los planes de discapacidad a largo plazo

Si queda discapacitado, tal y como se define en la sección **Cuándo califica para recibir los beneficios por discapacidad a largo plazo**, el plan de discapacidad a largo plazo le proporciona un beneficio del 50 % de su salario promedio mensual hasta un beneficio mensual máximo de $15,000, menos el importe de otros beneficios o ingresos a los que tenga derecho, tras el periodo de espera del beneficio.

Si queda discapacitado, tal y como se define en la sección **Cuándo califica para recibir los beneficios por discapacidad a largo plazo**, el plan de discapacidad a largo plazo mejorado le proporciona un beneficio del 60 % de su salario mensual medio hasta un beneficio mensual máximo de $18,000, menos el importe de otros beneficios o ingresos a los que tenga derecho, tras el periodo de espera del beneficio.

Ambos planes están asegurados con Lincoln. Para obtener más información sobre su periodo de espera para beneficios, consulte **Cuándo comienzan los beneficios por discapacidad a largo plazo** más adelante en este capítulo. Para obtener información sobre su salario mensual promedio u otros ingresos o beneficios que pueden reducir el monto de su beneficio, consulte **Cómo calcular su beneficio** y **Otros beneficios o ingresos que reducen los beneficios por discapacidad a largo plazo** más adelante en este capítulo.

COSTO DE LA COBERTURA POR DISCAPACIDAD A LARGO PLAZO

El costo de la cobertura por discapacidad a largo plazo se basa en sus ingresos elegibles, su edad y si selecciona el plan de discapacidad a largo plazo o el plan mejorado de discapacidad a largo plazo. Las primas se deducen de todo el salario, incluidas las bonificaciones. Si no tiene ingresos elegibles en un periodo de pago, no se debe pagar ninguna prima por ese periodo de pago. Si mientras recibe los beneficios de discapacidad a largo plazo percibe cualquier otro ingreso elegible, incluidos los bonos, a través de los sistemas de nómina de Walmart, las primas de todos los beneficios, incluida la discapacidad a largo plazo, se retendrán de esos pagos. Para revisar cómo mantener la cobertura de otros beneficios mientras recibe beneficios por discapacidad a largo plazo, consulte **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Cuándo califica para recibir los beneficios por discapacidad a largo plazo

Según los términos de los planes de discapacidad a largo plazo y discapacidad a largo plazo mejorado, “discapacidad” o “discapacitado” por lo general significa que, debido a una lesión o enfermedad cubierta durante el periodo de espera de beneficios y durante los 24 meses siguientes de discapacidad, usted es incapaz de realizar las tareas materiales y sustanciales de su ocupación, y después de 24 meses de pagos de beneficios, usted es incapaz de realizar, con una continuidad razonable, las tareas materiales y sustanciales de cualquier ocupación para la que esté razonablemente capacitado por su formación, educación, experiencia, edad y capacidad física o mental. Sin embargo, si está empleado como piloto, copiloto o miembro de la tripulación de una aeronave, “discapacidad” o “discapacitado” significa que, como resultado de una dolencia o enfermedad, no puede realizar las tareas materiales y sustanciales de su propia ocupación conforme a las normas de aptitud aplicables de la Administración Federal de Aviación.

Para determinar si usted sufre una discapacidad, para personas que no sean pilotos o copilotos, Lincoln no tiene en cuenta los factores del empleo, como conflicto interpersonal en el lugar de trabajo, recesión, obsolescencia laboral, recorte de pagos, trabajos compartidos o pérdida de una autorización o licencia profesional u ocupacional.

A fin de calificar para recibir los beneficios por discapacidad a largo plazo:

- Usted debe estar incapacitado de regresar al trabajo luego del periodo de espera inicial del beneficio por discapacidad.
- Usted debe continuar bajo la atención adecuada de un médico calificado (se incluyen, entre los médicos calificados, a los médicos y profesionales de la salud que no tienen parentesco con usted y prestan servicios dentro del alcance de sus licencias).
- Lincoln debe recibir y aprobar los certificados junto con la documentación médica de respaldo de una discapacidad que envíe su médico calificado antes de que se considere el pago de los beneficios.
- En el momento de su discapacidad, debe estar trabajando activamente. Se considerará que está trabajando activamente si está prestando servicios en el centro de trabajo habitual de Walmart o en un lugar designado por Walmart, o si ha estado realmente en el trabajo el día inmediatamente anterior:
  - Un fin de semana o un día festivo (excepto si uno o ambos días son días de trabajo programados)
  - Tiempo libre pagado (PTO)
  - Cualquier día de trabajo no programado, o
  - Una licencia de ausencia aprobada.

EXCLUSIÓN POR AFECCIÓN PREEXISTENTE

No recibirá beneficios de discapacidad a largo plazo por ninguna discapacidad o discapacidad parcial que comience en los primeros 12 meses después de la fecha de vigencia de la cobertura si dicha discapacidad o discapacidad parcial es causada por, en parte o totalmente, o es el resultado de, una afección preexistente. Una “afección preexistente” significa cualquier afección que resulte de una lesión o enfermedad por la cual se le diagnosticó o recibió tratamiento durante el periodo de tres meses anterior a la fecha de vigencia de la cobertura. Según los términos de la exclusión por afección preexistente, se entiende que está “bajo tratamiento” cuando consulta a un profesional de la salud o recibe atención o servicios médicos bajo la dirección de un médico, que incluye medidas para obtener un diagnóstico, la prescripción de medicamentos (ya sea que decida tomarlos o no) y el consumo de medicamentos.

Si se cambia del plan de discapacidad a largo plazo (beneficio del 50 %) al plan mejorado de discapacidad a largo plazo (beneficio del 60 %), la exclusión por afección preexistente se aplicará al monto de la cobertura adicional. Si cumplió con el requisito de afección preexistente del plan de discapacidad a largo plazo (beneficio del 50 %) y, luego, queda discapacitado antes de cumplir la exclusión por afección preexistente del plan mejorado de discapacidad a largo plazo (beneficio del 60 %), solo recibirá los beneficios conforme al plan de discapacidad a largo plazo (beneficio del 50 %).

Cómo presentar una reclamación por discapacidad a largo plazo

Si tiene una reclamación por discapacidad a corto plazo aprobada y está inscrito para recibir los beneficios por discapacidad a largo plazo, su reclamación se transferirá automáticamente de Sedgwick a Lincoln. Apenas tenga conocimiento de que necesitará utilizar su beneficio por discapacidad a largo plazo, puede comunicarse con Lincoln al **877-353-6404**. Lincoln le proporcionará información adicional sobre cómo completar su reclamación.

Los asociados que reciben beneficios de compensación para trabajadores y están inscritos en el plan de discapacidad a largo plazo y el plan de discapacidad a largo plazo mejorado pueden ser elegibles para recibir beneficios por discapacidad una vez que finalice su periodo de espera. Llame a Lincoln al **877-353-6404** para informar su reclamación por discapacidad a largo plazo.

Las reclamaciones se determinan dentro de los plazos y requisitos establecidos en el capítulo **Reclamaciones y apelaciones**. Tiene derecho a apelar una reclamación rechazada. Para obtener información, consulte el capítulo **Reclamaciones y apelaciones**.

Cuándo no se pagan los beneficios

No se pagan beneficios por ninguna reclamación de discapacidad a largo plazo que se deba a lo siguiente:

- Guerra, declarada o no, o cualquier acto de guerra
- Participación activa en disturbios
- Cometer o intento de cometer un delito común o delito menor
- Cirugía plástica, a menos que dicha cirugía esté relacionada con una lesión o enfermedad mientras usted tiene cobertura.

No se paga ningún beneficio durante cualquier periodo de encarcelación.

Cuándo comienzan los beneficios por discapacidad a largo plazo

Si Lincoln le aprueba los beneficios de discapacidad a largo plazo, los mismos comenzarán después del periodo de espera de los beneficios: 26 semanas o la finalización de sus beneficios por discapacidad a corto plazo, lo que sea más largo.

SI REGRESA A TRABAJAR DURANTE SU PERIODO DE ESPERA Y QUEDA DISCAPACITADO NUEVAMENTE

Si deja de estar discapacitado y regresa a trabajar a tiempo completo por un total de la cantidad especificada de días calendario (como se define a continuación) o menos durante un periodo de espera de beneficios, se interrumpirá el periodo de espera y deberá cubrir el saldo del periodo de espera si queda discapacitado otra vez. Si vuelve a trabajar durante un total de más de la cantidad especificada de días calendario mientras cumple su periodo de espera del beneficio, debe cumplir con un nuevo periodo de espera completo del beneficio si vuelve a quedar discapacitado antes de ser elegible para recibir los beneficios por discapacidad a largo plazo. La "cantidad especificada de días calendario" significa (i) 60 días para los asociados pagados por hora y farmacéuticos pagados por hora (que no sean los farmacéuticos pagados por hora que trabajen en California), y (ii) 180 días para los asociados asalariados, los farmacéuticos asalariados, los farmacéuticos pagados por hora que trabajen en California, la gerencia y los pilotos. No es necesario que la cantidad de días naturales especificada sea consecutiva.

Cómo calcular su beneficio

El monto de su beneficio por discapacidad a largo plazo se basa en:

- Su salario mensual promedio, tal como se define a continuación, y
- Si está inscrito al plan de discapacidad a largo plazo o al plan mejorado de discapacidad a largo plazo.

SALARIO MENSUAL PROMEDIO	
Duración del empleo	**Cómo se determina el salario mensual promedio**
Empleado durante 12 meses o más	Sus ingresos elegibles para los 26 periodos de pago inmediatamente anteriores a su último día de trabajo ÷ 12 Por ejemplo, el salario mensual promedio de un asociado con ingresos elegibles previos a la discapacidad de $36,000 por los 26 periodos de pago anteriores es $3,000 ($36,000 ÷ 12). *Si sus ingresos elegibles han sido pagados semanalmente durante el periodo de 12 meses, la cantidad de periodos de pago utilizados para calcular su salario mensual promedio se ajustará en consecuencia.
Empleado durante menos de 12 meses	Sus ingresos elegibles desde la fecha de contratación ÷ cantidad de meses trabajados Por ejemplo, el salario mensual promedio de un asociado con ingresos elegibles de $21,000 por los siete meses de trabajo es $3,000 ($21,000 ÷ 7).

Los ingresos elegibles utilizados para determinar el salario promedio mensual incluyen:

- Los ingresos regulares de los 26 periodos de pago anteriores a su último día trabajado (si sus ingresos regulares se pagaban semanalmente, la cantidad de periodos de pago utilizados se ajustará según corresponda).
- Horas extras
- Bonos de incentivos programados periódicamente para los que usted y los asociados que tienen tipos de trabajo o niveles de trabajo similares son elegibles
- Tiempo libre remunerado y remuneraciones similares que sustituyen los ingresos habituales (por ejemplo: por duelo, servicio de jurado y licencia por enfermedad)

Cualquier periodo de pago en el que no registra ingresos elegibles queda excluido, lo que reduce la cantidad de periodos de pagos para el cálculo.

Los ingresos elegibles utilizados para determinar el salario promedio mensual excluyen los beneficios de discapacidad pagados anteriormente, las comisiones o cualquier otra compensación extra o beneficios adicionales que no se mencionaron anteriormente.

Si ha estado empleado por menos de 12 meses, se utilizará un promedio anualizado de ingresos elegibles.

A continuación se muestra su beneficio por discapacidad a largo plazo:

SU BENEFICIO POR DISCAPACIDAD A LARGO PLAZO	
Si está inscrito	**Su cobertura es**
En el plan de discapacidad a largo plazo	50 % de su salario mensual promedio hasta un beneficio máximo mensual de $15,000, menos el importe de otros beneficios o ingresos para los cuales usted es elegible (por ejemplo, beneficios por discapacidad del sistema de Seguridad Social*)
En el plan mejorado de discapacidad a largo plazo	60 % de su salario mensual promedio hasta un beneficio máximo mensual de $18,000, menos el importe de otros beneficios o ingresos para los cuales usted es elegible (por ejemplo, beneficios por discapacidad del sistema de Seguridad Social*)
*Para más información, consulte **Otros beneficios o ingresos que reducen los beneficios por discapacidad a largo plazo**.	

Su beneficio será superior a $50 por cualquier mes en que sea elegible para recibir beneficios por discapacidad a largo plazo.

Los beneficios por discapacidad a largo plazo se pagan, siempre y cuando la discapacidad continúe de acuerdo con la definición de los planes de discapacidad a largo plazo.

Lincoln tiene derecho a recuperar, y usted debe reembolsar, cualquier monto pagado en exceso a usted por beneficios por discapacidad a largo plazo conforme al plan de discapacidad a largo plazo o el plan mejorado de discapacidad a largo plazo.

PTO Y SU BENEFICIO DE DISCAPACIDAD A LARGO PLAZO

No es necesario utilizar el tiempo libre pagado (PTO) mientras recibe los beneficios por discapacidad a largo plazo. Si está recibiendo beneficios por discapacidad a largo plazo al final del año del plan del PTO, consulte la póliza del PTO de su ubicación para obtener información sobre el pago y/o la transferencia de días. No se puede acumular PTO adicional mientras esté recibiendo beneficios de discapacidad a largo plazo.

OTROS BENEFICIOS O INGRESOS QUE REDUCEN LOS BENEFICIOS POR DISCAPACIDAD A LARGO PLAZO

El monto de su beneficio por discapacidad a largo plazo se reduce o compensa por otros beneficios o ingresos que usted recibe o es elegible para recibir. “Otros ingresos” incluye cualquier ingreso de cualquier forma de empleo, incluso bajo cualquier licencia por enfermedad formal o informal o planes de continuación de salario. Excepto con respecto a los beneficios de jubilación, los “otros beneficios” solo incluyen los montos a los que usted (o, en determinadas circunstancias, su familia) tiene derecho como resultado de la misma discapacidad a la que se refiere su beneficio de discapacidad a largo plazo que se paga. Ejemplos de otros beneficios incluyen montos de lo siguiente:

- Seguro de discapacidad del sistema de Seguridad Social (incluidos los montos que su familia recibe o es elegible para recibir debido a su discapacidad)
- Beneficios de jubilación del sistema de Seguridad Social otorgados después de la fecha de la discapacidad (incluidos los beneficios que su familia recibe o es elegible para recibir debido a su elegibilidad para los beneficios de jubilación)
- Compensación para trabajadores
- Planes de seguros grupales relacionados con la compañía que brindan beneficios de discapacidad
- Pólizas individuales pagadas por la compañía o pagadas parcialmente que brindan beneficios de discapacidad en la medida en que dichos beneficios, más su beneficio de discapacidad a largo plazo, excedan su salario mensual promedio
- Seguros de automóvil sin designación de culpa
- Cualquier beneficio de discapacidad a corto plazo en curso que se pague conforme a la cobertura por discapacidad a corto plazo de Walmart (p. ej., beneficios relacionados con recaídas)
- Pagos estatales por discapacidad
- Beneficios de desempleo, o beneficios en virtud de cualquier otra ley de beneficios gubernamentales
- Convenio o fallo, menos los costos asociados de una demanda, que represente o compense su pérdida de ingresos o de funcionamiento del cuerpo.

Si alguno de estos beneficios que reducen sus beneficios de discapacidad a largo plazo se ajusta posteriormente conforme al aumento del costo de vida, su beneficio de discapacidad a largo plazo no se reducirá aún más. Consulte la póliza para

obtener una lista completa de las compensaciones. Puede obtener una copia de la póliza de discapacidad a largo plazo llamando a Lincoln al **877-353-6404**.

EJEMPLO DE REDUCCIÓN DE BENEFICIO POR DISCAPACIDAD A LARGO PLAZO		
Salario anual: $36,000	**Plan de discapacidad a largo plazo (50 %)**	**Plan mejorado de discapacidad a largo plazo (60 %)**
Salario mensual promedio	$3,000	$3,000
Monto del beneficio (porcentaje del salario mensual promedio, sujeto al máximo)	$1,500	$1,800
Menos el beneficio por discapacidad del sistema de Seguridad Social	- $750	- $750
Menos los beneficios de Seguridad Social estimados que reciben los dependientes	- $375	- $375
Pago por discapacidad a largo plazo (mensual)	$375	$675

CÓMO SOLICITAR LOS BENEFICIOS POR DISCAPACIDAD DE SEGURIDAD SOCIAL

Puede ser elegible para recibir beneficios por discapacidad de Seguridad Social después de haber estado discapacitado durante cinco meses. Si su discapacidad duró, o se prevé que durará 12 meses consecutivos, los términos de la póliza de la cobertura por discapacidad a largo plazo para conductores de camión pueden requerir que solicite los beneficios por discapacidad del sistema de Seguridad Social. Si la Administración de Seguridad Social le niega la solicitud de beneficios, deberá seguir el proceso de apelación de la Administración de Seguridad Social.

Si tiene que solicitar los beneficios por discapacidad de la Seguridad Social y no los solicita, o no facilita un comprobante de la solicitud o del recurso, sus beneficios de discapacidad a largo plazo se reducirán en la cantidad que se calcula que usted y cualquier dependiente elegible recibirá del Seguro Social por discapacidad.

Si califica para recibir beneficios por discapacidad o jubilación de Seguridad Social mientras recibe beneficios de su plan de discapacidad a largo plazo y su reclamación de discapacidad de Seguridad Social se aprueba de manera retroactiva, debe reembolsar a Lincoln los beneficios de discapacidad a largo plazo que se hayan pagado de más durante el periodo cubierto por la aprobación retroactiva de Seguridad Social.

Lincoln puede ayudarlo a solicitar los beneficios por discapacidad del sistema de Seguridad Social. A fin de ser elegible para recibir asistencia, debe recibir un beneficio de Lincoln.

Si está discapacitado y trabaja

Puede ser elegible para recibir los beneficios de discapacidad si está parcialmente discapacitado. En el contexto del Plan, “discapacidad parcial” y “parcialmente discapacitado” significan que, como resultado de una enfermedad o lesión, usted puede hacer lo siguiente:

- Realizar una o más tareas materiales y sustanciales propias o de una ocupación a tiempo completo o tiempo parcial, aunque no todas o
- Realizar todas las tareas materiales y sustanciales de su propia ocupación o cualquier ocupación trabajando a tiempo parcial y
- Ganar entre el 20 % y el 80 % de sus ingresos mensuales promedios indexados.

Si acepta un nuevo puesto de trabajo y realiza todas las funciones materiales y sustanciales a tiempo completo, no está parcialmente discapacitado.

Lincoln ofrece un beneficio de incentivo al trabajo durante los seis primeros periodos de pago (12 periodos de pago si se paga semanalmente) en los que esté parcialmente discapacitado y trabajando. Continuará recibiendo el monto completo de su beneficio mensual durante los primeros seis a 12 periodos de pago, según corresponda, si queda parcialmente discapacitado, a menos que su beneficio e ingresos mensuales actuales del trabajo mientras está parcialmente discapacitado superen su salario mensual promedio. Si esto sucede, su beneficio mensual se reducirá por el monto excedido a fin de que el beneficio mensual más sus ingresos elegibles no superen el 100 % de su salario mensual promedio.

Luego de los primeros seis o 12 periodos de pago, según corresponda, que queda parcialmente discapacitado y sigue trabajando, el siguiente cálculo se utiliza para determinar su beneficio mensual para una discapacidad parcial.

CÁLCULO DE BENEFICIOS SI ESTÁ DISCAPACITADO Y TRABAJA	
[(A - B) ÷ A] x C = D	
A	Su salario mensual promedio indexado
B	Sus ingresos elegibles mensuales, parciales y actuales
C	El beneficio mensual por discapacidad a largo plazo pagadero si estuviera totalmente discapacitado, menos otros beneficios o ingresos que reduzcan los beneficios por discapacidad a largo plazo
D	Beneficio para pagar si está discapacitado y trabaja

*El “salario mensual promedio indexado” se refiere a que su salario mensual promedio aumentó anualmente en 7 % o el cambio de porcentaje en el Índice de precios al consumidor, lo que sea menor.

SI FALLECE MIENTRAS RECIBE BENEFICIOS POR DISCAPACIDAD A LARGO PLAZO

La cobertura del plan de discapacidad de largo plazo finaliza después de su fallecimiento. Sin embargo, si fallece mientras está recibiendo beneficios por discapacidad a largo plazo, se le pagará una suma única de $5,000 o tres veces su último beneficio por discapacidad a largo plazo mensual, el que sea superior, a su cónyuge/pareja sobreviviente. Si no lo sobrevive un cónyuge/pareja, el pago se realizará a sus hijos sobrevivientes en partes iguales, incluidos los hijastros y los hijos legalmente adoptados. Sin embargo, si alguno de estos hijos es menor de edad o está incapacitado, el pago se realizará en su nombre al tutor legal de los bienes de los hijos designado por un tribunal. Si un cónyuge/pareja o hijos no le sobreviven, el pago se hará a sus herederos.

Cuándo finalizan los beneficios por discapacidad a largo plazo

Los pagos de beneficios por discapacidad a largo plazo finalizan cuando se cumpla la primera de las siguientes condiciones:

- La fecha en que no presente prueba de que continúa con la discapacidad o discapacidad parcial y consulta regularmente a un médico
- La fecha en que no coopera con la administración de su reclamación. Por ejemplo, brindar información o documentos necesarios para determinar si se pagarán los beneficios y/o determinar el monto del beneficio
- La fecha en que se rehúsa a ser examinado o evaluado a intervalos razonables
- La fecha en que se rehúsa a recibir tratamiento adecuado disponible
- La fecha en que rechaza un trabajo en Walmart, que ofrece un salario comparable al suyo, en el cual se realizan modificaciones o ajustes en el lugar de trabajo para permitirle realizar su tarea
- En el momento en que pueda trabajar en su propia ocupación a tiempo parcial pero elija no hacerlo
- La fecha en que sus ganancias mensuales por discapacidad parcial superen el 80 % de sus salarios mensuales promedios indexados
- Cuando deje de coincidir con la definición de discapacidad del plan
- El último día de su periodo máximo en el cual recibirá los beneficios (consulte las tablas a continuación) o
- La fecha de su fallecimiento.

NOTA: Su empleo no es una condición para la continuación de los beneficios por discapacidad a largo plazo.

DURACIÓN MÁXIMA DE LOS BENEFICIOS POR DISCAPACIDAD A LARGO PLAZO

Edad cuando quedó discapacitado	Duración de los beneficios
Antes de los 62 años	Hasta la edad normal de jubilación del Seguro Social (como se indica a continuación)
62	48 meses
63	42 meses
64	36 meses
65	30 meses
66	27 meses
67	24 meses
68	21 meses
69 o más	18 meses

EDAD NORMAL DE JUBILACIÓN SEGÚN LA ADMINISTRACIÓN DE SEGURIDAD SOCIAL

Año de nacimiento	Edad normal de jubilación
1937 o antes	65
1938	65 + 2 meses
1939	65 + 4 meses
1940	65 + 6 meses
1941	65 + 8 meses
1942	65 + 10 meses
1943 hasta 1954	66
1955	66 + 2 meses
1956	66 + 4 meses
1957	66 + 6 meses
1958	66 + 8 meses
1959	66 + 10 meses
1960 o después	67

SI LA DISCAPACIDAD SE DEBE A UNA ENFERMEDAD MENTAL, ALCOHOLISMO O DROGADICCIÓN

Para recibir beneficios por discapacidad a largo plazo por más de 24 meses para las siguientes discapacidades, debe estar internado en un hospital u otro sitio autorizado para proporcionar atención médica:

- Enfermedad mental (no incluye daño cerebral estructural y demostrable)
- Cualquier afección que sea consecuencia de una enfermedad mental
- Alcoholismo y
- Uso no médico de narcóticos, sedantes, estimulantes, alucinógenos o sustancias similares.

Cuando no está internado en un hospital u otra institución autorizada, tiene un beneficio de 24 meses para estas discapacidades, a menos que participe totalmente de un plan de tratamiento extendido para la afección que ocasionó la discapacidad, en cuyo caso el beneficio se paga hasta 36 meses.

Si regresa a trabajar y queda discapacitado nuevamente

Si usted vuelve a trabajar durante menos de seis meses de trabajo activo a tiempo completo y se vuelve a incapacitar por la misma afección o una afección relacionada que causó el primer periodo de discapacidad, según lo determinado por Lincoln, lo que se conoce como una "recaída/reclamación sucesiva", la discapacidad sucesiva será parte de la misma discapacidad.

Sus beneficios por discapacidad a largo plazo continuarán a partir de donde habían quedado antes de que volviera a trabajar. No habrá periodos de espera adicionales. La duración del beneficio combinado para ambos periodos de discapacidad no superará la máxima duración que figura en la tabla que aparece a la izquierda.

Si regresa al trabajo como asociado a tiempo completo por seis meses o más, cualquier recurrencia de una discapacidad se tratará como una discapacidad nueva. Se deberá cumplir un nuevo periodo de espera de beneficios.

Si está con licencia de ausencia o sujeto a cesantía temporal

Una vez que entra en vigencia su cobertura por discapacidad a largo plazo, si no está trabajando activamente debido a una licencia de ausencia o cesantía temporal, su cobertura por discapacidad a largo plazo continúa durante 90 días desde el inicio de su licencia de ausencia o cesantía temporal. El derecho a la cobertura por discapacidad a largo plazo finaliza a los 91 días del inicio de la licencia de ausencia o de la cesantía temporal, pero se restablece si vuelve a trabajar en el plazo de un año. Para obtener más información, consulte el párrafo **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**, que incluye detalles sobre el pago de la cobertura de los beneficios durante una licencia.

NOTA: Si su cobertura por discapacidad a largo plazo finaliza porque su licencia o despido temporal excede los 90 días, seguirá teniendo derecho a los beneficios por discapacidad a largo plazo por cualquier enfermedad o lesión que se haya producido antes de la fecha de finalización de su cobertura.

Cuándo finaliza la cobertura por discapacidad a largo plazo

La cobertura por discapacidad a largo plazo finaliza:

- La fecha en la que abandone voluntariamente la cobertura (como se describe a continuación)
- En el momento en que termine la relación laboral, a menos que haya estado ausente por discapacidad durante el periodo de espera de 26 semanas del beneficio y cualquier periodo durante el cual se renuncie al pago de la prima
- El último día del periodo de pago inmediatamente anterior al periodo de pago en que su estado laboral cambia de un estado laboral elegible
- El último día de la cobertura para la que se pagaron las primas, si no pagó las primas dentro de los 30 días de la fecha de vencimiento de estas
- En la fecha en que pierde la elegibilidad
- Si no se reincorpora al trabajo tras el último día de la licencia
- Cuando Walmart deja de ofrecer el beneficio, o
- En la fecha de su fallecimiento.

Si su clasificación de empleo cambia, consulte la tabla correspondiente en la sección **Cambio de una clasificación laboral a otra** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información sobre cualquier repercusión en su cobertura.

Si cancela voluntariamente la cobertura después de un evento de cambio de elección o en la Inscripción Anual, la cobertura finaliza de la siguiente manera:

- **Tras un evento de cambio de elección:** la cobertura finaliza el día en que solicite el cambio de elección. Para obtener más información, consulte **Cambios de elección permitidos fuera del periodo de Inscripción anual** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.
- **En la Inscripción anual: la cobertura** finaliza el 31 de diciembre del año en curso.

Si deja Walmart y vuelve a ser contratado

Si usted es empleado pagado por hora o un miembro de la gerencia a tiempo completo (excluidos los conductores de camión a tiempo completo), consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para saber cómo lo afecta el hecho de dejar de trabajar en la compañía y regresar al trabajo afecta sus beneficios.

Discapacidad a largo plazo para conductores de camión

La información de este capítulo describe los beneficios por discapacidad a largo plazo a los que puede acceder si:

- Usted es un conductor de camión a tiempo completo
- Ha cumplido todos los requisitos para que la cobertura tenga vigencia, incluidos los requisitos de trabajo activo, y
- Se ha inscrito debida y oportunamente.

Si tiene preguntas sobre una transferencia reciente a una clasificación del puesto de conductor de camión a tiempo completo, los requisitos de elegibilidad, los requisitos para que la cobertura sea efectiva y la repercusión en sus beneficios de un cambio en su clasificación laboral, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Esta información pretende ser un resumen de sus beneficios y es posible que no incluya todas las condiciones de la póliza. Si existen diferencias entre este documento y la póliza emitida por The Lincoln National Life Insurance Company (Lincoln) respecto del cálculo de los beneficios y las limitaciones en virtud de la póliza, regirán los términos de la póliza. Puede obtener una copia de esta póliza si se comunica con el Plan.

Discapacidad a largo plazo para conductores de camión

Si una discapacidad no le permite conducir ni trabajar, los planes por discapacidad a largo plazo de Walmart se suman a otros beneficios que usted recibe para reemplazar parte de su cheque de pago. Existen dos planes de discapacidad a largo plazo para conductores de camiones que pagan diferentes niveles de beneficios.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Obtenga más información o presente una reclamación	Visite **One.Walmart.com/LOA > mySedgwick**	Llame a Lincoln al **877-353-6404**

Lo que debe saber sobre la discapacidad a largo plazo para conductores de camión

- Walmart les ofrece a los conductores de camiones un plan de discapacidad a largo plazo y un plan mejorado de discapacidad a largo plazo. Cada plan ofrece la posibilidad de elegir entre una cobertura de cinco años o de duración completa.
- Los planes de discapacidad a largo plazo para conductores de camión funcionan junto con ciertas otro beneficio que reciba mientras se encuentra discapacitado y reemplaza el 50 % de su salario mensual promedio si selecciona el plan de discapacidad a largo plazo para conductores de camión o el 60 % de su salario mensual promedio si selecciona el plan de discapacidad a largo plazo mejorado para conductores de camión.
- Si se inscribe en cualquier plan después del periodo de inscripción inicial: su cobertura está sujeta a la aprobación de Lincoln. Deberá presentar evidencia de buena salud y quizás se le exija someterse a un examen médico a su propio cargo para que se apruebe la cobertura.

Los planes de discapacidad a largo plazo para conductores de camión

Usted es elegible para inscribirse en la cobertura por discapacidad a largo plazo para conductores de camión si es un conductor de camión a tiempo completo. Puede elegir entre dos planes de cobertura, cada uno de los cuales ofrece dos opciones:

- **Plan de discapacidad a largo plazo**
  - Cobertura por cinco años
  - Cobertura por duración completa
- **Plan mejorado de discapacidad a largo plazo**
  - Cobertura por cinco años
  - Cobertura por duración completa

Las opciones del plan de discapacidad a largo plazo y del plan de discapacidad a largo plazo mejorado para conductores de camión pagan los beneficios como se describe en la siguiente tabla.

DISCAPACIDAD A LARGO PLAZO PARA CONDUCTORES DE CAMIÓN

	Plan de discapacidad a largo plazo	Plan mejorado de discapacidad a largo plazo
Cobertura por cinco años	Paga 50 % de salario mensual promedio hasta un beneficio máximo mensual de $15,000, menos el importe de otros beneficios o ingresos para los cuales usted es elegible*	Paga 60 % de salario mensual promedio hasta un beneficio máximo mensual de $18,000, menos el importe de otros beneficios o ingresos para los cuales usted es elegible*
	Ambos planes pagan beneficios durante 60 meses, a menos que la cantidad de tiempo indicada en la tabla **Máxima duración de la discapacidad a largo plazo para conductores de camión** (más adelante en este capítulo) dé como resultado una duración de beneficios de menos de 60 meses, en cuyo caso el beneficio mensual será pagadero por el periodo menor.	
	Plan de discapacidad a largo plazo	**Plan mejorado de discapacidad a largo plazo**
Cobertura por duración completa	Paga 50 % de salario mensual promedio hasta un beneficio máximo mensual de $15,000, menos el importe de otros beneficios o ingresos para los cuales usted es elegible*	Paga 60 % de salario mensual promedio hasta un beneficio máximo mensual de $18,000, menos el importe de otros beneficios o ingresos para los cuales usted es elegible*
	Ambas opciones de planes pagan beneficios por la cantidad de tiempo que se muestra en la tabla **Máxima duración de la discapacidad a largo plazo para conductores de camión** (más adelante en este capítulo).	

*Consulte **Cómo calcular su beneficio** y **Otros beneficios o ingresos que reducen los beneficios por discapacidad a largo plazo para conductores de camión** (más adelante en este capítulo) para obtener más información.

Ambos planes están asegurados con Lincoln. Para obtener más información sobre su periodo de espera para beneficios, consulte **Cuándo comienzan los beneficios por discapacidad a largo plazo para conductores de camión** más adelante en este capítulo. Para obtener información sobre su salario mensual promedio u otros ingresos o beneficios que pueden reducir el monto de su beneficio, consulte **Cómo calcular su beneficio** y **Otros beneficios o ingresos que reducen los beneficios por discapacidad a largo plazo para conductores de camión** más adelante en este capítulo.

Si se inscribe durante el periodo de inscripción inicial, la cobertura entrará en vigencia en la fecha de contratación.

Si se inscribe en cualquier momento después de su periodo de inscripción inicial, se considerará una inscripción tardía y deberá presentar una evidencia de buena salud. Es posible que le exijan que se realice un examen médico a su propio cargo antes de aprobar su cobertura.

Si se inscribe en la opción de cobertura por cinco años y posteriormente decide inscribirse en la opción de cobertura por tiempo indefinido, o si se inscribe en el plan de discapacidad a largo plazo para conductores de camión y posteriormente decide inscribirse en el plan de discapacidad a largo plazo mejorado para conductores de camión, se considerará una inscripción tardía y deberá presentar evidencia de buena salud antes de aprobar su cobertura.

Consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener más detalles sobre cuándo es efectiva la cobertura.

COSTO DE LA COBERTURA POR DISCAPACIDAD A LARGO PLAZO PARA CONDUCTORES DE CAMIÓN

El costo de la cobertura por discapacidad a largo plazo para conductores de camión se basa en sus ingresos que reúnan los requisitos, su edad y su elección de cobertura en el plan de discapacidad a largo plazo o en el plan mejorado de discapacidad a largo plazo. Las primas se deducen de todo el salario, incluidas las bonificaciones. Si no tiene ingresos en un periodo de pago, no se debe pagar ninguna prima por ese periodo de pago. Si recibe cualquier otro ingreso mientras recibe beneficios por discapacidad a largo plazo, incluyendo bonos, a través de los sistemas de nóminas de Walmart, sus primas para todos los beneficios, incluyendo la discapacidad a largo plazo, se retendrán de esos pagos. Para revisar cómo mantener la cobertura de otros beneficios mientras recibe beneficios por discapacidad a largo plazo, consulte **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Cuándo califica para recibir los beneficios por discapacidad a largo plazo para conductores de camión

De acuerdo los términos de los planes de discapacidad a largo plazo para conductores de camión, "discapacidad" o "discapacitado" significa generalmente que no puede realizar las tareas materiales y sustanciales de su propia ocupación, o pierde la certificación médica de acuerdo con la normativa de la Federal Motor Carrier Safety Administration debido a una lesión o enfermedad cubierta, durante el periodo de espera del beneficio y durante los siguientes 24 meses de discapacidad. Luego de 24 meses de pago de los beneficios,

"discapacidad" o "discapacitado" generalmente significa que usted es incapaz de realizar, con una continuidad razonable, las tareas materiales y sustanciales de cualquier ocupación para la que esté razonablemente capacitado por su formación, educación, experiencia, edad y capacidad física o mental.

Al momento de determinar si sufre una discapacidad, Lincoln no tiene en cuenta los factores del empleo, como un conflicto interpersonal en el lugar de trabajo, recesión, obsolescencia laboral, recorte de pagos, trabajos compartidos o pérdida de una autorización o licencia profesional u ocupacional por razones que no constituyan una lesión o enfermedad cubierta.

A fin de calificar para recibir los beneficios por discapacidad a largo plazo para conductores de camión:

- Usted debe estar incapacitado de regresar al trabajo luego del periodo de espera inicial del beneficio por discapacidad.
- Usted debe continuar bajo la atención adecuada de un médico calificado (se incluyen, entre los médicos calificados, a los médicos y profesionales de la salud que no tienen parentesco con usted y prestan servicios dentro del alcance de sus licencias).
- Lincoln debe recibir y aprobar los certificados junto con la documentación médica de respaldo de una discapacidad que envíe su médico calificado antes de que se considere el pago de los beneficios.
- En el momento de su discapacidad, debe estar trabajando activamente. Se considerará que está trabajando activamente si está prestando servicios en el centro de trabajo habitual de Walmart o en un lugar designado por Walmart, o si ha estado realmente en el trabajo el día inmediatamente anterior:
  - Un fin de semana o un día festivo (excepto si uno o ambos días son días de trabajo programados)
  - Tiempo libre pagado (PTO)
  - Cualquier día de trabajo no programado, o
  - Una licencia de ausencia aprobada.

Si su cobertura de discapacidad a largo plazo estaba sujeta a evidencia de buena salud y fue aprobada por Lincoln, Lincoln tiene derecho a reexaminar su cuestionario de evidencia de buena salud dentro de los dos primeros años a partir de la fecha en que entró en vigencia la cobertura de discapacidad a largo plazo. Si se descubre que declaró hechos materiales de manera incorrecta, se usarán las circunstancias reales para determinar si su cobertura debería estar vigente y por qué monto, y si su prima se puede ajustar.

EXCLUSIÓN POR AFECCIÓN PREEXISTENTE

No recibirá beneficios de discapacidad a largo plazo para conductores de camión por ninguna discapacidad o discapacidad parcial que comience en los primeros 12 meses después de la fecha de vigencia de la cobertura si dicha discapacidad o discapacidad parcial es causada por, en parte o totalmente, o es el resultado de, una afección preexistente. Una "afección preexistente" significa cualquier afección que resulte de una lesión o enfermedad por la cual se le diagnosticó o recibió tratamiento durante el periodo de tres meses anterior a su fecha de vigencia. Según los términos de la exclusión por afección preexistente, se entiende que está "bajo tratamiento" cuando consulta a un profesional de la salud o recibe atención o servicios médicos bajo la dirección de un médico, que incluye medidas para obtener un diagnóstico, la prescripción de medicamentos (ya sea que decida tomarlos o no) y el consumo de medicamentos.

Si se cambia de la cobertura de cinco años a la cobertura por duración completa en cualquiera de los planes de discapacidad a largo plazo para conductores de camión, o si se cambia del plan de discapacidad a largo plazo al plan de discapacidad a largo plazo mejorado para conductores de camión, se aplicará el concepto de exclusión de afección preexistente a la duración adicional o al nivel de beneficios, según corresponda. En este escenario, si cumplió con el requisito de afección preexistente de la opción de cobertura de cinco años o del plan de discapacidad a largo plazo para conductores de camión y luego sufre una discapacidad antes de cumplir con la exclusión por afección preexistente de la opción de cobertura por duración completa o del plan de discapacidad a largo plazo mejorado para conductores, únicamente recibirá sus beneficios conforme a la opción de cobertura de cinco años o del plan de discapacidad a largo plazo para conductores, según corresponda.

Cómo presentar una reclamación por discapacidad a largo plazo para conductores de camión

Si tiene una reclamación por discapacidad a corto plazo aprobada y está inscrito para recibir los beneficios por discapacidad a largo plazo, su reclamación se transferirá automáticamente de Sedgwick a Lincoln. Apenas tenga conocimiento de que necesitará utilizar su beneficio por discapacidad a largo plazo para conductores de camión, puede comunicarse con Lincoln al **877-353-6404**. Lincoln le proporcionará información adicional sobre cómo completar su reclamación.

Las reclamaciones se determinan dentro de los plazos y requisitos establecidos en el capítulo **Reclamaciones y apelaciones**. Tiene derecho a apelar una reclamación rechazada. Para obtener información, consulte el capítulo **Reclamaciones y apelaciones**.

Cuándo no se pagan los beneficios

No se pagan beneficios por ninguna reclamación de discapacidad a largo plazo para conductores de camión que se deba a lo siguiente:

- Guerra, declarada o no, o cualquier acto de guerra
- Participación activa en disturbios
- Cometer o intento de cometer un delito común o delito menor
- Cirugía plástica, a menos que dicha cirugía esté relacionada con una lesión o enfermedad mientras usted tiene cobertura.

No se paga ningún beneficio durante cualquier periodo de encarcelación.

Cuándo comienzan los beneficios por discapacidad a largo plazo para conductores de camión

Si Lincoln le aprueba los beneficios de discapacidad a largo plazo para conductores de camión, los mismos comenzarán después del periodo de espera de los beneficios: 26 semanas o la finalización de sus beneficios por discapacidad a corto plazo, lo que sea más largo.

SI REGRESA A TRABAJAR DURANTE SU PERIODO DE ESPERA Y QUEDA DISCAPACITADO NUEVAMENTE

Si deja de estar discapacitado y regresa a trabajar por un total de 60 días calendario o menos durante un periodo de espera, se interrumpirá el periodo de espera y deberá cubrir el saldo del periodo de espera si queda discapacitado otra vez. Si vuelve a trabajar durante un total de más de 60 días calendario mientras cumple su periodo de espera del beneficio, debe cumplir con un nuevo periodo de espera completo del beneficio si vuelve a quedar discapacitado antes de ser elegible para recibir los beneficios por discapacidad a largo plazo. No es necesario que la cantidad de días naturales especificada sea consecutiva.

Cómo calcular su beneficio

El importe de la cobertura por discapacidad a largo plazo para conductores de camión se basa en:

- Su salario mensual promedio, y
- Qué plan de discapacidad a largo plazo para conductores de camión seleccionó.

SALARIO MENSUAL PROMEDIO	
Duración del empleo	**Cómo se determina el salario mensual promedio**
Empleado durante 12 meses o más	Su pago por actividad, tarifa por distancia y bonificaciones, pagados en los periodos de 26 pagos anteriores a su último día de trabajo ÷ 12
Empleado durante menos de 12 meses	Su pago por la actividad, tarifa por distancia y bonificaciones desde la fecha de contratación ÷ cantidad de meses trabajados

Tenga en cuenta que se excluirán los periodo de pago en los que no registre ingresos elegibles, lo cual disminuye la cantidad de periodos de pago que se utilizan para el cálculo.

Sus beneficios por discapacidad a largo plazo para conductores de camión se muestran a continuación:

SUS BENEFICIOS POR DISCAPACIDAD A LARGO PLAZO PARA CONDUCTORES DE CAMIÓN	
Si está inscrito	**Su cobertura es**
En el plan de discapacidad a largo plazo de cobertura por cinco años para conductores de camión o en el plan de discapacidad a largo plazo de cobertura por tiempo indefinido	50 % de su salario mensual promedio hasta un beneficio máximo mensual de $15,000, menos el importe de otros beneficios o ingresos para los cuales usted es elegible (por ejemplo, beneficios por discapacidad del sistema de Seguridad Social*)
En el plan de discapacidad a largo plazo mejorado de cobertura por cinco años para conductores de camión o en el plan de discapacidad a largo plazo mejorado de cobertura por tiempo indeterminado	60 % de su salario mensual promedio hasta un beneficio máximo mensual de $18,000, menos el importe de otros beneficios o ingresos para los cuales usted es elegible (por ejemplo, beneficios por discapacidad del sistema de Seguridad Social*)
*Para obtener más información, consulte **Otros beneficios o ingresos que reducen los beneficios por discapacidad a largo plazo para conductores de camión**.	

Su beneficio será superior a $50 por cualquier mes en que sea elegible para recibir beneficios por discapacidad a largo plazo.

Los beneficios por discapacidad a largo plazo para conductores de camión se pagan, siempre y cuando la discapacidad continúe de acuerdo con la definición de los planes de discapacidad a largo plazo para conductores de camión.

Lincoln tiene el derecho de recuperar y usted debe devolver cualquier monto que se le haya pagado de más por beneficios por discapacidad a largo plazo para conductores de camión conforme al plan de discapacidad a largo plazo o el plan mejorado de discapacidad a largo plazo para conductores de camión.

PTO Y SU BENEFICIO DE DISCAPACIDAD A LARGO PLAZO

No es necesario utilizar el tiempo libre pagado (PTO) mientras recibe los beneficios por discapacidad a largo plazo. Si está recibiendo beneficios por discapacidad a largo plazo al final del año del plan del PTO, consulte la póliza del PTO de su ubicación para obtener información sobre el pago y/o la transferencia de días. No se puede acumular PTO adicional mientras esté recibiendo beneficios de discapacidad a largo plazo.

OTROS BENEFICIOS O INGRESOS QUE REDUCEN LOS BENEFICIOS POR DISCAPACIDAD A LARGO PLAZO PARA CONDUCTORES DE CAMIÓN

El monto de su beneficio por discapacidad a largo plazo de conductor de camión se reduce o compensa por otros beneficios o ingresos que usted recibe o es elegible para recibir. “Otros ingresos” incluye cualquier ingreso de cualquier forma de empleo, incluso bajo cualquier licencia por enfermedad formal o informal o planes de continuación de salario. Excepto con respecto a los beneficios de jubilación, los “otros beneficios” solo incluyen los montos a los que usted (o, en determinadas circunstancias, su

familia) tiene derecho como resultado de la misma discapacidad a la que se refiere su beneficio de discapacidad a largo plazo para conductores de camión que se paga. Ejemplos de otros beneficios incluyen montos de lo siguiente:

- Seguro de discapacidad del sistema de Seguridad Social (incluidos los montos que su familia recibe o es elegible para recibir debido a su discapacidad).
- Beneficios de jubilación del sistema de Seguridad Social que son otorgados después de la fecha de la discapacidad (incluidos los beneficios que su familia recibe o es elegible para recibir debido a su elegibilidad para los beneficios de jubilación).
- Compensación para trabajadores
- Planes de seguros grupales relacionados con la compañía que brindan beneficios de discapacidad
- Pólizas individuales pagadas por la compañía o pagadas parcialmente que brindan beneficios de discapacidad en la medida en que dichos beneficios, más su beneficio de discapacidad a largo plazo para conductores de camión, excedan su salario mensual promedio
- Seguros de automóvil sin designación de culpa
- Cualquier beneficio de discapacidad a corto plazo en curso que se pague conforme a la cobertura por discapacidad a corto plazo de Walmart (p. ej., beneficios relacionados con recaídas)
- Pagos estatales por discapacidad
- Beneficios de desempleo, o beneficios en virtud de cualquier otra ley de beneficios gubernamentales
- Convenio o fallo, menos los costos asociados de una demanda, que represente o compense su pérdida de ingresos o de funcionamiento del cuerpo.

Si alguno de estos beneficios que reducen sus beneficios de discapacidad a largo plazo se ajusta posteriormente conforme al aumento del costo de vida, su beneficio de discapacidad a largo plazo no se reducirá aún más. Consulte la póliza para obtener una lista completa de las compensaciones. Puede obtener una copia de la póliza de discapacidad a largo plazo para conductores de camión llamando a Lincoln al **877-353-6404**.

EJEMPLO: REDUCCIÓN DEL BENEFICIO POR DISCAPACIDAD A LARGO PLAZO PARA CONDUCTORES DE CAMIÓN

	Plan de discapacidad a largo plazo (50 %)	Plan mejorado de discapacidad a largo plazo (60 %)
Salario mensual promedio	$3,000	$3,000
Monto del beneficio (porcentaje del salario mensual promedio, sujeto al máximo)	$1,500	$1,800
Menos el beneficio por discapacidad del sistema de Seguridad Social	- $750	- $750
Menos los beneficios de Seguridad Social estimados que reciben los dependientes	- $375	- $375
Pago por discapacidad a largo plazo (mensual)	$375	$675

CÓMO SOLICITAR LOS BENEFICIOS POR DISCAPACIDAD DE SEGURIDAD SOCIAL

Puede ser elegible para recibir beneficios por discapacidad de Seguridad Social después de haber estado discapacitado durante cinco meses. Si su discapacidad ha durado, o se prevé que se durará 12 meses consecutivos, los términos de la póliza de la cobertura por discapacidad a largo plazo para conductores de camión pueden requerir que solicite los beneficios por discapacidad del sistema de Seguridad Social. Si la Administración de Seguridad Social le niega los beneficios, deberá seguir el proceso de apelación de la Administración de Seguridad Social.

Si tiene que solicitar los beneficios por discapacidad de la Seguridad Social y no los solicita, o no facilita un comprobante de la solicitud o del recurso, sus beneficios de discapacidad a largo plazo se reducirán en la cantidad que se calcula que recibirá de la Seguridad Social por discapacidad.

Si califica para recibir beneficios por discapacidad o jubilación de Seguridad Social mientras recibe beneficios bajo cualquiera de sus opciones de plan de discapacidad a largo plazo para conductores de camión y su reclamación de discapacidad de Seguridad Social se aprueba de manera retroactiva, debe reembolsar a Lincoln los beneficios de discapacidad a largo plazo que se hayan pagado de más durante el periodo cubierto por la aprobación retroactiva de Seguridad Social.

Lincoln puede ayudarlo a solicitar los beneficios por discapacidad del sistema de Seguridad Social. A fin de ser elegible para recibir asistencia, debe recibir un beneficio de Lincoln.

Si está discapacitado y trabaja

Puede ser elegible para recibir los beneficios de discapacidad si está parcialmente discapacitado. Conforme a los planes de discapacidad a largo plazo para conductores de camión, "discapacidad parcial" y "parcialmente discapacitado" significan que, como resultado de una enfermedad o lesión, usted puede hacer lo siguiente:

- Realizar una o más tareas materiales y sustanciales propias o de una ocupación a tiempo completo o tiempo parcial, aunque no todas o
- Realizar todas las tareas materiales y sustanciales de su propia ocupación o cualquier ocupación trabajando a tiempo parcial y
- Ganar entre el 20 % y el 80 % de sus ingresos mensuales promedios indexados.

Si acepta un nuevo puesto de trabajo y realiza todas las funciones materiales y sustanciales a tiempo completo, no está parcialmente discapacitado.

Lincoln ofrece un beneficio de incentivo laboral durante los primeros seis periodos de pago que usted queda parcialmente discapacitado y sigue trabajando. Continuará recibiendo el monto completo de su beneficio mensual durante los primeros seis periodos de pago si queda parcialmente discapacitado, a menos que su beneficio e ingresos actuales superen sus ingresos mensuales básicos anteriores a la discapacidad. Su beneficio mensual se reducirá por el monto excedido a fin de que el beneficio mensual más sus ingresos no superen el 100 % de su salario mensual promedio.

Luego de los primeros seis periodos de pago que queda parcialmente discapacitado y sigue trabajando, el siguiente cálculo se utiliza para determinar su beneficio mensual para una discapacidad parcial.

CÁLCULO DE BENEFICIOS SI ESTÁ DISCAPACITADO Y TRABAJA	
[(A - B) ÷ A] x C = D	
A	Su salario mensual promedio indexado
B	Sus ingresos mensuales parciales actuales
C	El beneficio mensual que le correspondería si estuviera totalmente discapacitado, menos otros beneficios o ingresos que reduzcan los beneficios por discapacidad a largo plazo del conductor de camión
D	Beneficio para pagar si está discapacitado y trabaja

*El "salario mensual promedio indexado" significa que sus ingresos mensuales previos a la discapacidad se incrementaron anualmente en 7 % o el cambio de porcentaje en el Índice de precios al consumidor, lo que sea menor.

SI FALLECE MIENTRAS RECIBE BENEFICIOS POR DISCAPACIDAD A LARGO PLAZO PARA CONDUCTORES DE CAMIÓN

La cobertura de los planes de discapacidad a largo plazo para conductores de camión finaliza después de su fallecimiento. Sin embargo, si fallece mientras está recibiendo beneficios por discapacidad a largo plazo para conductores de camión, se le pagará una suma única de $5,000 o tres veces su último beneficio por discapacidad a largo plazo mensual bruto, el que sea superior, a su cónyuge/pareja sobreviviente. Si no lo sobrevive un cónyuge/pareja, el pago se realizará a sus hijos sobrevivientes en partes iguales, incluidos los hijastros y los hijos legalmente adoptados. Sin embargo, si alguno de estos hijos es menor de edad o está incapacitado, el pago se realizará en su nombre al tutor legal de los bienes de los hijos designado por un tribunal. Si un cónyuge/pareja o hijos no le sobreviven, el pago se hará a sus herederos.

Cuándo finalizan los pagos de los beneficios por discapacidad a largo plazo para conductores de camión

Los pagos de beneficios por discapacidad a largo plazo para conductores de camión finalizan cuando se cumpla la primera de las siguientes opciones:

- La fecha en que no presente prueba de que continúa con la discapacidad y consulta regularmente a un médico
- La fecha en que no coopera con la administración de su reclamación. Por ejemplo, brindar información o documentos necesarios para determinar si se pagarán los beneficios y/o determinar el monto del beneficio
- La fecha en que se rehúsa a ser examinado o evaluado a intervalos razonables
- La fecha en que se rehúsa a recibir tratamiento adecuado disponible
- La fecha en que rechaza un trabajo similar en Walmart, que ofrece un salario comparable al suyo, en el cual se realizan modificaciones o ajustes en el lugar de trabajo para permitirle realizar su tarea
- En el momento en que pueda trabajar en su propia ocupación a tiempo parcial pero elija no hacerlo
- La fecha en que sus ganancias mensuales por discapacidad parcial superen el 80 % de sus salarios mensuales promedios indexados
- Cuando deje de coincidir con la definición de discapacidad del plan
- El último día de su periodo máximo en el cual recibirá los beneficios (consulte las tablas a continuación) o
- La fecha de su fallecimiento.

NOTA: Su empleo no es una condición para la continuación de los beneficios por discapacidad a largo plazo.

COBERTURA POR CINCO AÑOS

Los planes de cobertura por cinco años pagan beneficios durante 60 meses, a menos que la cantidad de tiempo que se muestra en la tabla **Máxima duración de la discapacidad a largo plazo para conductores de camión** de abajo dé como resultado una duración de beneficios de menos de 60 meses, en cuyo caso el beneficio mensual será pagadero por el periodo menor.

COBERTURA POR DURACIÓN COMPLETA

La cobertura por duración completa paga beneficios por la cantidad de tiempo que se muestra en la tabla **Máxima duración de la discapacidad a largo plazo para conductores de camión** de abajo.

MÁXIMA DURACIÓN DE LA DISCAPACIDAD A LARGO PLAZO PARA CONDUCTORES DE CAMIÓN	
Edad cuando quedó discapacitado	**Duración de los beneficios**
Antes de los 62 años	Hasta la edad normal de jubilación del Seguro Social (como se indica a continuación)
62	48 meses
63	42 meses
64	36 meses
65	30 meses
66	27 meses
67	24 meses
68	21 meses
69 o más	18 meses

EDAD NORMAL DE JUBILACIÓN SEGÚN LA ADMINISTRACIÓN DE SEGURIDAD SOCIAL	
Año de nacimiento	**Edad normal de jubilación**
1937 o antes	65
1938	65 + 2 meses
1939	65 + 4 meses
1940	65 + 6 meses
1941	65 + 8 meses
1942	65 + 10 meses
1943 hasta 1954	66
1955	66 + 2 meses
1956	66 + 4 meses
1957	66 + 6 meses
1958	66 + 8 meses
1959	66 + 10 meses
1960 o después	67

SI LA DISCAPACIDAD SE DEBE A UNA ENFERMEDAD MENTAL, ALCOHOLISMO O DROGADICCIÓN

Para recibir beneficios por discapacidad a largo plazo de conductores de camión durante más de 24 meses por las siguientes discapacidades, debe estar internado en un hospital u otro lugar autorizado para brindar atención médica:

- Enfermedad mental (no incluye daño cerebral estructural y demostrable)
- Cualquier afección que sea consecuencia de una enfermedad mental
- Alcoholismo y
- Uso no médico de narcóticos, sedantes, estimulantes, alucinógenos o sustancias similares.

Cuando no está internado en un hospital u otra institución autorizada, tiene un beneficio de 24 meses para estas discapacidades, a menos que participe totalmente de un plan de tratamiento extendido para la afección que ocasionó la discapacidad, en cuyo caso el beneficio se paga hasta 36 meses.

Si regresa a trabajar y queda discapacitado nuevamente

Si usted vuelve a trabajar durante menos de seis meses de trabajo activo a tiempo completo y se vuelve a incapacitar por la misma afección o una afección relacionada que causó el primer periodo de discapacidad, según lo determinado por Lincoln, lo que se conoce como una "recaída/reclamación sucesiva", la discapacidad sucesiva será parte de la misma discapacidad. Sus beneficios por discapacidad a largo plazo continuarán a partir de donde habían quedado antes de que volviera a trabajar. No habrá periodos de espera adicionales. La duración del beneficio combinado para ambos periodos de discapacidad no superará la máxima duración que figura en la tabla de la página anterior.

Si regresa al trabajo como asociado a tiempo completo por seis meses consecutivos o más, cualquier recurrencia de una discapacidad se tratará como una discapacidad nueva. Se deberá cumplir un nuevo periodo de espera de beneficios.

Si está con licencia de ausencia o sujeto a cesantía temporal

Una vez que entra en vigencia su cobertura por discapacidad a largo plazo para conductores de camión, si no está trabajando activamente debido a una licencia de ausencia o cesantía temporal, su cobertura por discapacidad a largo plazo continúa durante 90 días desde el inicio de su licencia de ausencia o cesantía temporal. El derecho a la cobertura por discapacidad a largo plazo para conductores de camión finaliza a los 91 días del inicio de la licencia de ausencia o de la cesantía temporal, pero se restablece si vuelve a trabajar en el plazo de un año. Para obtener más información, consulte el párrafo **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**, que incluye detalles sobre el pago de la cobertura de los beneficios durante una licencia.

NOTA: Si su cobertura por discapacidad a largo plazo finaliza porque su licencia o despido temporal excede los 90 días, seguirá teniendo derecho a los beneficios por discapacidad a largo plazo por cualquier enfermedad o lesión que se haya producido antes de la fecha de finalización de su cobertura.

Cuándo finaliza la cobertura por discapacidad a largo plazo

La cobertura por discapacidad a largo plazo para conductores de camión finaliza:

- La fecha en la que abandone voluntariamente la cobertura (como se describe a continuación)
- El último día del periodo de pago inmediatamente anterior al periodo de pago en que su estado laboral cambia de un estado laboral elegible
- El último día de la cobertura para la que se pagaron las primas, si no pagó las primas dentro de los 30 días de la fecha de vencimiento de estas
- En la fecha en que pierde la elegibilidad
- Si no regresa a trabajar después del último día de una licencia de ausencia
- Cuando Walmart deja de ofrecer el beneficio, o
- En la fecha de su fallecimiento.

Si su clasificación de empleo cambia, consulte la tabla correspondiente en la sección **Cambio de una clasificación laboral a otra** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información sobre cualquier repercusión en su cobertura.

Si cancela voluntariamente la cobertura después de un evento de cambio de elección o en la Inscripción Anual, la cobertura finaliza de la siguiente manera:

- **Tras un evento de cambio de elección:** la cobertura finaliza el día en que solicite el cambio de elección. Para obtener más información, consulte **Cambios de elección permitidos fuera del periodo de Inscripción anual** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.
- **En la Inscripción anual: la cobertura** finaliza el 31 de diciembre del año en curso.

Si deja Walmart y lo contratan nuevamente

Si es un conductor de camión a tiempo completo por hora, un miembro de la gerencia o conductor de camión, consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para saber cómo el hecho de dejar de trabajar en Walmart y volver a hacerlo afecta sus beneficios.

Seguro de vida pagado por la compañía

La información de este capítulo describe los beneficios del seguro de vida pagado por la compañía que pueden estar a su disposición si:

- Usted es un asociado a tiempo completo por hora o asalariado (gerencia), y
- Ha cumplido todos los requisitos para que la cobertura sea efectiva, incluidos los requisitos de trabajo activo.

Si tiene preguntas sobre los requisitos de elegibilidad, los requisitos para que la cobertura sea efectiva y la repercusión en sus beneficios de un cambio en su clasificación laboral, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Esta información pretende ser un resumen de sus beneficios y es posible que no incluya todas las condiciones de la póliza. Si existen diferencias entre este documento y la póliza emitida por Prudential respecto del cálculo de los beneficios y las limitaciones en virtud de la póliza, regirán los términos de la póliza. Puede obtener una copia de esta póliza si se comunica con el Plan.

Seguro de vida pagado por la compañía

Walmart le brinda automáticamente seguro de vida sin costo. Para que pueda estar tranquilo al saber que sus seres queridos tendrán ayuda financiera si pasara lo impensable.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Cambie su designación de beneficiario	Visite **One.Walmart.com/Beneficiary**	Los cambios de beneficiario no se pueden realizar por teléfono
• Obtenga más información sobre la cobertura • Solicite un beneficio acelerado • Obtenga más información sobre cómo continuar con el seguro		Llame a Prudential al **877-740-2116**
Cómo presentar una reclamación		Llame a Prudential al **877-740-2116**

Lo que debe saber sobre el seguro de vida pagado por la compañía

- Si usted es un asociado elegible, Walmart le ofrece una cobertura de seguro de vida sin costo alguno para usted. No es necesario inscribirse, ni presentar una evidencia de buena salud.
- Su monto de cobertura es igual a su salario anualizado, incluidas las horas extras y bonificaciones, durante el periodo de un año previo a su fallecimiento, redondeado a los $1,000 más cercanos, hasta un máximo de $50,000.
- Está disponible un pago de liquidación anticipado por enfermedad terminal.
- La cobertura se ofrece a través de Prudential Insurance Company of America (Prudential).
- Esta póliza es de un seguro de vida a plazo. No tiene valor en efectivo.
- El Certificado de seguro está disponible en línea en **One.Walmart.com** o en **Prudential.com/Walmart**. El certificado proporciona información detallada sobre el seguro de vida pagado por la compañía, además de los aspectos más destacados disponibles en este capítulo.

Seguro de vida pagado por la compañía

El monto de su cobertura pagada por la compañía es igual a su tasa salarial anualizada, que incluye las horas extra y los bonos, basado en los 26 periodos salariales anteriores de situación activa (si se paga quincenalmente) o 52 semanas (si se paga semanalmente) anteriores a su último día trabajado, redondeado a los $1,000 más cercanos, hasta un máximo de $50,000. Las comisiones y los demás beneficios no se incluyen en su salario anualizado.

Si fallece fuera de un radio de 100 millas de su hogar, existe un beneficio para los gastos por trasladar su cuerpo de regreso a un lugar escogido dentro de los Estados Unidos o a su residencia en el momento del fallecimiento. El beneficio incluye los gastos de embalsamamiento, cremación, un ataúd y el transporte de los restos mortales. El beneficio consiste en el monto que sea menor por el costo de transporte de sus restos mortales o $20,000.

Cómo nombrar a un beneficiario

A fin de garantizar que su beneficio de seguro de vida pagado por la compañía se pague como usted desea, debe nombrar a los beneficiarios. Para ello, visite **One.Walmart.com/Beneficiary**. La designación del beneficiario debe completarse y enviarse al Plan antes de su fallecimiento. Póngase en contacto con el Servicios al Personal llamando al **800-421-1362** si no puede acceder a la herramienta Beneficiary Online.

Puede nombrar a cualquier persona que desee. Si el (los) beneficiario(s) que figura(n) en su designación de beneficiarios archivada en el Plan difiere(n) del (de los) beneficiario(s) nombrado(s) en su testamento, la designación de beneficiarios archivada en el Plan prevalecerá. Si no ha designado beneficiarios conforme al beneficio de seguro de vida pagado por la compañía, el pago se realizará a los miembros sobrevivientes de su familia, tal como se describe en **Si no nombra a un beneficiario** más adelante en esta página.

Se necesita la siguiente información por cada beneficiario:

- Nombre
- Dirección y número de teléfono actuales
- Relación con usted
- Número de seguridad social
- Fecha de nacimiento
- Porcentaje que desea designar a cada beneficiario, hasta el 100 %.

Si se designa a dos o más beneficiarios y sus cuotas no están especificadas, compartirán el beneficio del seguro en partes iguales. Si un beneficiario designado falleciera antes que usted, el derecho de tal beneficiario cesará y se distribuirá en partes iguales entre los restantes beneficiarios, a menos que su formulario de beneficiarios indique lo contrario. Si usted y un beneficiario fallecen en el mismo evento y no se puede determinar quién falleció primero, se tratará al beneficiario como si hubiera fallecido antes que usted.

Puede nombrar a un menor de edad como beneficiario; sin embargo, es posible que Prudential no tenga autorización legal para pagarle al menor hasta que sea mayor de edad. Es recomendable que consulte a un abogado o a un asesor testamentario antes de nombrar a un menor de edad como beneficiario. Si nombra a un menor de edad como beneficiario, no se podrán pagar los gastos funerarios de los beneficios del menor.

CÓMO CAMBIAR DE BENEFICIARIO

Usted puede cambiar los beneficiarios en cualquier momento en **One.Walmart.com/Beneficiary**. Cualquier cambio de beneficiario se debe completar y enviar al Plan antes de su fallecimiento y solo puede ser enviado por usted, el asociado cubierto. Póngase en contacto con el Servicios al Personal llamando al **800-421-1362** si no puede acceder a la herramienta Beneficiary Online.

SI NO NOMBRA A UN BENEFICIARIO

Si no se nombra un beneficiario o si los beneficiarios no están vivos cuando usted fallece, el pago se realizará a sus familiares vivos en el siguiente orden:

- Cónyuge o pareja del difunto; si no viven, a sus
- Hijos en partes iguales; si no viven, a sus
- Padres en partes iguales; si no viven, a sus
- Hermanos en partes iguales; si no viven, a sus
- Herederos.

Mantenga actualizada la información de sus beneficiarios. Los beneficios serán para cualquier persona que se en`cuentre en la lista de la designación de beneficiarios con el Plan, independientemente de su relación actual con esa persona, a menos que la ley aplicable diga lo contrario. Usted puede cambiar los beneficiarios en cualquier momento en **One.Walmart.com/Beneficiary**.

Pago de liquidación anticipado por enfermedad terminal

Si tiene una enfermedad terminal, puede elegir recibir un "beneficio acelerado" en vida de hasta el 50 % del monto de cobertura que sus beneficiarios hubieran recibido después de su fallecimiento (calculado el día que presente el comprobante de enfermedad terminal). El pago se realiza a usted en una sola vez. Después de su fallecimiento, sus beneficiarios reciben el monto de cobertura del seguro de vida vigente en la fecha de su fallecimiento, menos el monto de pagos anticipados que haya recibido antes de su muerte.

Si finaliza su relación laboral en Walmart después de recibir (o comenzar a recibir) el beneficio acelerado, necesitará convertir la póliza para que sus beneficiarios reciban el saldo después de su fallecimiento. Si no convierte su póliza al finalizar la relación laboral, no se pagará ningún beneficio a sus beneficiarios. Consulte la sección **Cómo continuar su seguro de vida pagado por la compañía después de dejar de trabajar en Walmart o si pierde la cobertura**en este capítulo para obtener detalles sobre la conversión.

Conforme a la póliza, se considera que tiene una enfermedad terminal si su expectativa de vida es de 12 meses y un médico puede certificar que la enfermedad o dolencia es terminal.

En algunas circunstancias, no se paga el beneficio acelerado. Llame a Prudential al **877-740-2116** para obtener más información.

Consulte a un profesional fiscal para que evalúe las consecuencias de este beneficio.

Presentar una reclamación de seguro de vida pagado por la compañía

Se debe proporcionar la siguiente información a Prudential con respecto al asociado fallecido:

- Nombre
- Número de seguridad social
- Fecha del fallecimiento
- Causa del fallecimiento (si se conoce).

Es posible que se requiera presentar el original o una copia certificada del certificado de defunción como prueba del fallecimiento. El certificado de defunción debe enviarse por correo postal a la siguiente dirección:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

Si se requiere un certificado de defunción, la reclamación no se finalizará hasta que Prudential reciba el certificado de defunción. La aceptación del certificado de defunción no garantiza el pago.

Las reclamaciones se determinan dentro de los plazos y requisitos establecidos en el capítulo **Reclamaciones y apelaciones**. Sus beneficiarios tienen derecho a apelar una reclamación rechazada.

Los beneficios se pagan de acuerdo con los términos de la póliza del seguro. Para obtener información, llame a Prudential al **877-740-2116**.

Cuándo no se pagan los beneficios

No se pagan beneficios si fallece antes de la fecha de entrada en vigor de su cobertura.

Cuándo finaliza la cobertura del seguro de vida pagado por la compañía

La cobertura de su seguro de vida pagado por la compañía finaliza:

- El momento del cese de su relación laboral.
- El último día del periodo de pago en que su condición laboral cambia a asociado a tiempo parcial
- En la fecha de su fallecimiento
- En la fecha de pérdida de la elegibilidad.
- El último día de una licencia aprobada (a menos que vuelva a trabajar) o
- Cuando Walmart deje de ofrecer el beneficio.

Esta póliza es de un seguro de vida a plazo. No tiene valor en efectivo.

EstateGuidance®

EstateGuidance le permite preparar el testamento en línea desde su computadora personal sin costo alguno para usted. El testamento garantiza que sus bienes se distribuirán según su voluntad y le permite designar a un tutor para sus hijos menores de edad. Para completar el cuestionario en línea, ingrese en **willguidance.com**, contraseña: **Walmart**.

NOTA: Su testamento no anulará la designación de beneficiarios en una póliza de seguro de vida o en una cuenta de jubilación, como un plan 401(k). Por esta razón, consulte sus designaciones de beneficiarios, en especial luego de crear un testamento, para asegurarse de que sus designaciones se condigan con sus deseos. Si el (los) beneficiario(s) que usted haya puesto en su designación de beneficiarios archivada en el Plan difiere(n) del (de los) beneficiario(s) nombrado(s) en su testamento, la designación de beneficiarios archivada en el Plan prevalecerá.

Walmart pone EstateGuidance a su disposición para su comodidad y no recomienda ni avala específicamente EstateGuidance para la preparar su testamento. Debe elegir el servicio de preparación de testamentos o el proveedor de servicios que mejor se adapte a sus necesidades y metas personales. EstateGuidance no proporciona asesoramiento fiscal ni legal.

Cómo continuar su seguro de vida pagado por la compañía después de dejar de trabajar en Walmart o si pierde la cobertura

En la mayoría de los casos, tiene dos opciones para continuar con su seguro de vida pagado por la compañía si su cobertura de vida grupal finaliza. La primera opción, denominada **transferibilidad**, le permite continuar total o parcialmente su cobertura actual a través de una póliza grupal temporal con Prudential. La segunda opción, denominada **conversión**, le permite convertir su cobertura total o parcialmente en una póliza individual de Prudential.

Usted debe solicitar la transferibilidad o la conversión dentro de los 31 días a partir de la fecha en que finaliza su cobertura pagada por la compañía. Si fallece dentro de los 31 días de una pérdida de cobertura que califique y antes de elegir la posibilidad de transferir o la conversión de su cobertura de seguro de vida, Prudential le pagará a su beneficiario un Beneficio de fallecimiento. El beneficio se pagará sobre la base del monto de la cobertura que estaba en vigencia antes de que ocurriera la pérdida de cobertura que califique, incluso si usted no solicitó la transferencia o conversión de su cobertura.

Su cobertura no podrá continuar a menos que se ponga en contacto con Prudential en un plazo de 31 días a partir de la fecha de finalización de su cobertura.

La transferibilidad le permite mantener un seguro de vida temporal similar con Prudential luego de que termine su relación laboral, siempre que se reúnan determinadas condiciones. Se exige evidencia de buena salud para transferir su cobertura. Si usted no lo presenta o no se lo aprueban, será elegible para convertir su seguro de vida pagado por la compañía en una póliza individual, como se describe a continuación.

Puede solicitar una cobertura de vida a plazo en virtud de la transferibilidad si reúne todas estas condiciones:

- Su cobertura de vida pagada por la compañía finaliza por una razón que no sea que:
  - Abandona Walmart a causa de una discapacidad, o
  - Walmart cambia de compañía de seguros para el seguro de vida grupal y usted es elegible o pasa a ser elegible dentro de los 31 días siguientes.
- Está trabajando de manera activa el día que finaliza el seguro pagado por la compañía.
- Tiene menos de 80 años.
- El monto de su seguro es de $20,000, como mínimo, el día en que finaliza su seguro pagado por la compañía.

Si reúne estas condiciones, tendrá 31 días a partir de la fecha del cese para comunicarse con Prudential e inscribirse.

La conversión es una disposición obligatoria del Plan que le permite convertir su cobertura de seguro de vida en una póliza individual si la cobertura finalizara porque deja de trabajar en la compañía o cambia de clase elegible. No debe presentar evidencia de buena salud. Las tarifas se basan en su edad y en el monto convertido. Tiene 31 días a partir de la fecha del cese de la cobertura para solicitar convertir su cobertura en una póliza individual. Si se le envió un aviso de conversión por correo y fallece dentro del periodo de conversión de 31 días, el beneficio de fallecimiento se pagará hasta el monto que se haya podido convertir. Si no se le ha enviado por correo una notificación de conversión y fallece durante el periodo de 91 días inmediatamente posterior a la fecha de finalización de su cobertura, el beneficio por fallecimiento se abonará hasta el monto que podría haberse convertido.

Si es residente de Minnesota, tiene derecho a continuar la cobertura en lugar de convertirla cuando la pierde debido a una reducción de horas o la finalización de la relación laboral (que no sea una falta de conducta grave). Puede elegir continuar la cobertura por su cuenta hasta que obtenga cobertura de otra póliza de seguro de vida grupal; sin embargo, el periodo máximo por el que puede continuar con la cobertura es 18 meses. Si continúa la cobertura, cuando se venza el periodo de continuación, puede convertir su cobertura de seguro de vida en una póliza individual, como se describió anteriormente.

Para solicitar información sobre la transferibilidad o la conversión, llame a Prudential al **877-740-2116**.

Si deja Walmart y lo contratan nuevamente

Si es un asociado a tiempo completo por hora o de la gerencia (incluidos los conductores de camión a tiempo completo pero no los conductores de camión a tiempo parcial), consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener detalles sobre cómo el hecho de dejar de trabajar en Walmart y regresar al trabajo afecta sus beneficios.

Seguro de vida pagado por la compañía

Seguro de vida opcional para asociados

La información de este capítulo describe los beneficios opcionales del seguro de vida asociado que pueden estar a su disposición si:

- Es usted un conductor de camión por hora, temporal, a tiempo parcial, o un asociado asalariado (de la gerencia)
- Ha cumplido todos los requisitos para que la cobertura tenga vigencia, incluidos los requisitos de trabajo activo, y
- Se ha inscrito debida y oportunamente.

Si tiene preguntas sobre los requisitos de elegibilidad, los requisitos para que la cobertura sea efectiva y la repercusión en sus beneficios de un cambio en su clasificación laboral, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Esta información pretende ser un resumen de sus beneficios y es posible que no incluya todas las condiciones de la póliza. Si existen diferencias entre este documento y la póliza emitida por Prudential respecto del cálculo de los beneficios y las limitaciones en virtud de la póliza, regirán los términos de la póliza. Puede obtener una copia de esta póliza si se comunica con el Plan.

Seguro de vida opcional para asociados

El seguro de vida opcional para asociados cuida a su familia ofreciéndoles protección financiera adicional durante momentos difíciles.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Cambie su designación de beneficiario	Visite **One.Walmart.com/Beneficiary**	Los cambios de beneficiario no se pueden realizar por teléfono
• Obtenga más información • Solicite un beneficio acelerado • Obtenga más información sobre cómo continuar con el seguro		Llame a Prudential al **877-740-2116**
Cómo presentar una reclamación		Llame a Prudential al **877-740-2116**

Lo que debe saber sobre el seguro de vida opcional para asociados

- Según el monto de cobertura que elija y cuándo se inscriba, debe presentar evidencia de buena salud.
- Está disponible un pago de liquidación anticipado por enfermedad terminal.
- La cobertura se ofrece a través de Prudential Insurance Company of America (Prudential).
- Esta póliza es de un seguro de vida a plazo. No tiene valor en efectivo.
- El Certificado de seguro está disponible en línea en **One.Walmart.com** o en **Prudential.com/Walmart**. El certificado proporciona información detallada sobre el seguro de vida pagado por la compañía, además de los aspectos más destacados disponibles en este capítulo.

Seguro de vida opcional para asociados

El seguro de vida opcional para asociados protege a su familia si usted fallece mientras rige la cobertura. Si tiene una enfermedad terminal, es posible que se le pague un beneficio adicional en vida.

Las opciones de cobertura para el seguro de vida opcional para asociados dependen de su clasificación laboral, tal como se indica en el sistema de nóminas de Walmart. Los montos de cobertura que puede elegir se muestran en la siguiente tabla.

ASOCIADOS PAGADOS POR HORA Y CONDUCTORES DE CAMIÓN A TIEMPO PARCIAL		ASOCIADOS GERENCIALES	
$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

Para obtener los detalles de las clasificaciones de puestos que reúnan los requisitos, consulte la sección **Inscripción y fechas efectivas por clasificación laboral** del capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Si usted fallece, sus beneficiarios pueden recibir el pago de una única suma por el monto de cobertura que usted seleccione.

El costo del seguro de vida opcional para asociados se basa en el monto de cobertura que selecciona, su edad y si usted es elegible para las tarifas para personas libres de tabaco. Las primas de la cobertura del seguro de vida opcional para asociados no subsidian la cobertura conforme al seguro de vida pagado por la compañía.

EVIDENCIA DE BUENA SALUD

Debe presentar evidencia de buena salud para el seguro de vida opcional para asociados en caso de que:

- El monto de cobertura seleccionado supere los $25,000 durante su periodo de inscripción inicial
- Se inscriba después de su periodo de inscripción inicial por cualquier monto, o
- Aumente su cobertura después de su periodo de inscripción inicial.

La evidencia de buena salud consiste en completar un cuestionario relacionado con su historia clínica y, posiblemente, hacerse un examen médico. El cuestionario de la evidencia de buena salud se pone a su disposición en el momento de su inscripción.

Si se requiere evidencia de buena salud, la cobertura no será efectiva hasta que Prudential la apruebe. Para obtener información, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Cómo nombrar a un beneficiario

A fin de garantizar que su beneficio de seguro de vida se pague como usted desea, debe nombrar a los beneficiarios que recibirán el beneficio de su seguro de vida opcional para asociados si usted fallece. Para ello, visite **One.Walmart.com/Beneficiary**. La designación del beneficiario debe completarse y enviarse al Plan antes de su fallecimiento. Póngase en contacto con el Servicios al Personal llamando al **800-421-1362** si no puede acceder a la herramienta Beneficiary Online.

Puede nombrar a cualquier persona que desee. Si el (los) beneficiario(s) que figura(n) en su designación de beneficiarios archivada en el Plan difiere(n) del (de los) beneficiario(s) nombrado(s) en su testamento, la designación de beneficiarios archivada en el Plan prevalecerá. Si no ha designado beneficiarios conforme al beneficio de seguro de vida opcional para asociados, el pago se realizará a los miembros sobrevivientes de su familia, tal como se describe en **Si no nombra a un beneficiario** más adelante en este capítulo.

Se necesita la siguiente información por cada beneficiario:

- Nombre
- Dirección y número de teléfono actuales
- Relación con usted
- Número de seguridad social
- Fecha de nacimiento
- Porcentaje que desea designar a cada beneficiario, hasta el 100 %.

Si se designa a dos o más beneficiarios y sus cuotas no están especificadas, compartirán el beneficio del seguro en partes iguales. Si un beneficiario designado falleciera antes que usted, el derecho de tal beneficiario cesará y se distribuirá en partes iguales entre los restantes beneficiarios, a menos que su formulario de beneficiarios indique algo distinto. Si usted y un beneficiario fallecen en el mismo evento y no se puede determinar quién falleció primero, se tratará al beneficiario como si hubiera fallecido antes que usted.

Puede nombrar a un menor de edad como beneficiario; sin embargo, es posible que Prudential no tenga autorización legal para pagarle al menor hasta que sea mayor de edad. Es recomendable que consulte a un abogado o a un asesor testamentario antes de nombrar a un menor de edad como beneficiario. Si nombra a un menor de edad como beneficiario, no se podrán pagar los gastos funerarios de los beneficios del menor.

CÓMO CAMBIAR DE BENEFICIARIO

Usted puede cambiar los beneficiarios en cualquier momento en **One.Walmart.com/Beneficiary**. Cualquier cambio de beneficiario se debe completar y enviar al Plan antes de su fallecimiento y solo puede ser enviado por usted, el asociado. Póngase en contacto con el Servicios al Personal llamando al **800-421-1362** si no puede acceder a la herramienta Beneficiary Online.

Mantenga actualizada la información de sus beneficiarios. Los beneficios serán para cualquier persona que se encuentre en la lista de la designación de beneficiarios con el Plan, independientemente de su relación actual con esa persona, a menos que la ley aplicable diga lo contrario. Usted puede cambiar los beneficiarios en cualquier momento en **One.Walmart.com/Beneficiary**.

SI NO NOMBRA A UN BENEFICIARIO

Si no se nombra un beneficiario o si los beneficiarios no están vivos cuando usted fallece, el pago se realizará a sus familiares vivos en el siguiente orden:

- Cónyuge o pareja del difunto; si no viven, a sus
- Hijos en partes iguales; si no viven, a sus
- Padres en partes iguales; si no viven, a sus
- Hermanos en partes iguales; si no viven, a sus
- Herederos.

Pago de liquidación anticipado por enfermedad terminal

Si tiene una enfermedad terminal, puede elegir recibir un "beneficio acelerado" en vida de hasta el 50 % del monto de la cobertura que sus beneficiarios hubieran recibido después de su fallecimiento, hasta un máximo de $250,000. El pago se realiza a usted en una sola vez. Después de su fallecimiento, sus beneficiarios reciben el monto total de cobertura vigente al momento de su fallecimiento, menos el monto de pagos anticipados que haya recibido antes de su muerte.

Si finaliza su relación laboral en Walmart después de recibir (o comenzar a recibir) el beneficio acelerado, necesitará convertir la póliza para que sus beneficiarios reciban el saldo después de su fallecimiento. Si no convierte su póliza al finalizar la relación laboral, no se pagará ningún beneficio a sus beneficiarios. Consulte la sección **Cómo continuar su seguro de vida opcional para asociados cuando deja Walmart o si pierde la cobertura** más adelante en este capítulo para obtener detalles sobre la conversión.

Conforme a la póliza, se considera que tiene una enfermedad terminal si su expectativa de vida es de 12 meses y un médico puede certificar que la enfermedad o dolencia es terminal.

En algunas circunstancias, no se paga el beneficio acelerado. Llame a Prudential al **877-740-2116** para obtener más información.

Consulte a un profesional fiscal para que evalúe las consecuencias de este beneficio.

Presentar una reclamación de seguro de vida opcional para asociados

Se debe proporcionar la siguiente información a Prudential con respecto al asociado fallecido:

- Nombre
- Número de seguridad social
- Fecha del fallecimiento
- Causa del fallecimiento (si se conoce).

Es posible que se requiera presentar el original o una copia certificada del certificado de defunción como prueba del fallecimiento. El certificado de defunción debe enviarse por correo postal a la siguiente dirección:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

Si se requiere un certificado de defunción, la reclamación no se finalizará hasta que Prudential reciba el certificado de defunción. La aceptación del certificado de defunción no garantiza el pago.

Las reclamaciones se determinan dentro de los plazos y requisitos establecidos en el capítulo **Reclamaciones y apelaciones**. Su beneficiario tiene el derecho de apelar una reclamación rechazada.

Los beneficios se pagan de acuerdo con los términos de la póliza del seguro. Para obtener más información, comuníquese con Prudential al **877-740-2116**.

Cuándo no se pagan los beneficios

No se pagan beneficios a sus beneficiarios si usted se suicida, ya sea que se encuentre en su sano juicio o no, durante los primeros dos años de cobertura. Si aumenta su cobertura y se suicida dentro de los dos años de la fecha en que aumentó su cobertura, sus beneficiarios recibirán el monto de cobertura anterior.

Si sus beneficiarios presentan una reclamación dentro de los primeros dos años de la fecha de aprobación, Prudential tiene el derecho de volver a evaluar el cuestionario evidencia de buena salud. Si se descubre que los hechos materiales sobre usted se establecieron de manera incorrecta, se usarán las circunstancias reales para determinar qué monto de cobertura debería haber regido, si correspondiera, y:

- Se puede rechazar la reclamación.
- Se pueden reembolsar las primas pagadas.

Si fallece antes de la fecha de entrada en vigor de su cobertura, no se pagará ningún beneficio.

Interrupción de la cobertura

Puede haber ocasiones en las que deba tomar medidas especiales para pagar sus primas de seguro de vida opcional para asociados a fin de evitar la Interrupción de la cobertura. Estas situaciones se producen con más frecuencia si se encuentra con una licencia de ausencia o si su cheque de pago de Walmart no es suficiente para pagar toda la parte que le corresponde del costo de cobertura (por ejemplo, después de una reducción de horas). Si no realiza el pago de la prima dentro de los 30 días siguientes a la fecha de vencimiento, la cobertura se cancelará.

Consulte **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información detallada sobre cómo realizar los pagos de las primas para que no haya un lapso en su cobertura.

SI SE TOMA UNA LICENCIA DE AUSENCIA

Puede continuar su cobertura hasta el último día de una licencia de ausencia aprobado, solo si paga sus primas antes de que comience la licencia de ausencia o durante este. Para obtener información sobre cómo realizar los pagos durante una licencia, consulte la sección **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** .

Cuándo finaliza la cobertura del seguro de vida opcional para asociados

Su cobertura del seguro de vida opcional para asociados finaliza:

- En la fecha en la que abandone voluntariamente la cobertura (como se describe a continuación)
- El momento del cese de su relación laboral.
- El último día de la cobertura para la que se pagaron las primas, si no pagó las primas dentro de los 30 días de la fecha de vencimiento de estas
- En la fecha de su fallecimiento
- El último día de una licencia aprobada (a menos que vuelva a trabajar) o
- Cuando Walmart deje de ofrecer el beneficio.

Si su clasificación de empleo cambia, consulte la tabla correspondiente en la sección **Cambio de una clasificación laboral a otra** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información sobre cualquier repercusión en su cobertura.

Si cancela voluntariamente la cobertura después de un evento de cambio de elección o en la Inscripción Anual, la cobertura finaliza de la siguiente manera:

- **Tras un evento de cambio de elección:** la cobertura finaliza en la fecha efectiva del evento. Para obtener más información, consulte **Cambios de elección permitidos fuera del periodo de Inscripción anual** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.
- **En la Inscripción anual: la cobertura** finaliza el 31 de diciembre del año en curso.

Esta póliza es de un seguro de vida a plazo. No tiene valor en efectivo.

Cómo continuar su seguro de vida opcional para asociados cuando deja Walmart o si pierde la cobertura

En la mayoría de los casos, tiene dos opciones para continuar con su seguro de vida opcional para asociados si su cobertura de vida grupal finaliza. La primera opción, denominada **transferibilidad**, le permite continuar total o parcialmente su cobertura actual a través de una póliza grupal temporal con Prudential. La segunda opción, denominada **conversión**, le permite convertir su cobertura total o parcialmente en una póliza individual de Prudential.

Usted debe solicitar la transferibilidad o conversión dentro de los 31 días a partir de la fecha en que finaliza su cobertura. Si fallece dentro de los 31 días de una pérdida de cobertura que califique y antes de elegir la posibilidad de transferir o la conversión de su cobertura de seguro de vida, Prudential le pagará a su beneficiario un Beneficio de fallecimiento. El beneficio se pagará sobre la base del monto de la cobertura que estaba en vigencia antes de que ocurriera la pérdida de cobertura que califique, incluso si usted no solicitó la transferencia o conversión de su cobertura.

> **!** Su cobertura no podrá continuar a menos que se ponga en contacto con Prudential en un plazo de 31 días a partir de la fecha de finalización de su cobertura.

La transferibilidad le permite mantener un seguro de vida temporal similar con Prudential luego de que termine su relación laboral, siempre que se reúnan determinadas condiciones. No se exige evidencia de buena salud para transferir su cobertura. Sin embargo, puede recibir tarifas preferidas similares a las tarifas que pagaba mientras era un asociado activo si presenta evidencia de buena salud y se lo aprueban. Si usted no presenta evidencia de buena salud o no se lo aprueban, sus tarifas se basarán en las tarifas de transferibilidad estándar de Prudential.

Puede solicitar una cobertura de vida a plazo en virtud de la transferibilidad si reúne todas estas condiciones:

- Su cobertura de vida opcional del asociado finaliza por una razón que no sean las siguientes:
  - La falta de pago de las primas mientras es un asociado activo
  - Abandona Walmart a causa de una discapacidad, o
  - Walmart cambia de compañía de seguros para el seguro de vida grupal y usted es elegible o pasa a ser elegible dentro de los 31 días siguientes.
- Reúne el requisito de trabajo activo el día en que finaliza el seguro.
- Tiene menos de 80 años.
- El monto de su seguro es de $20,000, como mínimo, el día en que finaliza su seguro.

Si reúne estas condiciones, tendrá 31 días a partir de la fecha del cese para comunicarse con Prudential e inscribirse. Prudential le notificará el monto de cobertura de transferibilidad ofrecida. El monto de la cobertura de seguro ofrecido no será mayor que lo que sea menor del monto de cobertura elegido conforme al plan o no más de cinco veces sus ingresos anuales, siempre y cuando, sin embargo, que el monto no será menor que $20,000.

La conversión es una disposición obligatoria del Plan que le permite convertir su cobertura de seguro de vida en una póliza individual si la cobertura finalizara porque deja de trabajar en la compañía o cambia de clase elegible. No debe presentar evidencia de buena salud. Las tarifas se basan en su edad y en el monto convertido. Debe solicitar el contrato individual y pagar la primera prima antes de lo que ocurra último entre:

- el 31º día después de haber dejado de estar asegurado, o
- el 15º día después de que se le haya notificado por escrito el privilegio de la conversión.

Si se le ha enviado por correo un aviso de conversión y su fallecimiento se produce durante el periodo de conversión de 31 días, el beneficio por fallecimiento, se abonará hasta el monto que podría haberse convertido. Si no se le ha enviado por correo una notificación de conversión y fallece durante el periodo de 91 días inmediatamente posterior a la fecha de finalización de su cobertura, el beneficio por fallecimiento se abonará hasta el monto que podría haberse convertido.

Si es residente de Minnesota, tiene derecho a continuar la cobertura en lugar de convertirla cuando la pierde debido a una reducción de horas o la finalización de la relación laboral (que no sea una falta de conducta grave). Puede optar por continuar la cobertura a su cargo hasta que obtenga cobertura de otro plan de vida grupal; sin embargo, el periodo máximo durante el que puede continuar la cobertura es de 18 meses. Si continúa la cobertura, cuando venza el periodo de continuación, puede convertir su cobertura de seguro de vida en una póliza individual, hasta el monto de cobertura vigente en ese momento. Tiene 31 días a partir de la fecha en que finalizaría la continuación de la cobertura para solicitar convertir su cobertura en una póliza individual.

Para solicitar información sobre la transferibilidad o la conversión, llame a Prudential al **877-740-2116**.

Si deja Walmart y lo contratan nuevamente

Si es usted un asociado pagado por hora a tiempo parcial o temporal que está sujeto a las verificaciones de elegibilidad de 60 días, una sola vez y anualmente para los beneficios médicos, consulte la sección **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener detalles sobre cómo el hecho de terminar el empleo con Walmart y luego volver a trabajar afecta sus beneficios.

Si es un asociado a tiempo completo pagado por hora, un miembro de la gerencia o conductor de camión, consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para saber cómo el hecho de dejar de trabajar en Walmart y volver a hacerlo afecta sus beneficios.

Seguro de vida opcional para dependientes

La información de este capítulo describe los beneficios opcionales del seguro de vida para dependientes que pueden estar a su disposición si:

- Es usted un conductor de camión por hora, temporal, a tiempo parcial, o un asociado asalariado (de la gerencia)
- Ha cumplido todos los requisitos para que la cobertura tenga vigencia, incluidos los requisitos de trabajo activo, y
- Se ha inscrito debida y oportunamente.

Si tiene preguntas sobre los requisitos de elegibilidad, los requisitos para que la cobertura sea efectiva y la repercusión en sus beneficios de un cambio en su clasificación laboral, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Esta información pretende ser un resumen de sus beneficios y es posible que no incluya todas las condiciones de la póliza. Si existen diferencias entre este documento y la póliza emitida por Prudential respecto del cálculo de los beneficios y las limitaciones en virtud de la póliza, regirán los términos de la póliza. Puede obtener una copia de esta póliza si se comunica con el Plan.

Seguro de vida opcional para dependientes

El seguro de vida opcional para dependientes puede ayudar a aliviar su situación financiera si pierde a alguien cercano a usted, como su cónyuge, pareja o hijo.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Obtenga más información	Visite **One.Walmart.com**	Llame a Prudential al **877-740-2116**
Cómo presentar una reclamación		Llame a Prudential al **877-740-2116**

Lo que debe saber sobre el seguro de vida opcional para dependientes

- Los asociados pagados por hora a tiempo completo y los asociados gerenciales pueden inscribir a sus cónyuges/parejas y/o a sus hijos; los asociados pagados por hora a tiempo parcial y los conductores de camión a tiempo parcial pueden inscribir a sus hijos, pero no a su cónyuge/pareja.
- Deberá presentar un comprobante de buena salud para su cónyuge/pareja si se inscribe para una cobertura superior a $5,000 durante su periodo de inscripción inicial o por cualquier monto de cobertura si se inscribe en otro momento. No se necesita comprobante de buena salud para sus hijos.
- Su dependiente no tiene derecho a la cobertura mientras esté en servicio activo en las fuerzas armadas, independientemente del país.
- La cobertura se ofrece a través de Prudential Insurance Company of America (Prudential).
- Esta póliza es de un seguro de vida a plazo. No tiene valor en efectivo.
- El Certificado de seguro está disponible en línea en **One.Walmart.com** o en **Prudential.com/Walmart**. El certificado proporciona información detallada sobre el seguro de vida pagado por la compañía, además de los aspectos más destacados disponibles en este capítulo.

Seguro de vida opcional para dependientes

El seguro de vida opcional para dependientes le paga un beneficio financiero si es un asociado inscrito y su dependiente fallece mientras la cobertura está vigente.

Cuando usted se inscribe en el seguro de vida opcional para dependientes, si su cónyuge/pareja y/o dependiente cubierto fallece, usted recibe el pago de una suma única por el monto de cobertura que seleccione. Las opciones de cobertura para el seguro de vida opcional para dependientes son las siguientes:

COBERTURA PARA CÓNYUGE/PAREJA*		COBERTURA PARA HIJOS
$5,000	$75,000	$5,000
$15,000	$100,000	$10,000
$25,000	$150,000	$20,000
$50,000	$200,000	

*No está disponible para asociados pagados por hora a tiempo parcial, asociados temporales ni conductores de camión a tiempo parcial.

Según el monto de cobertura que elija y cuándo se inscriba, es posible que su cónyuge/pareja deba presentar una evidencia de buena salud.

Se asignará automáticamente al asociado (usted) como beneficiario principal de la cobertura del seguro de vida para dependientes. Si usted y su dependiente o dependientes con cobertura fallecen el mismo día, los beneficios se pagan a los herederos de sus dependientes o, según el criterio de Prudential, a un pariente vivo del dependiente.

El costo del seguro de vida opcional para dependientes para su cónyuge/pareja se basa en el monto de cobertura que seleccione, en su edad (la edad del asociado) y en si su cónyuge/pareja es elegible para las tarifas para personas libres de tabaco. El costo de cobertura para sus hijos se basa en el monto de cobertura que seleccione. Las primas de la cobertura del seguro de vida opcional para dependientes no subsidian la cobertura conforme al seguro de vida pagado por la compañía.

Su dependiente no tiene derecho a la cobertura mientras esté en servicio activo en las fuerzas armadas, independientemente del país.

Si su cónyuge/pareja o hijo dependiente está internado para recibir tratamiento médico (en su hogar u otro lugar), la fecha efectiva de cobertura se demora hasta que el cónyuge/pareja o hijo reciba el alta médica (no se aplica a un niño recién nacido).

Esta póliza es de un seguro de vida a plazo. No tiene valor en efectivo.

EVIDENCIA DE BUENA SALUD

Debe presentar una evidencia de buena salud para la cobertura del seguro de vida opcional para dependientes de su cónyuge/pareja si:

- El monto de cobertura seleccionado supera los $5,000 durante su periodo de inscripción inicial.
- Se inscribe después de su periodo de inscripción inicial por cualquier monto.
- Aumente su cobertura después de su periodo de inscripción inicial.

No se necesita una evidencia de buena salud para niños.

Dentro de los 60 días posteriores a la fecha en que contrajo matrimonio/se constituyó la pareja de hecho, puede elegir brindarle cobertura a su cónyuge/pareja o cambiar el monto de su seguro para su cónyuge/pareja. En este caso, aunque esté fuera de su periodo de inscripción inicial, no se requiere que su cónyuge/pareja presente una evidencia de buena salud, a menos que seleccione un monto de cobertura superior a $5,000.

La evidencia de buena salud consiste en completar un cuestionario relacionado con la historia clínica de su cónyuge/pareja y, posiblemente, que su cónyuge/pareja deba someterse a un examen médico. El cuestionario de la evidencia de buena salud se pone a su disposición en el momento de la inscripción de su cónyuge/pareja.

Si se requiere evidencia de buena salud, la cobertura no será efectiva hasta que Prudential la apruebe. Para obtener información, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Beneficios adicionales

Este tipo de beneficios se paga en las siguientes circunstancias:

- Si un hijo dependiente nace con vida y fallece dentro de los 60 días a partir de la fecha de nacimiento y era elegible, pero no fue inscrito en el seguro de vida opcional para dependientes antes de la pérdida (presentando los certificados de nacimiento y defunción) Prudential pagará un único beneficio de $5,000.
- Si un hijo dependiente nace sin vida, Prudential pagará un beneficio de $5,000 a los asociados que hayan cumplido el periodo de espera de elegibilidad para acceder al seguro de vida para dependientes. Para obtener información, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**. Se define como hijo nacido sin vida al hijo de un asociado elegible, cuyo fallecimiento ocurre antes de la expulsión, extracción o parto, y cuyo peso fetal es 350 gramos o más; o bien, si se desconoce el peso fetal, cuya permanencia en el útero fue de 20 semanas completas de gestación o más. Si tanto la madre como el padre del hijo nacido sin vida trabajan en Walmart, cada asociado es elegible para presentar una reclamación de este beneficio por separado por un total de $10,000.

Presentar una reclamación de seguro de vida opcional para dependientes

Se debe proporcionar a Prudential la siguiente información sobre el dependiente fallecido:

- Nombre
- Número de seguridad social
- Fecha del fallecimiento
- Causa del fallecimiento (si se conoce).

Es posible que se requiera presentar el original o una copia certificada del certificado de defunción como prueba del fallecimiento. Envíe el certificado de defunción por correo a:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

Si se requiere un certificado de defunción, la reclamación no se finalizará hasta que Prudential reciba el certificado de defunción. La aceptación del certificado de defunción no garantiza el pago.

Las reclamaciones se determinan dentro de los plazos y requisitos establecidos en el capítulo **Reclamaciones y apelaciones**. Tiene derecho a apelar una reclamación rechazada.

Los beneficios se pagan de acuerdo con los términos de la póliza del seguro. Para obtener más información, comuníquese con Prudential al **877-740-2116**.

Cuándo no se pagan los beneficios

No se le pagan beneficios si su cónyuge/pareja se suicida, ya sea que se encuentre en su sano juicio o no, durante los primeros dos años de cobertura. Si aumenta la cobertura de su cónyuge/pareja y su cónyuge/pareja se suicida dentro de los dos años desde la fecha en que aumentó la cobertura, recibirá el monto de la cobertura anterior.

Si presenta una reclamación por su cónyuge/pareja dentro de los primeros dos años de su fecha de aprobación, Prudential tiene el derecho de volver a evaluar el cuestionario de la evidencia de buena salud de su cónyuge/pareja. Si se descubre que los hechos materiales sobre su cónyuge/pareja se establecieron de manera incorrecta, se usarán las circunstancias reales para determinar qué monto de la cobertura debería haber regido, si correspondiera, y:

- Se puede rechazar la reclamación.
- Se pueden reembolsar las primas pagadas.

A menos que se disponga lo contrario, si su dependiente fallece antes de la fecha de entrada en vigencia de la cobertura, no se pagará ningún beneficio.

Interrupción de la cobertura

Puede haber ocasiones en las que deba tomar medidas especiales para pagar sus primas de seguro de vida opcional para dependientes a fin de evitar la suspensión de la cobertura. Estas situaciones se producen con más frecuencia si se encuentra con una licencia de ausencia o si su cheque de pago de Walmart no es suficiente para pagar toda la parte que le corresponde del costo de cobertura (por ejemplo, después de una reducción de horas). Si no realiza el pago de la prima dentro de los 30 días siguientes a la fecha de vencimiento, la cobertura se cancelará.

Consulte **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información detallada sobre cómo realizar los pagos de las primas para que no haya un lapso en su cobertura.

SI SE TOMA UNA LICENCIA DE AUSENCIA

Puede continuar la cobertura de vida opcional para dependiente hasta el último día de una licencia de ausencia aprobado, solo si paga sus primas antes de que comience el permiso de ausencia o durante este. Para obtener información sobre cómo realizar los pagos durante una licencia, consulte la sección **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** .

Cuándo finaliza la cobertura del seguro de vida opcional para dependientes

Su cobertura del seguro de vida opcional de dependientes finaliza:

- En la fecha en la que abandone voluntariamente la cobertura (como se describe a continuación)
- El momento del cese de su relación laboral.
- El último día de la cobertura para la que se pagaron las primas, si no pagó las primas dentro de los 30 días de la fecha de vencimiento de estas.
- En la fecha de su fallecimiento
- En la fecha en que usted o su cónyuge/pareja o hijo pierden la elegibilidad (consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**). No obstante, si su cónyuge/pareja deja de ser elegible porque usted pasa a ser asociado a tiempo parcial pagado por hora, asociado temporal o conductor de camión a tiempo parcial, se dará de baja la cobertura para su cónyuge/pareja el último día del periodo de pago en que cambió su condición laboral.
- El último día de una licencia aprobada (a menos que vuelva a trabajar) o
- Cuando Walmart deje de ofrecer el beneficio.

Si su clasificación de empleo cambia, consulte la tabla correspondiente en la sección **Cambio de una clasificación laboral a otra** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información sobre cualquier repercusión en su cobertura.

Si cancela voluntariamente la cobertura después de un evento de cambio de elección o en la Inscripción Anual, la cobertura finaliza de la siguiente manera:

- **Tras un evento de cambio de elección:** la cobertura finaliza en la fecha efectiva del evento. Para obtener más información, consulte **Cambios de elección permitidos fuera del periodo de Inscripción anual** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.
- **En la Inscripción anual: la cobertura** finaliza el 31 de diciembre del año en curso.

Continuación de la cobertura para cónyuges/parejas cuando deja Walmart o pierde la cobertura

Si es asociado a tiempo completo o asociado gerencial y tiene un seguro de vida opcional para dependientes para su cónyuge/pareja, tiene dos opciones para continuar con la cobertura de su cónyuge/pareja después de que su cobertura de vida grupal finalice. La primera opción, denominada **portabilidad**, le permite a usted y a su cónyuge/pareja continuar con toda o parte de su cobertura actual a través de una póliza grupal a plazo con Prudential. La segunda opción, denominada **conversión**, le permite convertir total o parcialmente la cobertura de su cónyuge/pareja en una póliza individual de Prudential. Estas opciones no están disponibles para los asociados pagados por hora a tiempo parcial, los asociados temporales ni los conductores de camión a tiempo parcial.

Debe solicitar la transferibilidad o la conversión dentro de los 31 días a partir de la fecha en que finaliza la cobertura de su cónyuge/pareja. Si su cónyuge/pareja fallece en los 31 días siguientes a una pérdida de cobertura cualificativa y antes de elegir la portabilidad o conversión de la cobertura del seguro de vida, Prudential pagará un beneficio por fallecimiento. El beneficio será el monto de la cobertura que su cónyuge/pareja podría haber convertido, aunque su dependiente no haya solicitado la portabilidad o la conversión de la cobertura.

> La cobertura de su cónyuge/pareja no podrá continuar a menos que se ponga en contacto con Prudential en un plazo de 31 días a partir de la fecha de finalización de la cobertura.

La transferibilidad le permite mantener un seguro de vida temporal similar para su cónyuge/pareja con Prudential una vez que finalice su cobertura de asociado o su cónyuge/pareja pierda la elegibilidad porque se divorcia o separa, si se cumplen ciertas condiciones.

No se exige una evidencia de buena salud para transferir la cobertura de su cónyuge/pareja. Sin embargo, usted puede recibir tarifas preferidas para la cobertura de su cónyuge/pareja similares a las tarifas que pagaba mientras era un asociado activo si su cónyuge/pareja presenta la evidencia de buena salud y se lo aprueban. Si no presenta la evidencia de buena salud para su cónyuge/pareja, o no se lo aprueban, sus tarifas se basarán en las tarifas de transferibilidad estándar de Prudential.

Puede solicitar una cobertura de vida a plazo en virtud de la transferibilidad si reúne todas estas condiciones:

- La cobertura de vida opcional para dependientes finaliza debido a que su cobertura de vida opcional para asociados finaliza por algún motivo que no sean los siguientes:
  - La falta de pago de las primas mientras es un asociado activo
  - El final de su relación laboral a causa de su retiro por discapacidad; o
  - El final de su cobertura de seguro de vida opcional para todos los asociados cuando dicha cobertura sea remplazada por un seguro de vida grupal de cualquier compañía de seguro para la cual usted es elegible o pasa a ser elegible dentro de los 31 días siguientes.
- Usted solicita y se aprueba la cobertura de vida a plazo en virtud del plan de transferibilidad.
- Con respecto a un cónyuge/pareja dependiente, que esa persona tenga menos de 80 años.
- El dependiente queda cubierto para la cobertura de vida opcional para dependientes el día en que finaliza su cobertura de vida opcional para asociados.
- El dependiente no está internado para recibir atención o tratamiento médico, en su hogar u otro lugar, en el día en que finaliza su cobertura de vida opcional para asociados.

Su cónyuge/pareja también puede solicitar la cobertura de vida temporal en virtud de la función de portabilidad si satisface todas las siguientes condiciones:

- La cobertura de su cónyuge/pareja finaliza debido a que se produce el divorcio o finaliza la relación de pareja.
- Su cónyuge/pareja es menor de 80 años.
- Su cónyuge/pareja no está internado/a para recibir atención o tratamiento médico, en su hogar u otro lugar, el día en que finaliza su cobertura de vida opcional para dependientes.

Si reúne estas condiciones, tendrá 31 días a partir de la fecha del cese para comunicarse con Prudential e inscribirse. Prudential le notificará el monto de cobertura de transferibilidad ofrecida. El monto de la cobertura del seguro que se ofrece no será mayor que el monto de la cobertura del cónyuge/pareja que eligió conforme al plan. Sin embargo, si su cónyuge/pareja presenta una evidencia de buena salud y Prudential lo acepta, puede aumentar el monto de la cobertura de su cónyuge/pareja a $20,000 (o, si es inferior, según el monto de sus ingresos anuales).

La conversión es una disposición obligatoria del Plan que le permite convertir la cobertura de seguro de vida de su dependiente en una póliza individual si la cobertura finalizara

por cualquier motivo que no sea la falta de pago de las primas o la finalización de la cobertura de los dependientes para todos los asociados. No debe presentar evidencia de buena salud. Las tarifas se basan en la edad del dependiente y en el monto convertido. Tiene 31 días a partir de la fecha del cese de la cobertura para solicitar convertir la cobertura de dependiente en una póliza individual. Si su dependiente fallece dentro del periodo de conversión de 31 días, el beneficio de fallecimiento se pagará hasta el monto que se haya podido convertir.

Si es residente de Minnesota, tiene derecho a continuar la cobertura en lugar de convertirla cuando se pierde la cobertura del dependiente debido a una reducción de horas o la finalización de la relación laboral (que no sea una falta de conducta grave). Puede elegir continuar la cobertura para dependiente por su cuenta hasta que obtenga cobertura de otra póliza de seguro de vida grupal para el dependiente; sin embargo, el periodo máximo por el que puede continuar con la cobertura es 18 meses. Si continúa la cobertura para su dependiente, cuando venza el periodo de continuación, puede convertir la cobertura de seguro de vida del dependiente en una póliza individual, hasta el monto de cobertura vigente en ese momento. Tiene 31 días a partir de la fecha en que la continuación de la cobertura finalizaría para solicitar convertir la cobertura del dependiente en una póliza individual. Además, si pierde la cobertura por cualquier motivo que no sea una reducción de las horas laborales o la finalización de la relación laboral (que no sea por una falta de conducta grave), puede convertir hasta alcanzar el monto de la cobertura que estaba en vigencia conforme al plan.

Para solicitar información sobre la transferibilidad o la conversión, llame a Prudential al **877-740-2116**.

Si deja Walmart y lo contratan nuevamente

Si es usted un asociado pagado por hora a tiempo parcial o temporal que está sujeto a las verificaciones de elegibilidad de 60 días, una sola vez y anualmente para los beneficios médicos, consulte la sección **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener detalles sobre cómo el hecho de terminar el empleo con Walmart y luego volver a trabajar afecta sus beneficios.

Si es un asociado a tiempo completo por hora, un miembro de la gerencia o conductor de camión, consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para saber cómo el hecho de dejar de trabajar en Walmart y volver a hacerlo afecta sus beneficios.

Seguro contra accidentes durante viajes de negocios

La información de este capítulo describe los beneficios opcionales del seguro contra accidentes en viaje de negocios que pueden estar a su disposición si:

- Usted es un asociado elegible, y
- Ha cumplido todos los requisitos para que la cobertura sea efectiva, incluidos los requisitos de trabajo activo.

Si tiene preguntas sobre la elegibilidad, la inscripción y los requisitos para que la cobertura sea efectiva, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Esta información pretende ser un resumen de sus beneficios y es posible que no incluya todas las condiciones de la póliza. Si existen diferencias entre este documento y las pólizas emitidas por los aseguradores correspondientes conforme a este capítulo respecto del cálculo de los beneficios y las limitaciones en virtud de la póliza, regirán los términos de las pólizas. Puede obtener una copia de estas pólizas si se comunica con el Plan.

Seguro contra accidentes durante viajes de negocios

Si realiza un viaje de negocios autorizado, este seguro les brinda protección financiera a usted y a sus seres queridos en caso de sufrir un accidente que le provoque ciertos tipos de lesiones o la muerte.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Cambie su designación de beneficiario	Visite **One.Walmart.com/Beneficiary**	Los cambios de beneficiario no se pueden realizar por teléfono
Obtenga más información		Llame a Prudential al **877-740-2116**
Presente una reclamación del seguro contra accidentes durante viajes de negocios		Llame a Prudential al **877-740-2116**
Obtenga más información sobre el seguro médico para accidentes durante viajes de negocios internacionales a través de GeoBlue	Visite **geo-blue.com**	Llame a GeoBlue al **888-412-6403** Fuera de los EE. UU., llame al **610-254-5830**

Lo que debe saber sobre el seguro contra accidentes durante viajes de negocios

- Walmart ofrece a todos los asociados un seguro contra accidentes durante viajes de negocios. No implica costo alguno y no es necesario inscribirse.
- El seguro contra accidentes durante viajes de negocios paga un beneficio de suma única si pierde la vida, una extremidad, la visión, el habla o la audición, o queda paralítico debido a un accidente que tiene lugar mientras realiza un viaje de negocios autorizado por la compañía.
- El monto de su cobertura por accidentes durante un viaje es tres veces sus ingresos anuales básicos hasta cubrir $1 millón como máximo.
- Este seguro pagado por la compañía se proporciona a través de The Prudential Insurance Company of America (Prudential).
- El seguro médico de accidente durante viajes de negocios internacionales está disponible para viajeros de negocios a través de GeoBlue.

Seguro contra accidentes durante viajes de negocios

Para brindarle protección mientras se encuentra en un viaje de negocios, Walmart les proporciona a todos los asociados un seguro contra accidentes durante viajes de negocios. No implica costo alguno y no es necesario inscribirse. Si sufre una lesión cubierta, la cual deriva en la pérdida de una extremidad o la muerte mientras está en un viaje de negocios autorizado por la compañía, se paga un beneficio de suma única a usted o sus beneficiarios de hasta tres veces sus ingresos anuales básicos, con un máximo de $1 millón y un mínimo de $200,000 (a menos que se especifique lo contrario).

Los ingresos anuales básicos se definen del siguiente modo:

- **Para asociados pagados por hora:** pago por hora anualizado según se muestra en el sistema de pagos de Walmart desde la fecha de la pérdida o fallecimiento.
- **Para asociados gerenciales y directivos:** salario básico según se muestra en el sistema de pagos de Walmart desde la fecha de la pérdida o fallecimiento.
- **Para conductores de camión:** pago diario promedio anualizado desde la fecha de la pérdida o fallecimiento según lo determine el Departamento de Finanzas Logísticas.

Tenga en cuenta que cualquier bono que reciba no se incluye en los ingresos anuales básicos.

Cómo nombrar a un beneficiario

A fin de garantizar que su beneficio del seguro contra accidentes durante viajes de negocios se pague como usted desea, debe nombrar a los beneficiarios. Para ello, visite **One.Walmart.com/Beneficiary**. La designación del beneficiario debe completarse y enviarse al Plan antes de su fallecimiento. Póngase en contacto con el Servicios al Personal llamando al **800-421-1362** si no puede acceder a la herramienta Beneficiary Online. Usted (el asociado) o su beneficiario recibirán los beneficios que se paguen por las lesiones que se indican en **Cuándo se pagan los beneficios** más adelante en este capítulo.

Puede nombrar a cualquier persona que desee. Si el (los) beneficiario(s) que figura(n) en su designación de beneficiarios archivada en el Plan difiere(n) del (de los) beneficiario(s) nombrado(s) en su testamento, la designación de beneficiarios archivada en el Plan prevalecerá. Si no ha designado beneficiarios conforme al beneficio de seguro de viajero durante viajes de negocios, el pago se realizará a los miembros sobrevivientes de su familia, tal como se describe en **Si no nombra a un beneficiario** más adelante en esta página.

Se necesita la siguiente información por cada beneficiario:

- Nombre
- Dirección y número de teléfono actuales
- Relación con usted
- Número de seguridad social
- Fecha de nacimiento
- Porcentaje que desea designar a cada beneficiario, hasta el 100 %.

Si se designa a dos o más beneficiarios y sus cuotas no están especificadas, compartirán el beneficio del seguro en partes iguales. Si un beneficiario designado falleciera antes que usted, el derecho de tal beneficiario cesará, y se distribuirá en partes iguales entre los restantes beneficiarios, a menos que su formulario de beneficiarios indique lo contrario. Si usted y un beneficiario fallecen en el mismo evento y no se puede determinar quién falleció primero, se tratará al beneficiario como si hubiera fallecido antes que usted.

Puede nombrar a un menor de edad como beneficiario; sin embargo, es posible que Prudential no tenga autorización legal para pagarle al menor hasta que sea mayor de edad. Es recomendable que consulte a un abogado o a un asesor testamentario antes de nombrar a un menor de edad como beneficiario. Si nombra a un menor de edad como beneficiario, no se podrán pagar los gastos funerarios de los beneficios del menor.

CÓMO CAMBIAR DE BENEFICIARIO

Usted puede cambiar los beneficiarios en cualquier momento en **One.Walmart.com/Beneficiary**. Cualquier cambio de beneficiario se debe completar y enviar al Plan antes de su fallecimiento y solo puede ser enviado por usted, el asociado cubierto. Póngase en contacto con el Servicios al Personal llamando al **800-421-1362** si no puede acceder a la herramienta Beneficiary Online.

SI NO NOMBRA A UN BENEFICIARIO

Si no se nombra un beneficiario o si los beneficiarios no están vivos cuando usted fallece, el pago se realizará a sus familiares vivos en el siguiente orden:

1. Cónyuge o pareja del difunto; si no viven, a sus
2. Hijos en partes iguales; si no viven, a sus
3. Padres en partes iguales; si no viven, a sus
4. Hermanos en partes iguales; si no viven, a sus
5. Herederos.

> Mantenga actualizada la información de sus beneficiarios. Los beneficios serán para cualquier persona que se encuentre en la lista de la designación de beneficiarios con el Plan, independientemente de su relación actual con esa persona, a menos que la ley aplicable diga lo contrario. Usted puede cambiar los beneficiarios en cualquier momento en **One.Walmart.com/Beneficiary**.

Presentar una reclamación del seguro contra accidentes durante viajes de negocios

Dentro de los 12 meses posteriores a la lesión o la muerte del asociado con cobertura, o dentro de los 90 días posteriores al vencimiento de cualquier pago periódico (como los pagos periódicos por coma), se debe proporcionar la siguiente información con respecto al asociado:

- Nombre
- Número de seguridad social
- Suceso, tipo y extensión de la lesión
- Fecha de la lesión o el fallecimiento y
- Causa de la lesión o el fallecimiento (si se conoce).

Es posible que se requiera presentar el original o una copia certificada del certificado de defunción como prueba del fallecimiento. El certificado de defunción debe enviarse por correo postal a la siguiente dirección:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

Si se requiere un certificado de defunción, la reclamación no se finalizará hasta que Prudential reciba tal certificado de defunción. La aceptación del certificado de defunción no garantiza el pago.

Los beneficios se pueden pagar en una única suma o, mediante solicitud por escrito, en cuotas mensuales. Solo se pagará un beneficio, el más alto, si usted sufre más de una pérdida como resultado de un único accidente.

Las reclamaciones se determinan dentro de los plazos y requisitos establecidos en el capítulo **Reclamaciones y apelaciones**. Sus beneficiarios tienen derecho a apelar una reclamación rechazada.

Los beneficios se pagan de acuerdo con los términos de la póliza del seguro. Para obtener información, llame a Prudential al **877-740-2116**.

Cuándo se pagan los beneficios

Los beneficios se pagan si sufre una lesión accidental durante un viaje de negocios autorizado por la compañía o como resultado de una agresión delictiva mientras trabaja; sus lesiones son la causa directa y única de un siniestro cubierto; y usted presenta una prueba del siniestro accidental y cubierto a Prudential.

Un viaje de negocios incluye viajar con una compañía de transportes común o cualquier medio de transporte que le pertenezca y opere Walmart. Una lesión accidental incluye una exposición a factores climáticos. "Causa directa y única" significa que el siniestro cubierto ocurre dentro de los 12 meses de la fecha de la lesión accidental como resultado directo de esta, independientemente de otras causas.

MONTO DEL BENEFICIO

UNA LESIÓN CUBIERTA SE PRODUCE:	MONTO DEL BENEFICIO
Durante un viaje de negocios autorizado por la compañía	Tres veces sus ingresos anuales básicos hasta cubrir $1,000,000 como máximo Beneficio mínimo: $200,000
Como resultado de una agresión delictiva mientras trabaja	Hasta $10,000

SINIESTROS CUBIERTOS QUE SE PAGAN COMO BENEFICIO COMPLETO

- Cuadriplejía: Parálisis total de ambas extremidades inferiores y superiores.
- Paraplejía: Parálisis total de ambas extremidades inferiores.
- Hemiplejía: Parálisis total de las extremidades superiores e inferiores de un lado del cuerpo.
- Pérdida de ambas manos, ambos pies, la vista de ambos ojos: amputación por o sobre la articulación de ambas muñecas o ambos tobillos, o pérdida total e irrecuperable de la vista.
- Pérdida de una mano y un pie: amputación por o sobre la articulación de la muñeca o del tobillo.
- Pérdida del habla y de la audición en ambos oídos: pérdida total del habla y de la audición que dure al menos seis meses consecutivos tras el accidente.
- Pérdida de mano o pie y la vista de un ojo: amputación por o sobre la articulación de la muñeca o del tobillo, o pérdida total e irrecuperable de la vista en un ojo.

50 % DEL BENEFICIO COMPLETO

- Pérdida de mano o pie: amputación permanente en la muñeca o encima de ella pero debajo del codo o amputación permanente en el tobillo o encima de él pero debajo de la rodilla.
- Daño cerebral: daño cerebral significa daño físico permanente e irreversible en el cerebro, lo cual provoca incapacidad total para llevar a cabo todas las funciones y actividades materiales y sustanciales de la vida cotidiana. Dicho daño se debe manifestar dentro de los 30 días de la lesión accidental, requerir hospitalización de al menos cinco días y persistir por 12 meses consecutivos.
- Pérdida de la vista en un ojo: pérdida total y permanente de la vista en un ojo.
- Pérdida del habla o de la audición en ambos oídos: pérdida total del habla o de la audición que dure al menos seis meses consecutivos tras el accidente.

25 % DEL BENEFICIO COMPLETO

- Pérdida del dedo pulgar e índice de la misma mano: amputación permanente en la articulación más cercana a la muñeca o encima de ella.
- Monoplejía: parálisis total de una extremidad.

"Parálisis": significa perder el uso de un miembro, sin amputación. Un médico debe determinar que la pérdida es completa y no reversible. ("Separación" se refiere a la separación total y desmembramiento del miembro del cuerpo).

BENEFICIO POR ESTADO COMATOSO

Si está en coma o entra en coma dentro de los 365 días como resultado de un accidente cubierto, se pagará un beneficio por estado comatoso mensual equivalente al 2 % del monto del beneficio completo o $100 durante 50 meses como máximo. El beneficio se pagará después de 31 días consecutivos de haber entrado en coma.

Estar en "coma" significa un estado profundo de inconsciencia del cual el individuo no puede despertar, incluso mediante estimulación potente, según lo determina el médico del individuo. Dicho estado debe comenzar dentro de los 365 días de la lesión accidental y debe continuar por 31 días consecutivos, además debe ser total, continuo y permanente una vez que finalice el periodo de 31 días.

El monto máximo que el seguro contra accidentes durante viajes de negocios le pagará por todos los siniestros cubiertos que resulten de un accidente cubierto es el monto del beneficio completo. Si más de un asociado sufre un siniestro como resultado del mismo accidente, el monto máximo que pagará la póliza de seguro contra accidentes de viajes de negocios por todos los siniestros es de $10 millones por accidente y, si es necesario, los beneficios se pagarán prorrateados entre los asociados afectados que sufran un siniestro durante el accidente. El pago total máximo aumenta a $20 millones si el accidente cubierto se produce mientras viaja hacia o desde Walmart, o mientras asiste a la Reunión Anual de Accionistas de Walmart, a la reunión anual para las fiestas o a la reunión anual de inicio de año.

Beneficios adicionales

El seguro contra accidentes durante viajes de negocios brinda estos beneficios adicionales:

- Beneficio de uso de cinturón de seguridad: si pierde la vida como resultado de un accidente cubierto que ocurre mientras usaba el cinturón de seguridad, se puede pagar un beneficio adicional de hasta $10,000.
- Beneficio por el uso de la bolsa de aire: si pierde la vida como resultado de un accidente cubierto que ocurre mientras usaba el cinturón de seguridad y se despliega una bolsa de aire que funciona correctamente en el asiento que estaba ocupando, se puede pagar un beneficio adicional de hasta $10,000.
- Beneficio para gastos funerarios: si pierde la vida dentro de 365 días como resultado de un accidente cubierto, se puede pagar un beneficio adicional de hasta $5,000.
- Beneficio de evacuación médica: si, como resultado de un accidente cubierto, es necesario realizar una evacuación médica y se encuentra al menos a 100 millas de su hogar, se puede pagar un beneficio adicional de hasta $15,000.
- Traslado y acompañamiento de familiares: si su cónyuge/pareja o hijo dependiente sufre un siniestro cubierto mientras se encuentra en un viaje de negocios con usted (o mientras viaja para encontrarse con usted), se puede pagar un beneficio adicional de hasta $100,000 por los siniestros que sufra su cónyuge/pareja y de $10,000 por los siniestros que sufra cada hijo dependiente.

Todos estos beneficios adicionales están sujetos a los criterios de elegibilidad adicionales establecidos por Prudential. Comuníquese con Prudential, si le pudiese corresponder alguno de estos beneficios, para solicitar más información.

Cuándo no se pagan los beneficios

Los beneficios del seguro contra accidentes durante viajes de negocios no se pagarán por ningún siniestro que resulte de las siguientes circunstancias:

- Suicidio o intento de suicidio, ya sea que se encuentre en su sano juicio o no;
- Lesiones autoinfligidas intencionalmente o intento de causarse tales lesiones;
- Enfermedad, ya sea que la pérdida resulte directa o indirectamente de la enfermedad;
- Tratamiento médico o quirúrgico de una enfermedad, ya sea que el siniestro sea ocasionado directa o indirectamente por el tratamiento;
- Cualquier infección bacteriana o viral, excepto una infección piógena que resulte de un corte o herida o una infección bacteriana producida por la ingestión accidental de una sustancia contaminada;
- Guerra o actos de guerra (declarada o no declarada), incluso resistencia a agresión armada o un accidente mientras está en servicio activo en las fuerzas armadas durante más de 30 días (esto no incluye el servicio activo para entrenamiento de la Reserva o la Guardia Nacional);
- Viajar en una aeronave sin licencia;
- Volar como miembro de la tripulación de una aeronave, excepto uno que sea propiedad de Walmart y esté operado por ella;
- Cometer o intentar cometer una agresión o un delito;
- Operar un vehículo terrestre, acuático o aéreo en estado de ebriedad legal; o
- Estar bajo la influencia de cualquier sustancia controlada, según se establece en el Título II de la Ley de Control y Prevención Integral del Abuso de Drogas (Comprehensive Drug Abuse Prevention and Control Act) de 1970 y todas sus modificaciones, a menos que dicha sustancia haya sido recetada y administrada de acuerdo con las instrucciones del médico del asegurado.

Cuándo finaliza la cobertura del seguro contra accidentes durante viajes de negocios

Su cobertura del seguro contra accidentes durante viajes de negocios finaliza en su último día de empleo.

Si deja Walmart y lo contratan nuevamente

Cualquier cobertura que estuviera en vigencia (o la más similar que ofrezca el Plan) en la fecha de la terminación del empleo se restablecerá cuando se reincorpore al trabajo.

Seguro médico durante viajes de negocios internacionales

El seguro médico durante viajes de negocios internacionales está disponible a través de una póliza con GeoBlue para los asociados que viajan al exterior para hacer negocios.

GeoBlue proporciona servicios de asistencia durante viajes a usted y a sus dependientes elegibles si necesita un tratamiento médico de emergencia mientras está de viaje por negocios autorizados por la compañía. Walmart paga esta cobertura en su totalidad; es sin cargo y no es necesario que se inscriba. La cobertura es válida para un viaje que dura hasta 180 días. La cobertura no está disponible para viajes personales, incluso si su viaje personal coincide con un viaje de negocios.

No es elegible para realizar aportes a una cuenta de ahorro de salud durante ningún mes en los que está viajando fuera de los EE. UU. por negocios de Walmart y están cubiertas conforme a la póliza de GeoBlue. Si tiene cobertura del Plan Saver, se le recomienda consultar con su asesor fiscal si tiene preguntas sobre el monto para reducir los aportes a la HSA en función de sus circunstancias individuales.

SERVICIOS DE GEOBLUE

El seguro médico durante viajes de negocios a través de GeoBlue proporciona cobertura para tratamientos médicos de emergencia, incluida la cobertura para la internación, las consultas médicas y los medicamentos con receta médica (excepto los medicamentos de venta libre).

GeoBlue tiene una red de médicos y centros médicos en más de 180 países, y también puede programar citas en su nombre y acordar la facturación directa. Se recomienda que los asociados se comuniquen con el Servicio de Atención al Cliente al **888-412-6403** antes de someterse a un tratamiento médico a fin de asegurarse de que el tratamiento esté cubierto.

GeoBlue proporciona los siguientes servicios:

- Reembolso por los gastos médicos elegibles
- Asistencia para localizar un médico, un centro de salud y para programar citas médicas
- Facturación directa y garantías de pago
- Coordinar una evaluación médica de emergencia en el centro médico adecuado más cercano para el asociado y un miembro de su familia como acompañante y
- Repatriación de restos.

Si incurre en gastos médicos elegibles, envíelos a GeoBlue para obtener un reembolso. No se deberían cargar en la tarjeta de crédito corporativa ni enviar para obtener un reembolso a través del sistema de viajes y gastos.

Se aconseja a los asociados que se registren en **geo-blue.com** antes de su viaje de negocios, utilizando el código de acceso del grupo **QHG99999WALM**. Al registrarse, tendrá acceso a servicios y beneficios, tales como:

- Opción de imprimir su tarjeta de identificación del seguro, en caso de que la pierda
- Localizador de médicos y centros de salud
- Controlador de síntomas
- Traducir términos médicos y medicamentos e
- Información sobre los riesgos de salud y seguridad.

Descargar la aplicación de GeoBlue: una vez que se registre, descargue la aplicación de GeoBlue e inicie sesión con la dirección de correo electrónico y la contraseña que creó cuando se registró en el sitio web. La aplicación le permite acceder fácilmente a su tarjeta de identificación y a las herramientas de autoservicio de GeoBlue, incluida la función de localización del centro médico o proveedor aprobado más cercano, programar citas, etc.

Tarjetas de identificación para miembros de GeoBlue: las tarjetas tienen el logotipo de Blue Cross Blue Shield y están disponibles en el Departamento de Viajes. Las tarjetas adicionales o de reemplazo se pueden descargar a través de **geo-blue.com**.

Reclamaciones: por lo general, los formularios para reclamaciones no se requieren para los servicios de GeoBlue. Sin embargo, si tiene alguna pregunta sobre sus beneficios o no está de acuerdo con los beneficios que le ofrecen, puede comunicarse con GeoBlue o presentar una reclamación. Para enviar una reclamación por correo electrónico o por fax, descargue un formulario de reclamación y consulte las instrucciones detalladas en el Centro para Miembros en **geo-blue.com**. Envíe su reclamación por correo electrónico a **claims@geo-blue.com** o por fax al **610-482-9623**.

También puede enviar reclamaciones por correo postal. Descargue un formulario de reclamación del Centro para Miembros en **geo-blue.com** y envíe el formulario completo a:

GeoBlue
Claims Department
P.O. Box 1748
Southeastern, Pennsylvania 19399-1748

Las reclamaciones y las apelaciones se determinan conforme a los plazos y los requisitos establecidos en la póliza de GeoBlue. Comuníquese con GeoBlue en cualquier momento llamando al **888-412-6403**. Fuera de los EE. UU., llame por cobrar al: **610-254-5830**.

Seguro contra accidentes

La información de este capítulo describe los beneficios por accidente a los que puede acceder si:

- Es usted un conductor de camión por hora, temporal, a tiempo parcial, o un asociado asalariado (de la gerencia)
- Ha cumplido todos los requisitos para que la cobertura tenga vigencia, incluidos los requisitos de trabajo activo, y
- Se ha inscrito debida y oportunamente.

Si tiene preguntas sobre los requisitos de elegibilidad, los requisitos para que la cobertura sea efectiva y la repercusión en sus beneficios de un cambio en su clasificación laboral, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Esta información pretende ser un resumen de sus beneficios y es posible que no incluya todas las condiciones de la póliza. Si existen diferencias entre este documento y la póliza emitida por Allstate Benefits respecto del cálculo de los beneficios y las limitaciones en virtud de la póliza, regirán los términos de la póliza. Puede obtener una copia de esta póliza si se comunica con el Plan. La cobertura se proporciona mediante los formularios GACWM4 o las variantes estatales correspondientes. Hay exclusiones y limitaciones para la cobertura. Allstate Benefits es el nombre comercial de American Heritage Life Insurance Company, la compañía aseguradora y subsidiaria de The Allstate Corporation.

Seguro contra accidentes

Este seguro lo ayuda si tiene un accidente fuera del trabajo. Si el accidente está cubierto, puede cubrir los gastos de tratamiento de atención inmediata, hospitalización, fisioterapia, transporte y alojamiento. Los beneficios se le pagan directamente a usted, a menos que desee que se paguen al proveedor.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Obtenga información detallada	Visite **One.Walmart.com** o **AllstateBenefits.com/Walmart**	Llame a Allstate Benefits al **800-514-9525**

Lo que debe saber sobre el seguro contra accidentes

- Usted puede adquirir un seguro contra accidentes para ayudarlo a usted y su familia en caso de que usted o su dependiente cubierto tenga un accidente cubierto que requiera atención médica.
- El seguro contra accidentes paga un beneficio fijo en una suma única, según la naturaleza del accidente y la atención recibida.
- No se requiere una evidencia de buena salud para ningún nivel de cobertura.
- La cobertura se brinda a través de Allstate Benefits. El Certificado de Seguro disponible en **One.Walmart.com** o **AllstateBenefits.com/Walmart** proporciona información detallada sobre el seguro contra accidentes, además de los puntos importantes disponibles en este capítulo.

Seguro contra accidentes

El seguro contra accidentes le brinda beneficios si usted o sus dependientes cubiertos reciben un tratamiento cubierto debido a un accidente que sufrió fuera del trabajo. Los beneficios incluidos en esta póliza no se reducen debido a ningún otro beneficio que usted pueda recibir.

SELECCIÓN DE UN NIVEL DE COBERTURA

Cuando se inscribe en un seguro contra accidentes, además selecciona a los miembros elegibles de la familia que desea cubrir:

- Asociado solo
- Asociado + cónyuge/pareja (excepto para asociados a tiempo parcial pagados por hora, asociados temporales o conductores de camión a tiempo parcial)
- Asociado + hijos o
- Asociado + familia (excepto para asociados a tiempo parcial pagados por hora, los asociados temporales y los conductores de camión a tiempo parcial).

Si tiene cobertura para asociado únicamente o asociado + cónyuge/pareja y usted (o su cónyuge/pareja) da a luz un hijo, su hijo recién nacido recibirá cobertura automáticamente por 60 días después del nacimiento. Debe cambiar su nivel a asociado + hijo(s) o asociado + familia si desea continuar con la cobertura de su hijo después de los 60 días. Consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información sobre cuándo y cómo modificar su elección.

El costo de la cobertura se calcula según los dependientes elegibles a los que desea incluir en la cobertura.

Todas las lesiones que se producen mientras sea un miembro activo del servicio militar, la Fuerza Naval o las Fuerzas Aéreas de un país o de una combinación de países. Cuando se reciba la notificación y el comprobante de servicio en esas fuerzas, Allstate Benefits devolverá la parte proporcional a la prima pagada durante el periodo de ese servicio.

Beneficios del seguro contra accidentes

El seguro contra accidentes paga un beneficio si usted o un dependiente cubierto sufre una lesión causada por un accidente fuera del trabajo, que resulta en cualquiera de las pérdidas enumeradas en la tabla de la siguiente página.

Las lesiones deben ser diagnosticadas por un médico. Por lo general, un accidente está cubierto si se produce mientras usted o su dependiente cubierto no están trabajando en ningún empleo remunerado o con beneficios y es el resultado de un evento repentino, imprevisto e inesperado que ocurre sin la intención del individuo cubierto y que resulta en lesiones a usted o a su dependiente cubierto. Ciertos accidentes no están cubiertos. Para obtener información, consulte **Cuándo no se pagan los beneficios** más adelante en este capítulo.

Los beneficios se pagan de acuerdo con los términos del Certificado de Seguro disponible en **One.Walmart.com** o **AllstateBenefits.com/Walmart**. También puede llamar a Allstate Benefits al **800-514-9525** para solicitar una copia y la cual se proporcionará sin costo. La cobertura debe ser efectiva antes de que se produzca el accidente para que tal evento quede cubierto. No se pagan beneficios por cualquier accidente que ocurra antes de su fecha efectiva de cobertura. Si usted falleciera antes de la fecha efectiva, no se pagarán a sus beneficiarios los beneficios del seguro contra accidentes.

El seguro contra accidentes paga los beneficios que se describen en el siguiente cuadro por las lesiones resultantes de un accidente cubierto y los servicios relacionados, sujeto a los términos del Certificado de Seguro.

SERVICIOS/ LESIONES	MONTO DEL BENEFICIO	LIMITACIONES
Ambulancia	$400 por ambulancia terrestre o $4,000 por ambulancia aérea si un individuo cubierto requiere transporte en ambulancia a un hospital o centro de emergencia como resultado de un accidente cubierto.	El transporte en ambulancia debe ser dentro de las 72 horas posteriores al accidente cubierto. El servicio debe ser facilitado por una compañía de ambulancias profesional autorizada.
Aparato para ayudar con la locomoción o movilidad personal	$200 si el individuo cubierto, como consecuencia de un accidente cubierto y por consejo de un médico, requiere el uso de un aparato médico	Los aparatos médicos cubiertos incluyen: muletas, sillas de ruedas, aparato ortopédico para la pierna, aparato ortopédico para la espalda, andador y bota ortopédica. Se paga una vez por individuo cubierto, por accidente cubierto.
Sangre, plasma y/o plaquetas	$100 si un individuo cubierto, como resultado de un accidente cubierto, requiere sangre, plasma y/o plaquetas	No se paga por inmunoglobulina. Se paga una vez por individuo cubierto, por accidente cubierto.
Quemaduras	Entre $100 y $10,000, dependiendo del grado de la quemadura y el tamaño de la zona afectada, cuando un individuo cubierto sufre una quemadura como resultado de un accidente cubierto.	Si en el comprobante de siniestro no se especifica la extensión de la quemadura, se pagará el monto del beneficio más bajo. El tratamiento por parte de un médico debe ser dentro de las 72 horas posteriores al accidente cubierto. Las lesiones que se deban a quemaduras por el sol no están cubiertas.
Estado comatoso	$10,000 si un individuo cubierto está en coma como consecuencia de un accidente cubierto	Coma se refiere a un estado continuo de profunda inconsciencia que dura siete o más días consecutivos como consecuencia de un accidente cubierto. El coma se caracteriza por la ausencia de movimientos oculares espontáneos, de respuesta a estímulos dolorosos y de vocalización. La afección debe requerir intubación para asistencia respiratoria. Se excluye el coma médicamente inducido.
Conmoción cerebral	$50 si un individuo cubierto sufre una conmoción cerebral como resultado de un accidente cubierto	
Dislocación	Entre $188 y $3,750, dependiendo de la articulación dislocada, cuando un individuo cubierto sufre una dislocación como resultado de un accidente cubierto	Se paga solamente por la primera dislocación de una articulación. Paga el 25 % del monto del beneficio si un médico reduce una dislocación cubierta. Se pagan hasta dos dislocaciones cubiertas por persona cubierta, por accidente. En caso de más de dos dislocaciones durante un accidente cubierto, el beneficio paga las dos dislocaciones de mayor costo en dólares.
Servicios odontológicos de emergencia	$50 para dientes rotos que resulten en extracciones y $150 para reparación de piezas dentarias rotas con coronas	Paga el monto del beneficio indicado cuando una persona cubierta recibe servicios odontológicos como consecuencia de un accidente cubierto. Se paga una vez por individuo cubierto, por accidente cubierto.
Lesión ocular	$250 para reparación quirúrgica; $50 para la extracción de un cuerpo extraño	Para los servicios que preste un médico como consecuencia de un accidente cubierto.
Alojamiento de la familia en caso de ingreso en un hospital que no sea local	$100 por noche para una habitación de hotel/motel para un familiar directo del individuo cubierto	Se paga hasta 30 días por accidente cubierto, y solamente durante los días cuando un individuo cubierto está ingresado en un hospital que no sea local.
Tratamiento de seguimiento (no está cubierto por la fisioterapia)	$50 por visita de seguimiento para un tratamiento de seguimiento necesario después de recibir un tratamiento de emergencia por el que se paga un beneficio en virtud del beneficio de atención inmediata	El tratamiento de seguimiento debe ser administrado por un médico en un consultorio o en un hospital como paciente ambulatorio y debe comenzar dentro de los 30 días siguientes al tratamiento inicial cubierto. Se paga un tratamiento de seguimiento por día hasta un máximo de seis tratamientos por individuo cubierto, por accidente cubierto. No se pagan los tratamientos por los que se paga el beneficio de fisioterapia.
Fracturas	Entre $375 y $3,750, dependiendo de la ubicación de la fractura, cuando la misma se corrige mediante una reparación abierta o cerrada como resultado de un accidente cubierto; 25 % para las fracturas por astillamiento u otras fracturas que no se corrijan mediante una reparación abierta o cerrada	No se pagan más de dos fracturas por individuo cubierto, por accidente cubierto. En caso de más de dos fracturas durante un accidente cubierto, el beneficio paga las dos fracturas de mayor costo en dólares.
Hospitalización	Beneficio diario de $300 por una hospitalización continua de al menos 18 horas, hasta 365 días, por accidente cubierto.	La hospitalización debe comenzar dentro de los 30 días posteriores al accidente cubierto. No se paga el mismo día que se paga el beneficio de rehabilitación. Se paga además del beneficio de la hospitalización inicial.
Atención inmediata (honorarios del médico, radiografías y departamento de emergencia)	$170 para el tratamiento médico necesario de un individuo cubierto como consecuencia de un accidente cubierto	Servicio pagadero a honorarios del médico, radiografías y sala de emergencia. Los tratamientos se deben recibir dentro de los 30 días posteriores al accidente cubierto. Se paga una sola vez por todos los tratamientos que surjan en un periodo de 24 horas, por individuo cubierto y por accidente cubierto.

(Continúa en la próxima página)

SERVICIOS/ LESIONES	MONTO DEL BENEFICIO	LIMITACIONES
Hospitalización inicial	$1,500 que se pagan la primera vez que un individuo cubierto es hospitalizado por al menos 24 horas para recibir tratamiento como resultado de una lesión cubierta; $2,250 si ingresa directamente a una unidad hospitalaria de cuidado intensivo	La hospitalización debe comenzar dentro de los 30 posteriores al accidente cubierto. Solamente se paga una vez por hospitalización continua por año calendario, por persona cubierta.
Hospitalización en unidad de cuidado intensivo (ICU)	$900 por día, hasta 15 días por cada accidente	La hospitalización debe comenzar dentro de los 30 días posteriores al accidente cubierto. Se paga además del beneficio por hospitalización.
Desgarros	$25–$400, según la extensión del desgarro	El tratamiento debe ser dentro de las 72 horas posteriores al accidente cubierto. Si en el comprobante de siniestro no se especifica la extensión del desgarro, se pagará el monto del beneficio más bajo.
Exámenes de diagnóstico complejos	$400 por uno de los siguientes conceptos, si una persona cubierta requiere el examen como consecuencia de un accidente cubierto: TC, RM o EEG	Debe realizarse en un hospital, consultorio médico o centro quirúrgico ambulatorio. Un pago por persona cubierta, por año calendario.
Fisioterapia (no está cubierta por el tratamiento de seguimiento)	$50 por día por la fisioterapia recibida como consecuencia de un accidente cubierto	La terapia debe ser prescrita por un médico y comenzar dentro de los 30 días posteriores al accidente cubierto o al alta del hospital y efectuarse dentro de los seis meses posteriores al accidente cubierto o al alta del hospital. Se paga un tratamiento por día, hasta 10 tratamientos por accidente cubierto, por individuo cubierto. No se pagan los tratamientos para los que se paga el beneficio de tratamiento de seguimiento.
Trastorno de estrés postraumático (PTSD)	$100 por día para asesoramiento por PTSD	Se paga solo una vez por día, por individuo cubierto, hasta un máximo de seis días por año calendario. Un médico o un profesional de la salud mental autorizado debe haber diagnosticado a la persona cubierta con un trastorno de estrés postraumático y debe estar recibiendo asesoramiento mediante terapia grupal y/o individual. Trastorno de estrés postraumático se refiere a un trastorno de salud mental desencadenado por un accidente cubierto. Los síntomas deben incluir escenas retrospectivas, pesadillas y ansiedad grave, al igual que pensamientos incontrolables sobre el accidente cubierto.
Prótesis	$1,000 por una prótesis necesaria como consecuencia de un accidente cubierto	No se paga por audífonos, pelucas y dispositivos odontológicos (incluidas piezas dentadura postiza). Se paga una vez por individuo cubierto, por accidente cubierto.
Rehabilitación interna (después de la hospitalización)	$100 por día si el individuo cubierto está internado en una unidad de rehabilitación como resultado de un accidente cubierto	Debe haber sido hospitalizado inmediatamente antes de ser trasladado a la unidad de rehabilitación. Se paga por cada día en que se incurra en gastos por tener una habitación, hasta 30 días por persona cubierta, por periodo continuo de hospitalización; máximo de 60 días. No se pagan los días en los que se paga el beneficio de hospitalización.
Injertos de piel	El 50 % del monto del beneficio por quemaduras, si un individuo cubierto recibe uno o más injertos de piel por una quemadura cubierta.	Se paga además del beneficio por quemaduras.
Hospitalización en una unidad de cuidados intermedios de ICU	$200 al día por hospitalización de al menos 18 horas	Se paga por persona cubierta, por accidente cubierto, además de cualquier beneficio por hospitalización. Hasta 15 días por persona asegurada y accidente cubierto.
Procedimientos quirúrgicos	$350–$1,400, según el procedimiento quirúrgico	Dos o más procedimientos quirúrgicos que se realicen a través de la misma incisión o punto de entrada se consideran una sola operación. El beneficio solo pagará el procedimiento cuyo costo sea mayor. Se deben realizar dentro del año posterior al accidente cubierto. La cirugía miscelánea es cirugía que requiere anestesia general y no debe estar cubierta por ningún otro beneficio quirúrgico específico de la lista. El beneficio de cirugías varias se paga una vez cada 24 horas a pesar de que se realice más de una cirugía o procedimiento.
Transporte para recibir tratamiento en un hospital que no sea local	$400 por viaje de ida y vuelta para el tratamiento en un hospital que no sea local, como resultado de un accidente cubierto; $400 adicionales por viaje de ida y vuelta para uno de los padres o el tutor legal si la persona que está recibiendo tratamiento es el hijo dependiente	El médico debe recetar el tratamiento. Se pagan hasta tres viajes de ida y vuelta por año calendario y por persona cubierta. No se paga el transporte en ambulancia.

Cómo nombrar a un beneficiario

Si fallece mientras tiene cobertura de seguro contra accidentes, sus beneficiarios recibirán cualquier beneficio adeudado en el momento de su fallecimiento. Debe nombrar a los beneficiarios que recibirán su beneficio del seguro contra accidentes si usted fallece. Para ello, visite **One.Walmart.com/Beneficiary**. La designación del beneficiario debe completarse y enviarse al Plan antes de su fallecimiento. Póngase en contacto con el Servicios al Personal llamando al **800-421-1362** si no puede acceder a la herramienta Beneficiary Online.

Puede nombrar a cualquier persona que desee. Si el (los) beneficiario(s) que figura(n) en su designación de beneficiarios archivada en el Plan difiere(n) del (de los) beneficiario(s) nombrado(s) en su testamento, la designación de beneficiarios archivada en el Plan prevalecerá. Si no ha designado beneficiarios conforme al beneficio de seguro por accidentes del asociado, el pago se realizará a los miembros sobrevivientes de su familia, tal como se describe en **Si no nombra a un beneficiario** más adelante en esta página.

Se necesita la siguiente información por cada beneficiario:

- Nombre
- Dirección y número de teléfono actuales
- Relación con usted
- Número de seguridad social
- Fecha de nacimiento
- Porcentaje que desea designar a cada beneficiario, hasta el 100 %.

Si se designa a dos o más beneficiarios y sus cuotas no están especificadas, compartirán el beneficio del seguro en partes iguales. Si un beneficiario designado falleciera antes que usted, el derecho de tal beneficiario cesará y se distribuirá en partes iguales entre los restantes beneficiarios, a menos que su formulario de beneficiarios indique lo contrario.

Puede nombrar a un menor de edad como beneficiario; sin embargo, es posible que Allstate Benefits no tenga autorización legal para pagarle al menor hasta que sea mayor de edad. Es recomendable que consulte a un abogado o a un asesor testamentario antes de nombrar a un menor de edad como beneficiario.

Se asignará automáticamente a usted (el asociado) como beneficiario principal de la cobertura contra accidentes de sus dependientes cubiertos. Si usted y su dependiente fallecen al mismo tiempo, los beneficios se pagarán como si no se hubiera designado a ningún beneficiario. Consulte **Si no nombra a un beneficiario**adelante.

CÓMO CAMBIAR DE BENEFICIARIO

Usted puede cambiar los beneficiarios en cualquier momento en **One.Walmart.com/Beneficiary**. Cualquier cambio en los beneficiarios debe ser completado y enviado al Plan antes de su fallecimiento. Póngase en contacto con el Servicios al Personal llamando al **800-421-1362** si no puede acceder a la herramienta Beneficiary Online.

SI NO NOMBRA A UN BENEFICIARIO

Si no se designa ningún beneficiario o el beneficiario que usted designó no le sobrevive, el pago de los beneficios que se deban a su fallecimiento se efectuará en el siguiente orden:

- Su cónyuge/pareja; si no vive, a sus
- Hijos en partes iguales; si no viven, a sus
- Padres en partes iguales; si no viven, a sus
- Hermanos en partes iguales; si no viven, a sus
- Herederos.

Mantenga actualizada la información de sus beneficiarios. Los beneficios son para cualquier persona que se encuentre en la lista de la designación de beneficiarios con el Plan, independientemente de su relación actual con esa persona, a menos que la ley aplicable diga lo contrario. Usted puede cambiar los beneficiarios en cualquier momento en **One.Walmart.com/Beneficiary**.

Presentar una reclamación al seguro por accidentes

Dentro de los 60 días de que se produzca o comience un accidente cubierto, debe enviar lo antes posible una notificación de reclamación a:

Allstate Benefits
Attn: Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488

También puede proporcionar una notificación de reclamación de la siguiente manera:

En línea: **AllstateBenefits.com/mybenefits**
Por teléfono: **800-514-9525**
Por fax: **877-423-8804**

Incluir la siguiente información de la persona cubierta:

- Nombre
- Número de seguridad social
- Fecha en que se produjo el accidente cubierto

Puede solicitar un formulario de reclamación a Allstate Benefits o ingresar a **One.Walmart.com** o **AllstateBenefits.com/Walmart** para obtener una copia. Si no recibe un formulario de reclamación dentro de los 15 días de su reclamación, puede enviar una notificación de la reclamación a Allstate Benefits y proporcionar a Allstate Benefits una declaración de la naturaleza y la magnitud del siniestro.

Se le pedirá que presente una prueba escrita de su reclamación a Allstate Benefits. Por lo general, debe presentar una prueba escrita de su reclamación dentro de los 90 días posteriores al servicio o a la pérdida, o lo más pronto que sea razonablemente posible después de la pérdida si no es posible presentarla dentro de los 90 días. En cualquier caso, por lo general, debe presentar las pruebas necesarias de la reclamación a Allstate Benefits dentro de los 15 meses, o se rechazará su reclamación.

Las reclamaciones se determinan dentro de los plazos y requisitos establecidos en el capítulo **Reclamaciones y apelaciones**. Usted o su beneficiario tienen derecho a apelar una reclamación rechazada. Para obtener información, consulte el capítulo **Reclamaciones y apelaciones**.

Cuándo no se pagan los beneficios

No se pagará ningún beneficio por un accidente que se produzca como consecuencia de:

- Una lesión que se produce como resultado de un accidente que sucedió en el trabajo;
- Una lesión que se produce antes de la fecha de entrada en vigencia de la cobertura
- Cualquier acto de guerra, ya sea declarada o no, o participación en disturbios, insurrección o rebeliones;
- Suicidio o intento de suicidio, ya sea que se encuentre en su sano juicio o no;
- Una lesión que se produce mientras se encuentra bajo los efectos del alcohol o de narcóticos, a menos que se administren según recomendación de un médico
- Cirugía odontológica o plástica para fines cosméticos, excepto cuando la cirugía sea necesaria para el tratamiento de una lesión o la corrección de un problema del funcionamiento normal del cuerpo que fuera causado por una lesión
- Cometer o intento de cometer un ataque o un delito; o
- Las lesiones que se producen mientras el individuo cubierto es miembro activo del servicio militar, la fuerza naval o las fuerzas aéreas de un país o de una combinación de países.

Interrupción de la cobertura

Puede haber ocasiones en las que deba tomar medidas especiales para pagar sus primas de seguro contra accidentes a fin de evitar la suspensión de la cobertura. Estas situaciones se producen con más frecuencia si se encuentra con una licencia de ausencia o si su cheque de pago de Walmart no es suficiente para pagar toda la parte que le corresponde del costo de cobertura (por ejemplo, después de una reducción de horas). El incumplimiento del pago de las primas dentro de los 30 días de la fecha de vencimiento causará que se interrumpa el pago de cualquier reclamación de beneficio y/o se suspenda la cobertura.

Consulte **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información detallada sobre cómo realizar los pagos de las primas para que no haya un lapso en su cobertura.

SI SE TOMA UNA LICENCIA DE AUSENCIA

Puede continuar su cobertura hasta el último día de una licencia de ausencia aprobado, solo si paga sus primas antes de que comience la licencia de ausencia o durante este. Para obtener información sobre cómo realizar los pagos durante una licencia, consulte la sección **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** .

Cuándo finaliza la cobertura del seguro contra accidentes

Su cobertura de seguro contra accidentes finaliza en el momento en que ocurra la primera de las siguientes situaciones:

- En la fecha en la que abandone voluntariamente la cobertura (como se describe a continuación)
- En la fecha en que termine el empleo
- El último día hasta el cual se pagaron las primas requeridas, si no pagó las primas dentro de los 30 días de la fecha de vencimiento de estas.
- En la fecha de su fallecimiento
- El último día de una licencia aprobada (a menos que vuelva a trabajar) o
- Cuando Walmart deja de ofrecer el seguro contra accidentes.

La cobertura de seguro contra accidentes de su cónyuge/pareja finaliza:

- En la fecha en que finaliza su cobertura de seguro contra accidentes.
- El último día del periodo de pago en que su condición laboral cambia a asociado a tiempo parcial, temporal o conductor de camión a tiempo parcial.
- En la fecha en que usted y su cónyuge se separen legalmente
- En la fecha en que usted y su cónyuge se divorcien o se finalice la relación de pareja, o
- Al momento del fallecimiento de su cónyuge/pareja.

La cobertura del seguro contra accidentes para su(s) hijo(s) dependiente(s) finaliza en la fecha más temprana de las siguientes:

- En la fecha en que finaliza su cobertura de seguro contra accidentes.
- En la fecha en que su hijo dependiente pierde su elegibilidad o
- Al momento del fallecimiento de su hijo elegible.

Si su clasificación de empleo cambia, consulte la tabla correspondiente en la sección **Cambio de una clasificación laboral a otra** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información sobre cualquier repercusión en su cobertura.

Si cancela voluntariamente la cobertura después de un evento de cambio de elección o en la Inscripción Anual, la cobertura finaliza de la siguiente manera:

- **Tras un evento de cambio de elección:** la cobertura finaliza en la fecha efectiva del evento. Para obtener más información, consulte **Cambios de elección permitidos fuera del periodo de Inscripción anual** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.
- **En la Inscripción anual: la cobertura** finaliza el 31 de diciembre del año en curso.

CONTINUACIÓN DE LA COBERTURA CUANDO FINALIZA

Si su cobertura del seguro contra accidentes finaliza como se ha descrito anteriormente (excepto por falta de pago de las primas o por fallecimiento), usted y sus dependientes cubiertos pueden seguir teniendo la cobertura del seguro contra accidentes directamente de Allstate Benefits a través de la cobertura de transferibilidad. Los beneficios, los términos y las condiciones de la cobertura de portabilidad serán los mismos que los previstos en el seguro contra accidentes disponible en el Plan en el momento de la terminación del empleo. Para recibir la cobertura de transferibilidad, debe informar su deseo de continuar con la cobertura a Allstate Benefits y enviar la primera prima dentro de los 60 días de la fecha en que termine su cobertura del seguro contra accidentes.

> No podrá continuar con su cobertura a menos que se ponga en contacto con Allstate Benefits y envíe el primer pago de la prima dentro de los 60 días siguientes a la fecha de finalización de su cobertura.

La cobertura de transferibilidad entrará en vigencia el día siguiente a la finalización de la cobertura del Plan y finalizará en la fecha más temprana de las siguientes:

- La fecha en la que usted vuelve a tener derecho a un seguro contra accidentes conforme al Plan.
- El último día hasta el cual se pagaron las primas requeridas, si no pagó las primas dentro de los 30 días de la fecha de vencimiento de estas.
- Para sus dependientes cubiertos, en la fecha de finalización de su cobertura o en la fecha en que el dependiente deja de serlo.

Cualquier dependiente elegible que esté cubierto por un seguro contra accidentes en el momento en que tal cobertura finalice como consecuencia de haber alcanzado la edad máxima para tener derecho a la misma, también podrá recibir la cobertura de portabilidad bajo los términos descritos anteriormente. Para obtener información, comuníquese con Allstate Benefits al **800-514-9525**.

Las primas para la cobertura de transferibilidad se deben pagar antes de recibir la cobertura de cada mes, el primer día del mes calendario. Las primas tienen la misma tarifa que esté vigente para el seguro por enfermedades graves para los asociados activos que tengan la misma cobertura.

Para obtener más información, comuníquese con Allstate Benefits al **800-514-9525**.

Si deja Walmart y lo contratan nuevamente

Si es usted un asociado pagado por hora a tiempo parcial o temporal que está sujeto a las verificaciones de elegibilidad de 60 días, una sola vez y anualmente para los beneficios médicos, consulte la sección **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener detalles sobre cómo el hecho de terminar el empleo con Walmart y luego volver a trabajar afecta sus beneficios.

Si es un asociado a tiempo completo pagado por hora, un miembro de la gerencia o conductor de camión, consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para saber cómo el hecho de dejar de trabajar en Walmart y volver a hacerlo afecta sus beneficios.

Seguro por muerte accidental y desmembramiento (AD&D)

La información de este capítulo describe los beneficios opcionales del seguro por muerte accidental y desmembramiento que pueden estar a su disposición si:

- Es usted un conductor de camión por hora, temporal, a tiempo parcial, o un asociado asalariado (de la gerencia)
- Ha cumplido todos los requisitos para que la cobertura tenga vigencia, incluidos los requisitos de trabajo activo, y
- Se ha inscrito debida y oportunamente.

Si tiene preguntas sobre los requisitos de elegibilidad, los requisitos para que la cobertura sea efectiva y la repercusión en sus beneficios de un cambio en su clasificación laboral, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Esta información pretende ser un resumen de sus beneficios y es posible que no incluya todas las condiciones de la póliza. Si existen diferencias entre este documento y la póliza emitida por Prudential respecto del cálculo de los beneficios y las limitaciones en virtud de la póliza, regirán los términos de la póliza. Puede obtener una copia de esta póliza si se comunica con el Plan.

Seguro por muerte accidental y desmembramiento (AD&D)

Los beneficios de la cobertura por AD&D pueden ayudar a pagar los costos de atención médica, cuidado de niños y gastos de educación si sufre una lesión grave o fallece en un accidente.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Cambie su designación de beneficiario	Visite **One.Walmart.com/Beneficiary**	Los cambios de beneficiario no se pueden realizar por teléfono
Obtenga más información		Llame a Prudential al **877-740-2116**
Cómo presentar una reclamación		Llame a Prudential al **877-740-2116**

Lo que debe saber sobre el seguro por AD&D

- No se exige presentar una evidencia de buena salud para el seguro por AD&D, independientemente del monto de cobertura que elija.
- Si se produce un siniestro cubierto, el seguro por AD&D paga un beneficio en una suma única según la naturaleza del siniestro y el monto de la cobertura que elija. Se pueden pagar otros beneficios, dependiendo de las circunstancias en las que se produzca el siniestro cubierto.
- La cobertura se ofrece a través de Prudential Insurance Company of America (Prudential).
- El certificado de seguro está disponible en **One.Walmart.com** o en **Prudential.com/Walmart**. El certificado proporciona información detallada sobre el seguro de vida pagado por la compañía, además de los aspectos más destacados disponibles en este capítulo.

Seguro por muerte accidental o desmembramiento (AD&D)

El seguro por AD&D paga un beneficio en una suma única para usted o sus beneficiarios si usted o un dependiente con cobertura tienen un siniestro cubierto. El monto de su beneficio depende del tipo de siniestro que sufre, tal como se describe más adelante en este capítulo.

Debe tomar dos decisiones acerca de la cobertura por AD&D. Debe elegir a quién desea cubrir y el monto de cobertura.

Puede elegir estos tipos de cobertura:

- Asociado solo
- Asociado + dependientes

Si es un asociado a tiempo parcial pagado por hora, un asociado temporal o un conductor de camión a tiempo parcial y elige la cobertura para asociado + dependientes, podrá brindarles cobertura a sus hijos dependientes, pero no a su cónyuge/pareja.

El monto de cobertura para sus dependientes será un porcentaje del monto de cobertura que elija para usted (consulte **Monto de cobertura por AD&D** más adelante en este capítulo). Los montos disponibles para que elija como su monto de cobertura de asociado son:

- $25,000
- $50,000
- $75,000
- $100,000
- $150,000
- $200,000

Los asociados gerenciales también pueden elegir los siguientes montos adicionales de cobertura:

- $300,000
- $500,000
- $750,000
- $1,000,000

El costo del seguro por AD&D se basa en el monto de cobertura que seleccione y si elige cobertura únicamente para el asociado o para el asociado y sus dependientes.

Cómo nombrar a un beneficiario

Para garantizar que su beneficio por AD&D se pague como usted desea, debe nombrar a los beneficiarios. Para ello, visite **One.Walmart.com/Beneficiary**. La designación del beneficiario debe completarse y enviarse al Plan antes de su fallecimiento. Póngase en contacto con el Servicios al Personal llamando al **800-421-1362** si no puede acceder a la herramienta Beneficiary Online.

Usted (el asociado) recibirá todos los beneficios pagaderos para sus dependientes cubiertos.

Puede nombrar a cualquier persona que desee. Si el (los) beneficiario(s) que figura(n) en su designación de beneficiarios archivada en el Plan difiere(n) del (de los) beneficiario(s) nombrado(s) en su testamento, la designación de beneficiarios archivada en el Plan prevalecerá. Si no ha designado beneficiarios conforme al beneficio por AD&D del asociado, el pago se realizará a los miembros sobrevivientes de su familia, tal como se describe en **Si no nombra a un beneficiario** en la siguiente columna.

Se necesita la siguiente información por cada beneficiario:

- Nombre
- Dirección y número de teléfono actuales
- Relación con usted
- Número de seguridad social
- Fecha de nacimiento
- Porcentaje que desea designar a cada beneficiario, hasta el 100 %.

Si se designa a dos o más beneficiarios y sus cuotas no están especificadas, compartirán el beneficio del seguro en partes iguales. Si un beneficiario designado falleciera antes que usted, el derecho de tal beneficiario cesará, y se distribuirá en partes iguales entre los restantes beneficiarios, a menos que su formulario de beneficiarios indique lo contrario.

Puede nombrar a un menor de edad como beneficiario; sin embargo, es posible que Prudential no tenga autorización legal para pagarle al menor hasta que sea mayor de edad. Es recomendable que consulte a un abogado o a un asesor testamentario antes de nombrar a un menor de edad como beneficiario. Si nombra a un menor de edad como beneficiario, no se podrán pagar los gastos funerarios de los beneficios del menor.

CÓMO CAMBIAR DE BENEFICIARIO

Usted puede cambiar los beneficiarios en cualquier momento en **One.Walmart.com/Beneficiary**. Cualquier cambio de beneficiario se debe completar y enviar a Walmart antes de su fallecimiento y solo puede ser enviado por usted, el asociado cubierto. Póngase en contacto con el Servicios al Personal llamando al **800-421-1362** si no puede acceder a la herramienta Beneficiary Online.

SI NO NOMBRA A UN BENEFICIARIO

Si no se nombra un beneficiario o si los beneficiarios no están vivos cuando usted fallece, el pago se realizará a sus familiares vivos en el siguiente orden:

1. Cónyuge/pareja del difunto; si no viven, a sus
2. Hijos en partes iguales; si no viven, a sus
3. Padres en partes iguales; si no viven, a sus
4. Hermanos en partes iguales; si no viven, a sus
5. Herederos.

Mantenga actualizada la información de sus beneficiarios. Los beneficios son para cualquier persona que se encuentre en la lista de la designación de beneficiarios con el Plan, independientemente de su relación actual con esa persona, a menos que la ley aplicable diga lo contrario. Usted puede cambiar los beneficiarios en cualquier momento en **One.Walmart.com/Beneficiary**.

Monto de cobertura por AD&D

Cuando se inscribe en el seguro por AD&D, el monto de la cobertura que selecciona es el monto que se aplica a usted, el asociado. Si se inscribe en una cobertura para asociado + dependientes, el monto de la cobertura para ellos será un porcentaje del monto de su cobertura como asociado. El monto de su cobertura para dependientes depende del tipo de dependientes que estén cubiertos. Consulte la tabla **Monto del beneficio completo** a continuación para obtener información sobre el monto de cobertura para sus familiares.

Cuándo se pagan los beneficios por AD&D

Si eligió la cobertura de asociado + dependientes y usted o su dependiente sufre una lesión accidental como la única causa directa de un siniestro cubierto, los beneficios del seguro por AD&D se pagan cuando se hayan presentado las pruebas de la lesión accidental y el siniestro cubierto a Prudencial.

Prudential considera un siniestro como el resultado directo de una lesión accidental si esta es provocada por una exposición inevitable a factores climáticos.

"Causa directa y única" significa que el siniestro cubierto ocurre dentro de los 12 meses de la fecha de la lesión accidental como resultado directo de esta, independientemente de otras causas.

SINIESTROS CUBIERTOS QUE SE PAGAN COMO BENEFICIO COMPLETO

Los siguientes siniestros cubiertos que se produzcan por un accidente se pagarán como beneficio completo:

- Pérdida de la vida: se supondrá que ha perdido la vida si no se encuentra su cuerpo dentro de un año de que haya desaparecido, haya quedado varado, se haya hundido o haya naufragado cualquier vehículo en el cual usted era ocupante.
- Pérdida de ambas manos por encima de las muñecas, pérdida de ambos pies por encima de la línea de los tobillos; pérdida total y permanente de la vista en ambos ojos; pérdida del habla y de la audición en ambos oídos que continúa durante al menos los seis meses consecutivos posteriores al accidente.
- Una mano y un pie: amputación por o sobre la articulación de la muñeca y del tobillo.
- Pérdida de un brazo o una pierna: amputación en el codo o la rodilla, o por encima de estos.
- Pérdida de una mano o pie y la vista de un ojo. Amputación por o sobre la articulación de la muñeca o del tobillo, o pérdida total y permanente de la vista en un ojo.
- Cuadriplejía: Parálisis total de ambas extremidades inferiores y superiores.
- Paraplejía: Parálisis total de ambas extremidades inferiores.
- Hemiplejía: Parálisis total de las extremidades superiores e inferiores de un lado del cuerpo.

MONTO DEL BENEFICIO COMPLETO

Monto de cobertura del asociado	Si el único dependiente cubierto es su cónyuge/pareja	Si los dependientes cubiertos son cónyuge/pareja y los hijos		Si los únicos dependientes son hijos
El asociado: 100 %	Cónyuge/pareja: 50 %	Cónyuge/pareja: 40 %	Hijos: 10 %	Hijos: 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
Asociados gerenciales únicamente:				
$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 % DEL BENEFICIO COMPLETO

Los siguientes siniestros cubiertos que se produzcan por un accidente se pagarán al 50 % del beneficio completo:

- Daño cerebral: significa daño físico permanente e irreversible en el cerebro, lo cual provoca incapacidad total para llevar a cabo todas las funciones y actividades materiales y sustanciales normales de la vida cotidiana. Dicho daño debe manifestarse dentro de los 30 días de la lesión accidental, requerir hospitalización de más de cinco días consecutivos dentro de los 30 días posteriores al accidente y persistir durante 12 meses consecutivos.
- Pérdida de un pie o mano: amputación en la muñeca o el tobillo, o por encima de estos.
- Pérdida de la vista en un ojo: pérdida total y permanente de la vista en un ojo.
- Pérdida del habla o de la audición en ambos oídos: pérdida total y permanente del habla o de la audición (es decir, que persiste, como mínimo, seis meses consecutivos luego del accidente).

25 % DEL BENEFICIO COMPLETO

Los siguientes siniestros cubiertos que se produzcan por un accidente se pagarán al 25 % del beneficio completo:

- Pérdida de la audición en un oído: pérdida total y permanente de la audición (es decir, que persiste, como mínimo, seis meses consecutivos luego del accidente).
- Pérdida del dedo pulgar e índice de la misma mano: amputación en el punto donde se unen con la mano, o por encima de este.
- Monoplejía: parálisis total de una extremidad.

"Parálisis": significa perder el uso de un miembro, sin amputación. Un médico debe determinar que la pérdida es completa e irreversible. "Amputación" significa la separación completa y el desmembramiento de una extremidad del cuerpo.

BENEFICIO POR ESTADO COMATOSO

Si usted o un dependiente con cobertura están en coma o entran en coma dentro de los 365 días como resultado de un accidente, se pagará un beneficio por coma igual al 1 % del monto del beneficio completo durante 11 meses consecutivos a usted, a su cónyuge/pareja, a sus hijos o a un tutor legal. El beneficio se pagará después de 31 días consecutivos de haber entrado en coma. Si usted o un dependiente con cobertura permanecen en coma más de 11 meses, se le pagará a usted o a su beneficiario designado la suma completa de la cobertura, menos cualquier beneficio por AD&D que ya se haya pagado.

Estar en "coma" significa un estado profundo de inconsciencia del cual el individuo no puede despertar, incluso mediante estimulación potente, según lo determina el médico del individuo. Dicho estado debe comenzar dentro de los 365 días de la lesión accidental y debe continuar por 31 días consecutivos, además debe ser total, continuo y permanente una vez que finalice el periodo de 31 días.

El monto máximo que pagará el seguro por AD&D por todos los siniestros cubiertos de un individuo como resultado de un accidente cubierto es el monto del beneficio completo.

Beneficios por AD&D adicionales

Es posible que el Plan pague beneficios adicionales:

- Beneficio por uso del cinturón de seguridad: si usted o sus dependientes cubiertos pierden la vida como resultado de un accidente cubierto que ocurre usando cinturón de seguridad, es posible que se pague un beneficio adicional.
- Beneficio para motociclista seguro: si usted y/o el dependiente cubierto pierden la vida como resultado de un accidente cubierto que ocurre usando casco, es posible que se pague un beneficio adicional.
- Beneficio de reembolso de matrícula (asociados gerenciales y a tiempo completo pagados por hora únicamente): si usted (el asociado) pierde la vida, es posible que se pague un beneficio de educación a su cónyuge/pareja.
- Reembolso de matrícula y beneficio de cuidado de niños: si usted (el asociado) o su cónyuge/pareja con cobertura pierden la vida, es posible que se pague un beneficio por el cuidado de niños o un beneficio de educación para los hijos.
- Beneficio para reforma del hogar y modificación de vehículo: si usted o sus dependientes cubiertos sufren un siniestro cubierto que requiere una reforma del hogar o modificación del vehículo, es posible que se pague un beneficio adicional.
- Beneficio de prima médica mensual de COBRA: si usted (el asociado) sufre una lesión física accidental cubierta que produce su muerte o el cese de la relación laboral después de un permiso de ausencia, es posible que se pague un beneficio adicional para ayudar a la continuación de sus beneficios médicos del Plan Médico para Asociados.
- Beneficio de rehabilitación mensual: si usted o sus dependientes cubiertos sufren una lesión física accidental cubierta que requiere rehabilitación médicamente necesaria, es posible que se pague un beneficio adicional.
- Beneficio común por accidente: si usted (el asociado) o su cónyuge/pareja con cobertura pierden la vida a causa del mismo accidente o a causa de accidentes que sucedan en un plazo de 48 horas de diferencia, se puede pagar un beneficio común por accidente.

Todos los beneficios adicionales del seguro por AD&D están sujetos a los criterios de elegibilidad establecidos por Prudential. Si alguno de estos beneficios se podría aplicar en su caso, comuníquese con Prudential para obtener información.

BENEFICIOS ADICIONALES		
Beneficio	**Monto del beneficio**	**Limitaciones**
Beneficio por el uso del cinturón de seguridad	$10,000	Si no se puede determinar que la persona llevaba puesto el cinturón de seguridad al momento del accidente, se pagará un beneficio de $1,000.
Beneficio para motociclista seguro	$10,000	Si no se puede determinar que la persona estaba usando el equipo de seguridad necesario al momento del accidente, se pagará un beneficio de $1,000.
Reembolso de matrícula para el cónyuge/pareja	Un monto equivalente al menor de los siguientes: • la matrícula real que se cobra por el programa; • el 10 % del monto del seguro (del asociado); y • $25,000	Se paga hasta por 4 años. Debe estar inscrito en un programa profesional o comercial dentro de los 30 meses siguientes a la fecha de su fallecimiento. *Solo para asociados pagados por hora a tiempo completo y asociados gerenciales.*
Reembolso de la matrícula de un hijo	Un monto equivalente al menor de los siguientes: • la matrícula anual real, sin incluir el alojamiento y la comida que cobra la escuela; • el 10 % del monto del seguro de la persona que tiene el siniestro; y • $25,000	Se paga todos los años por hasta 4 años consecutivos, pero no después que el hijo cumpla los 26 años. El hijo debe estar matriculado como estudiante a tiempo completo en la fecha de su fallecimiento; o, si está en el 12° grado en la fecha del fallecimiento, debe pasar a ser un estudiante a tiempo completo en los 365 días siguientes a la fecha de su fallecimiento.
Beneficio por el cuidado de niños	Un monto equivalente al menor de los siguientes: • el costo real que cobra un centro de cuidado infantil por año; • el 10 % del monto del seguro de la persona que tiene el siniestro; y • $12,500	Se paga todos los años por hasta 5 años consecutivos, pero no después de que el hijo cumpla los 13 años. El hijo debe estar inscrito en la fecha de su fallecimiento o dentro de los 90 días siguientes a la fecha de su fallecimiento.
Beneficio para reforma del hogar y modificación del vehículo	Un monto equivalente al menor de los siguientes: • el costo real que se cobra por la reforma o modificación; • el 10 % del monto del seguro de la persona que tiene el siniestro; y • $10,000	Se paga un monto que no supere los $10,000.
Beneficio de la prima del seguro médico para el asociado (COBRA)	Un monto equivalente al menor de los siguientes: • el monto de la prima del seguro médico; • el 5 % del monto del seguro (del asociado); y • $500	Se paga todos los meses hasta que suceda la primera de las siguientes situaciones: • Finaliza la continuación de la inscripción en el AMP. • Obtiene cobertura de cualquier otro plan de seguro médico grupal. • El beneficio se pagó por 36 meses consecutivos.
Beneficio de la prima del seguro médico para el dependiente (COBRA)	Un monto equivalente al menor de los siguientes: • el monto real de la prima del seguro médico; y • $10,000	Se paga todos los años hasta que suceda la primera de las siguientes situaciones: • Finaliza la continuación de la inscripción de sus dependientes en el AMP. • El dependiente obtiene cobertura de cualquier otro plan de seguro médico grupal. • El beneficio se pagó por 3 años consecutivos. *El beneficio de primas para cónyuge/pareja solo está disponible para asociados pagados por hora a tiempo completo y asociados gerenciales.*
Beneficio de rehabilitación mensual	Un monto equivalente al menor de los siguientes: • el 10 % del monto del seguro de la persona que tiene el siniestro; y • $250	Se paga todos los meses hasta que suceda la primera de las siguientes situaciones: • Un médico determina que la persona ya no necesita rehabilitación. • La persona no presenta ninguna de las pruebas necesarias para continuar recibiendo rehabilitación. • La persona no se somete a ningún examen médico obligatorio. • El beneficio se pagó por 36 meses consecutivos.
Beneficio común por accidente	Un monto equivalente a la diferencia entre: • el monto del seguro que se paga conforme a la cobertura por pérdida de la vida; y • el monto del seguro que se paga conforme a la cobertura por la pérdida de la vida de su cónyuge/pareja de hecho.	

Presentar una reclamación al seguro AD&D

La siguiente información se debe proporcionar a Prudential con respecto al reclamante:

- Nombre
- Número de seguridad social
- Fecha de la lesión o el fallecimiento
- Causa de la lesión o el fallecimiento (si se conoce).

Prudential le enviará un paquete de reclamación a la dirección que figura en su legajo. La información que se exige debe completarse y enviarse con los formularios de reclamación y un original o una copia certificada del certificado de defunción, si corresponde, a:

The Prudential Insurance Company of America
Group Claim Life Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

Los beneficios se pagan en una suma única. Si usted o un dependiente cubierto sufren más de una pérdida cubierta debido a una lesión accidental, el monto abonado, a nombre de cualquiera de las personas lesionadas, no excederá el monto total del beneficio.

Las reclamaciones se determinan dentro de los plazos y requisitos establecidos en el capítulo **Reclamaciones y apelaciones**. Usted o su beneficiario tienen derecho a apelar una reclamación rechazada.

Cuándo no se pagan los beneficios

Los beneficios de la cobertura por AD&D no se pagan por ningún siniestro que ocurra antes de su inscripción en el plan ni por ningún siniestro causado o relacionado con los siguientes motivos:

- Suicidio o intento de suicidio, ya sea que se encuentre en su sano juicio o no;
- Lesiones autoinfligidas intencionalmente o intento de causarse tales lesiones;
- Enfermedad, ya sea que la pérdida resulte directa o indirectamente de la enfermedad;
- Tratamiento médico o quirúrgico de una enfermedad, ya sea que el siniestro sea ocasionado directa o indirectamente por el tratamiento;
- Infección bacteriana o viral, pero no se incluye lo siguiente:
  - Infección piógena ocasionada por un corte o una herida accidentales; o
  - Infección bacteriana ocasionada por la ingestión accidental de una sustancia contaminada.
- Participación en una insurrección;
- Guerra, declarada o no, o cualquier acto de guerra
- Un accidente que ocurre mientras la persona presta servicio activo a tiempo completo durante más de 30 días en cualquiera de las fuerzas armadas (no incluye servicio activo para entrenamiento de la Reserva o la Guardia Nacional);
- Viajar o volar en un vehículo usado para la navegación aérea si viaja como pasajero en un avión que no esté destinado o no tenga licencia para el transporte de pasajeros (incluye entrar y subir a dichos vehículos, y salir y bajar de ellos);
- Cometer o intentar cometer una agresión o un delito;
- Operar un vehículo terrestre, acuático o aéreo en estado de ebriedad legal; o
- Estar bajo la influencia de cualquier sustancia controlada, según se establece en el Título II de la Ley de Control y Prevención Integral del Abuso de Drogas de 1970 y todas sus modificaciones, a menos que dicha sustancia haya sido recetada y administrada de acuerdo con las instrucciones del médico del asegurado.

Interrupción de la cobertura

Puede haber ocasiones en las que deba tomar medidas especiales para pagar sus primas de seguro por AD&D a fin de evitar la suspensión de la cobertura. Estas situaciones se producen con más frecuencia si se encuentra con una licencia de ausencia o si su cheque de pago de Walmart no es suficiente para pagar toda la parte que le corresponde del costo de cobertura (por ejemplo, después de una reducción de horas). El incumplimiento del pago de las primas dentro de los 30 días de la fecha de vencimiento causará que se interrumpa el pago de cualquier reclamación de beneficio y/o se suspenda la cobertura.

Consulte **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información detallada sobre cómo realizar los pagos de las primas para que no haya un lapso en su cobertura.

SI SE TOMA UNA LICENCIA DE AUSENCIA

Puede continuar su cobertura hasta el último día de una licencia de ausencia aprobado, solo si paga sus primas antes de que comience la licencia de ausencia o durante este. Para obtener información sobre cómo realizar los pagos durante una licencia, consulte la sección **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** .

Cuándo finaliza la cobertura del seguro por AD&D

Su cobertura por AD&D finaliza:

- En la fecha en que abandone voluntariamente la cobertura (como se describe en la siguiente página)
- El momento del cese de su relación laboral.
- El último día de la cobertura para la que se pagaron las primas, si no pagó las primas dentro de los 30 días de la fecha de vencimiento de estas
- En la fecha de su fallecimiento
- En la fecha en que usted o su cónyuge/pareja, o hijo dependiente pierdan la elegibilidad.
- El último día de una licencia aprobada (a menos que vuelva a trabajar), o
- Cuando Walmart deje de ofrecer el beneficio. La cobertura por AD&D no se puede cambiar por una cobertura individual después de la finalización de la cobertura.

Asimismo, si elige una cobertura de asociado + dependientes y pasa a ser un asociado a tiempo parcial pagado por hora, asociado temporal o conductor de camión a tiempo parcial, se dará de baja la cobertura para su cónyuge/pareja el último día del periodo de pago en que cambió su estado laboral.

Si su clasificación de empleo cambia, consulte la tabla correspondiente en la sección **Cambio de una clasificación laboral a otra** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información sobre cualquier repercusión en su cobertura.

Si cancela voluntariamente la cobertura después de un evento de cambio de elección o en la Inscripción Anual, la cobertura finaliza de la siguiente manera:

- **Tras un evento de cambio de elección:** la cobertura finaliza en la fecha efectiva del evento. Para obtener más información, consulte **Cambios de elección permitidos fuera del periodo de Inscripción anual** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.
- **En la Inscripción anual:** la cobertura finaliza el 31 de diciembre del año en curso.

Si deja Walmart y lo contratan nuevamente

Si es usted un asociado pagado por hora a tiempo parcial o temporal que está sujeto a las verificaciones de elegibilidad de 60 días, una sola vez y anualmente para los beneficios médicos, consulte la sección **Cambios de elección permitidos fuera del periodo de Inscripción anual** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener detalles sobre cómo el hecho de terminar el empleo con Walmart y luego volver a trabajar afecta sus beneficios.

Si es un asociado a tiempo completo por hora, un miembro de la gerencia o conductor de camión, consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para saber cómo el hecho de dejar de trabajar en Walmart y volver a hacerlo afecta sus beneficios.

Seguro por enfermedades graves

La información de este capítulo describe los beneficios opcionales del seguro por enfermedad grave que pueden estar a su disposición si:

- Es usted un conductor de camión por hora, temporal, a tiempo parcial, o un asociado asalariado (de la gerencia)
- Ha cumplido todos los requisitos para que la cobertura tenga vigencia, incluidos los requisitos de trabajo activo, y
- Se ha inscrito debida y oportunamente.

Si tiene preguntas sobre los requisitos de elegibilidad, los requisitos para que la cobertura sea efectiva y la repercusión en sus beneficios de un cambio en su clasificación laboral, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Esta información pretende ser un resumen de sus beneficios y es posible que no incluya todas las condiciones de la póliza. Si existen diferencias entre este documento y la póliza emitida por Allstate Benefits respecto del cálculo de los beneficios y las limitaciones en virtud de la póliza, regirán los términos de la póliza. Puede obtener una copia de esta póliza si se comunica con el Plan. La cobertura se proporciona mediante los formularios GCICWM4 o las variantes estatales correspondientes. Hay exclusiones y limitaciones para la cobertura. Allstate Benefits es el nombre comercial de American Heritage Life Insurance Company, la compañía aseguradora y subsidiaria de The Allstate Corporation.

Seguro por enfermedades graves

Si se inscribe a sí mismo y a sus dependientes en el seguro por enfermedad grave, usted o su beneficiario tendrán derecho a un beneficio directo en efectivo para ayudar a pagar los gastos relacionados con las enfermedades graves cubiertas.

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Obtenga información detallada	Visite **One.Walmart.com** o **AllstateBenefits.com/Walmart**	Llame a Allstate Benefits al **800-514-9525**

Lo que debe saber sobre el seguro por enfermedades graves

- Usted puede adquirir un seguro por enfermedades graves que los ayude a usted y a su familia en caso de que a usted o a su dependiente cubierto se le diagnostique una enfermedad grave a una persona cubierta.
- Puede elegir montos de cobertura de $5,000, $10,000, $15,000 o $20,000.
- Si a usted o a una persona con cobertura se le diagnostica una enfermedad grave cubierta, el seguro por enfermedades graves paga un porcentaje del monto de cobertura en una suma única, según la naturaleza de la afección.
- No se requiere una evidencia de buena salud para ningún nivel de cobertura.
- El Certificado de Seguro disponible en línea en **One.Walmart.com** o **AllstateBenefits.com/Walmart** proporciona información detallada sobre el seguro por enfermedades graves, además de los puntos importantes disponibles en este capítulo.

Seguro por enfermedades graves

El seguro por enfermedades graves brinda un beneficio directo si a usted o a sus dependientes cubiertos se les diagnostica una enfermedad para la que tiene cobertura. La póliza paga beneficios independientemente de cualquier otro seguro que tenga, y además de este.

La cobertura está disponible en incrementos de $5,000 hasta un límite máximo de $20,000 sin la necesidad de presentar una evidencia de buena salud.

SELECCIÓN DE UN NIVEL DE COBERTURA

Cuando se inscribe en un seguro por enfermedades graves, además puede seleccionar los miembros elegibles de la familia que desea cubrir.

- Asociado solo
- Asociado + cónyuge/pareja (excepto para asociados a tiempo parcial pagados por hora, asociados temporales o conductores de camión a tiempo parcial)
- Asociado + hijos o
- Asociado + familia (excepto para asociados a tiempo parcial pagados por hora, los asociados temporales y los conductores de camión a tiempo parcial).

Si tiene cobertura para asociado únicamente o asociado + cónyuge/pareja y usted (o su cónyuge/pareja) da a luz un hijo, su hijo recién nacido recibirá cobertura automáticamente por 60 días después del nacimiento. Debe cambiar su elección a asociado + hijo(s) o asociado + familia si desea continuar con la cobertura de su hijo después de los 60 días. Consulte el **Elegibilidad, inscripción y fechas de vigencia**capítulo para obtener información sobre cuándo y cómo modificar su elección.

El costo de la cobertura se basa en los montos de cobertura que usted elija, los dependientes elegibles que decida que sean cubiertos, su edad y si usted (y/o su cónyuge/pareja cubierto) es elegible para las tarifas para personas libres de tabaco.

Beneficios por enfermedades graves

Los beneficios se pagan si se le diagnostica una de las condiciones que se mencionan a continuación, sujeto a los términos del Certificado de Seguro disponible en **One.Walmart.com** o **AllstateBenefits.com/Walmart**. También puede llamar a Allstate Benefits al **800-514-9525** para solicitar una copia. La cobertura debe ser efectiva antes de la fecha de diagnóstico para que la afección o enfermedad esté cubierta por la póliza.

No se pagan beneficios por ninguna enfermedad diagnosticada antes de la fecha efectiva de cobertura. Si usted fallece antes de la fecha efectiva de la cobertura, no se pagarán a sus beneficiarios los beneficios del seguro por enfermedades graves.

Se pagarán los beneficios del 100 % del monto de la cobertura que usted elija si se producen las siguientes enfermedades graves, de acuerdo con los detalles completos que figuran en el Certificado de Seguro:

- Cáncer invasivo
- Enfermedad de Alzheimer (implica la pérdida de tres actividades de la vida diaria)
- Cirugía de revascularización coronaria (excluye la angioplastia con balón, la embolectomía con láser, la aterectomía, la colocación de stents y otros procedimientos que no sean quirúrgicos)
- Insuficiencia renal terminal
- Ataque cardíaco
- Accidente cerebrovascular
- Enfermedad de Parkinson (demanda la pérdida de tres actividades de la vida diaria)
- Pérdida total e irreversible de la audición en ambos oídos que continúe durante los seis meses consecutivos siguientes a la enfermedad que la causó y que no pueda corregirse mediante el uso de ningún audífono o dispositivo
- Pérdida permanente e incorregible de la visión en uno o ambos ojos debido a una enfermedad
- Cuadriplejía
- Paraplejía
- Pérdida de al menos un pie, una mano, un brazo o una pierna
- Tumor cerebral benigno, distinto de los tumores de cráneo, los adenomas hipofisarios o los germinomas, que provoque deficiencias neurológicas persistentes
- Coma (no inducido médicamente) que dure al menos siete días consecutivos debido a una enfermedad subyacente o a una lesión cerebral traumática que comienza dentro de los 31 días de la enfermedad
- Anemia drepanocítica
- Lupus sistémico
- Tuberculosis o
- Trasplante de uno de los órganos mayores o inscripción en la Lista nacional de trasplantes como candidato activo o inactivo a un trasplante de órgano mayor (consulte la siguiente nota).

Si deben realizarle el trasplante de un órgano vital, según se especifica en la cláusula correspondiente del certificado de seguro, recibirá el 100 % del monto de cobertura que elija. Si está inscrito en el Plan Saver, no es elegible para dicha cláusula incluida en el seguro por enfermedades graves.

Los siguientes beneficios se pagan a menos del 100 por ciento del monto de cobertura que elija:

- Carcinoma in situ: 25 % del monto de cobertura
- Pérdida completa de uno o más dedos de la mano y/o uno o más dedos del pie: 25 % del monto de cobertura
- Ataques isquémicos transitorios (AIT): 25 % del monto de la cobertura
- Aneurisma (ruptura o disección pro lo cual se somete a cirugía): 25 por ciento del monto de cobertura
- Enfermedades específicas: 50 % del monto de cobertura
  - Enfermedad de Addison
  - Esclerosis lateral amiotrófica (enfermedad de Lou Gehrig)
  - Meningitis cerebroespinal (bacteriana)
  - Parálisis cerebral
  - Fibrosis quística

- Difteria
- Encefalitis
- Corea de Huntington
- Enfermedad del legionario (confirmación mediante cultivo o esputo)
- Malaria
- Esclerosis múltiple
- Distrofia muscular
- Miastenia gravis
- Fascitis necrotizante
- Osteomielitis
- Poliomielitis
- Rabia
- Esclerosis sistémica (esclerodermia)
- Tétanos.

Todos los beneficios descritos anteriormente suelen pagarse solo una vez, conforme al beneficio inicial de enfermedades graves.

Los siguientes beneficios de Recurrencia de enfermedad grave se pagan por un segundo diagnóstico: *

- Tumor cerebral benigno
- Cáncer invasivo
- Carcinoma in situ
- Ruptura o disección de un aneurisma
- Estado comatoso
- Rabia
- Cirugía de derivación de la arteria coronaria
- Accidente cerebrovascular
- Ataque cardíaco

*Los beneficios en caso de tener una Recurrencia de enfermedad grave se pagarán por segunda vez al 100 % del monto de la cobertura si:

- La reaparición se produce al menos 181 días después de la aparición inicial.
- Para una reaparición del mismo tipo de cáncer, debe estar libre de síntomas y de tratamiento durante 181 días después de la aparición inicial. (Los medicamentos de mantenimiento y las visitas de seguimiento no cuentan como tratamiento).
- No se excluye el diagnóstico de un cáncer no relacionado.

Otros beneficios que se pagan:

- Ambulancia: $400 por ambulancia terrestre o $4,000 por ambulancia aérea si un individuo cubierto requiere transporte en ambulancia a un hospital o centro de emergencia debido a una enfermedad cubierta.
- Trastorno de estrés postraumático (PTSD): $100 por cada día que un individuo cubierto recibe asesoramiento por PTSD; se paga una vez al día por individuo cubierto y se limita a seis días por año calendario.
- Beneficio en caso de padecer cáncer de piel: $500 después del diagnóstico positivo de cáncer de piel (carcinoma de piel de células basales y carcinoma escamoso) realizado por un doctor en medicina autorizado y certificado por la Junta Americana de Patología para practicar anatomía patológica o por un patólogo osteopático basado en el examen microscópico de muestras de biopsia de piel. Este beneficio no se paga por melanoma maligno (que está cubierto por el beneficio de cáncer invasivo). Tampoco incluye ninguna afección que se considere precancerosa, como leucoplasia; queratosis actínica; carcinoide; hiperplasia; policitemia; melanoma benigno; lunares; u otras enfermedades o lesiones similares. Se paga solo una vez por individuo cada año calendario.
- Evaluación del Instituto Nacional del Cáncer (National Cancer Institute, NCI) o del Centro de excelencia de Walmart: cuando se evalúa para determinar el tratamiento apropiado de una enfermedad cubierta con diagnóstico previo, $500 por evaluación; $250 por transporte y alojamiento si el centro NCI o la instalación de los Centros de Excelencia de Walmart se encuentra a más de 100 millas de su casa. Se paga una vez por cada aparición inicial o reaparición de una enfermedad cubierta.
- Beneficio que recibirá por alojamiento: $60 por día cuando un individuo cubierto recibe tratamiento para una enfermedad cubierta de forma ambulatoria en un centro de tratamiento situado a más de 100 millas del domicilio del individuo cubierto. Este beneficio está limitado a 60 días por año calendario y no se paga en caso de que el alojamiento sea por más de 24 horas antes o después del tratamiento.
- Beneficio de transporte: $0.50 por milla para los vehículos personales, hasta $1,500, o hasta $1,500 para transporte de ida y vuelta para tarifas económicas en una compañía de transportes común. Se debe solicitar un medio de transporte para el tratamiento de una enfermedad grave cubierta en un hospital (atención hospitalaria o ambulatoria), centro de radioterapia, clínica oncológica o de quimioterapia, o cualquier otro centro de tratamiento especializado independiente. Si el tratamiento es para un niño con cobertura y se necesita una compañía de transporte común, se pagará el beneficio hasta dos adultos para que acompañen al niño. Este beneficio no se pagará si el individuo cubierto vive dentro de las 100 millas del lugar de tratamiento. El Plan no se hace cargo del transporte de una persona que acompañe o visite a la persona cubierta que recibe tratamiento; de las visitas al consultorio del médico o a la clínica; ni de otros servicios.

Cómo nombrar a un beneficiario

Si fallece mientras tiene cobertura de seguro por enfermedades graves, sus beneficiarios recibirán cualquier beneficio adeudado en el momento de su fallecimiento.

A fin de garantizar que su beneficio de seguro por enfermedad crítica se pague como usted desea, debe nombrar a los beneficiarios que recibirán el beneficio de su seguro por enfermedad crítica opcional para asociados si usted fallece. Para ello, visite **One.Walmart.com/Beneficiary**. La designación del beneficiario debe completarse y enviarse al Plan antes de su fallecimiento. Póngase en contacto con el Servicios al Personal llamando al **800-421-1362** si no puede acceder a la herramienta Beneficiary Online.

Puede nombrar a cualquier persona que desee. Si el (los) beneficiario(s) que figura(n) en su designación de beneficiarios archivada en el Plan difiere(n) del (de los) beneficiario(s) nombrado(s) en su testamento, la designación de beneficiarios archivada en el Plan prevalecerá. Si no ha designado beneficiarios conforme al seguro por enfermedad crítica opcional para asociados, el pago se realizará a los miembros sobrevivientes de su familia, tal como se describe en **Si no nombra a un beneficiario** más adelante en esta página.

Se necesita la siguiente información para cada beneficiario que designe:

- Nombre
- Dirección y número de teléfono actuales
- Relación con usted
- Número de seguridad social
- Fecha de nacimiento
- Porcentaje que desea designar a cada beneficiario, hasta el 100 %

Si se designa a dos o más beneficiarios y sus cuotas no están especificadas, compartirán el beneficio del seguro en partes iguales. Si un beneficiario designado falleciera antes que usted, el derecho de tal beneficiario cesará y se distribuirá en partes iguales entre los restantes beneficiarios, a menos que su formulario de beneficiarios indique lo contrario.

Puede nombrar a un menor de edad como beneficiario; sin embargo, es posible que Allstate Benefits no tenga autorización legal para pagarle al menor hasta que sea mayor de edad. Es recomendable que consulte a un abogado o a un asesor testamentario antes de nombrar a un menor de edad como beneficiario.

Se asignará automáticamente a usted (el asociado) como beneficiario principal de la cobertura del seguro por enfermedades graves de sus dependientes cubiertos. Si usted y su dependiente fallecen al mismo tiempo, los beneficios se pagarán como si no se hubiera designado a ningún beneficiario. Consulte **Si no nombra a un beneficiario** a continuación.

CÓMO CAMBIAR DE BENEFICIARIO

Usted puede cambiar los beneficiarios en cualquier momento en **One.Walmart.com/Beneficiary**. Cualquier cambio de beneficiario se debe completar y enviar al Plan antes de su fallecimiento y solo puede ser enviado por usted, el asociado cubierto. Póngase en contacto con el Servicios al Personal llamando al **800-421-1362** si no puede acceder a la herramienta Beneficiary Online.

SI NO NOMBRA A UN BENEFICIARIO

Si no se designa un beneficiario o no hay beneficiario sobreviviente al momento de su fallecimiento, el pago de los beneficios debidos a su fallecimiento se realizará en el siguiente orden:

- Su cónyuge/pareja; si no vive, a sus
- Hijos en partes iguales; si no viven, a sus
- Padres en partes iguales; si no viven, a sus
- Hermanos en partes iguales; si no viven, a sus
- Herederos.

Mantenga actualizada la información de sus beneficiarios. Los beneficios son para cualquier persona que se encuentre en la lista de la designación de beneficiarios con el Plan, independientemente de su relación actual con esa persona, a menos que la ley aplicable diga lo contrario. Usted puede cambiar los beneficiarios en cualquier momento en **One.Walmart.com/Beneficiary**.

Presentar una reclamación de seguro por enfermedad grave

Dentro de los 60 días en que se produzca o comience un accidente cubierto, debe enviar lo antes posible una notificación de reclamación a:

Allstate Benefits
Attn: Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488

También puede proporcionar una notificación de reclamación de la siguiente manera:

En línea: **AllstateBenefits.com/mybenefits**
Por teléfono: **800-514-9525**
Por fax: **877-423-8804**

Asegúrese de incluir la siguiente información de la persona cubierta:

- Nombre
- Número de seguridad social
- Fecha en que comenzó la enfermedad cubierta

Puede solicitar un formulario de reclamación a Allstate Benefits o ingresar a **One.Walmart.com** o **AllstateBenefits.com/Walmart** para obtener una copia. Si no recibe un formulario de reclamación dentro de los 15 días de su reclamación, puede enviar una notificación de la reclamación a Allstate Benefits y proporcionar a Allstate Benefits una declaración de la naturaleza y la magnitud del siniestro.

Las reclamaciones se determinan dentro de los plazos y requisitos establecidos en el capítulo **Reclamaciones y apelaciones**. Usted o su beneficiario tienen derecho a apelar una reclamación rechazada. Para obtener información, consulte el capítulo **Reclamaciones y apelaciones**.

Cuándo no se pagan los beneficios

No se pagará ningún beneficio por ninguna enfermedad grave que se deba o resulte directa o indirectamente de:

- Una enfermedad grave que ocurra antes de la fecha de entrada en vigencia de la cobertura
- Cualquier acto de guerra, ya sea declarada o no, o participación en disturbios, insurrección o rebeliones;
- Lesiones autoinfligidas intencionalmente;
- Participación en una ocupación ilegal o intento de cometer un delito;
- Intento de suicidio, ya sea que se encuentre en su sano juicio o no;
- Encontrarse bajo los efectos de narcóticos o de cualquier sustancia química controlada a menos que se administre según recomendación de un médico;
- Participación en cualquier forma de aeronáutica excepto como pasajero que abona pasaje en una aeronave autorizada de una compañía de transportes común y que opera entre aeropuertos establecidos definitivamente; o
- Abuso de alcohol o alcoholismo, drogadicción o dependencia de cualquier sustancia controlada.

Interrupción de la cobertura

Es posible que en ocasiones deba hacer arreglos especiales para pagar sus primas del seguro por enfermedades graves para evitar que se suspenda la cobertura. Estas situaciones se producen con más frecuencia si se encuentra con una licencia de ausencia o si su cheque de pago de Walmart no es suficiente para pagar toda la parte que le corresponde del costo de cobertura (por ejemplo, después de una reducción de horas). El incumplimiento del pago de las primas dentro de los 30 días de la fecha de vencimiento causará que se interrumpa el pago de cualquier reclamación de beneficio y/o se suspenda la cobertura.

Consulte **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información detallada sobre cómo realizar los pagos de las primas para que no haya un lapso en su cobertura.

SI SE TOMA UNA LICENCIA DE AUSENCIA

Puede continuar su cobertura hasta el último día de una licencia de ausencia aprobado, solo si paga sus primas antes de que comience la licencia de ausencia o durante este. Para obtener información sobre cómo realizar los pagos durante una licencia, consulte la sección **Mantener las primas al día** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.

Cuándo finaliza la cobertura del seguro por enfermedades graves

Su cobertura de seguro por enfermedades graves finaliza en el momento en que ocurra la primera de las siguientes situaciones:

- En la fecha en la que abandone voluntariamente la cobertura (como se describe en esta página)
- En la fecha en que termine su empleo
- El último día hasta el cual se pagaron las primas requeridas, si no pagó las primas dentro de los 30 días de la fecha de vencimiento de estas.
- En la fecha de su fallecimiento
- El último día de una licencia aprobada (a menos que vuelva a trabajar) o
- Cuando Walmart deja de ofrecer el seguro por enfermedades graves.

La cobertura del seguro por enfermedad grave para su cónyuge/pareja finaliza en la fecha más temprana de las siguientes:

- En la fecha en que finaliza su cobertura de seguro.
- El último día del periodo de pago en que su condición laboral cambia a asociado a tiempo parcial, temporal o conductor de camión a tiempo parcial.
- En la fecha en que usted y su cónyuge se separen legalmente
- En la fecha en que usted y su cónyuge se divorcien o se termine su relación de pareja, o
- Al momento del fallecimiento de su cónyuge/pareja.

La cobertura del seguro por enfermedad grave para su(s) hijo(s) dependiente(s) finaliza en la fecha más temprana de las siguientes:

- En la fecha en que finaliza su cobertura de seguro.
- En la fecha en que su hijo dependiente pierde su elegibilidad o
- Al momento del fallecimiento de su hijo elegible.

Si su clasificación de empleo cambia, consulte la tabla correspondiente en la sección **Cambio de una clasificación laboral a otra** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener información sobre cualquier repercusión en su cobertura.

Si cancela voluntariamente la cobertura después de un evento de cambio de elección o en la Inscripción Anual, la cobertura finaliza de la siguiente manera:

- **Tras un evento de cambio de elección**: la cobertura finaliza en la fecha efectiva del evento. Para obtener más información, consulte **Cambios de elección permitidos fuera del periodo de Inscripción anual** en el capítulo **Elegibilidad, inscripción y fechas de vigencia**.
- **En la Inscripción Anual:** la cobertura finaliza el 31 de diciembre del año en curso.

CONTINUACIÓN DE LA COBERTURA CUANDO FINALIZA

Si su cobertura del seguro por enfermedad grave finaliza como se ha descrito anteriormente (excepto por falta de pago de las primas o por fallecimiento), usted y sus dependientes cubiertos pueden seguir teniendo la cobertura del seguro por enfermedad grave de Allstate Benefits a través de la cobertura de transferibilidad. Los beneficios, los términos y las condiciones de la cobertura de portabilidad serán los mismos que los previstos en el seguro por enfermedad grave en el Plan en el momento de la terminación del empleo. Para recibir la cobertura de transferibilidad, debe informar su deseo de continuar con la cobertura a Allstate Benefits y enviar la primera prima dentro de los 60 días de la fecha después de que finalice su cobertura del seguro por enfermedades graves.

> **!** No podrá continuar con su cobertura a menos que se ponga en contacto con Allstate Benefits y envíe el primer pago de la prima dentro de los 60 días siguientes a la fecha de finalización de su cobertura.

La cobertura de transferibilidad entrará en vigencia el día siguiente a la finalización de la cobertura del Plan y finalizará en la fecha más temprana de las siguientes:

- La fecha en la que usted vuelve a tener derecho a un seguro de enfermedad grave conforme al Plan.
- El último día hasta el cual se pagaron las primas requeridas, si no pagó las primas dentro de los 30 días de la fecha de vencimiento de estas.
- Para sus dependientes cubiertos, en la fecha de finalización de su cobertura o en la fecha en que el dependiente deja de serlo.

Cualquier dependiente elegible que esté cubierto por un seguro de enfermedad grave en el momento en que tal cobertura finalice como consecuencia de haber alcanzado la edad máxima para tener derecho a la misma, también podrá recibir la cobertura de portabilidad bajo los términos descritos anteriormente. Para obtener información, comuníquese con Allstate Benefits al **800-514-9525**.

Las primas para la cobertura de transferibilidad se deben pagar antes de recibir la cobertura de cada mes, el primer día del mes calendario. Las primas tienen la misma tarifa que esté vigente para el seguro por enfermedades graves para los asociados activos que tengan la misma cobertura.

Para obtener más información, comuníquese con Allstate Benefits al **800-514-9525**.

Si deja Walmart y lo contratan nuevamente

Si es usted un asociado pagado por hora a tiempo parcial o temporal que está sujeto a las verificaciones de elegibilidad de 60 días, una sola vez y anualmente para los beneficios médicos, consulte la sección **Asociados pagados por hora a tiempo parcial y asociados temporales: verificaciones de elegibilidad para los beneficios médicos** del capítulo **Elegibilidad, inscripción y fechas de vigencia** para obtener detalles sobre cómo el hecho de terminar el empleo con Walmart y luego volver a trabajar afecta sus beneficios.

Si es un asociado a tiempo completo pagado por hora, un miembro de la gerencia o conductor de camión, consulte la sección **Si deja Walmart y vuelve a ser contratado** en el capítulo **Elegibilidad, inscripción y fechas de vigencia** para saber cómo el hecho de dejar de trabajar en Walmart y volver a hacerlo afecta sus beneficios.

Reclamaciones y apelaciones

Reclamaciones y apelaciones

Como participante del Plan de Salud y Bienestar para Asociados, tiene derecho a apelar una decisión sobre la elegibilidad y los beneficios del Plan. En este capítulo se describen el proceso y los plazos para apelar una determinación relativa a su estado de inscripción o elegibilidad o una reclamación de los siguientes beneficios que haya sido denegada parcial o totalmente: médico, farmacia, dental, de la visión, opciones del Plan HMO y PPO, discapacidad y seguro de vida, AD&D, enfermedad grave o accidente.

RECURSOS	
Encuentre lo que necesita	
Presentar una reclamación de beneficios	Las reclamaciones deberán presentarse en los plazos que se detallan en este capítulo. Para presentar reclamaciones médicas, farmacéuticos, dentales y de la visión, consulte su tarjeta de identificación del plan para conocer la dirección donde debe presentar su reclamación o llame a su asesor de atención de la salud al número que aparece en su tarjeta de identificación del plan. Envíe sus reclamaciones de Centros de Excelencia al administrador, tal como se indica en la tabla **Centros de Excelencia** más adelante en el capítulo. Envíe los demás reclamaciones a los administradores de terceros del Plan o a la compañía aseguradora, si corresponde, tal como se indica más adelante en este capítulo.
Apelar una reclamación rechazada	Presente apelaciones a las direcciones y dentro de los plazos previstos en este capítulo. En su carta de decisión de la reclamación inicial también se debe especificar dónde y cuándo presentar una apelación.
Apelar una decisión sobre elegibilidad con respecto a la cobertura o al estado de inscripción	Escriba a: **Mail Stop 3610** **Benefits Total Rewards Team** **Attn: Internal Appeals** **508 SW 8th Street** **Bentonville, Arkansas 72716-3610** O por correo electrónico a **ghappeal@wal-mart.com** NOTA: **Debe enviar su solicitud a la dirección específica indicada anteriormente, incluida la Dirección interna. Si no envía su solicitud a esta dirección, el administrador del plan tardará en recibirla.** O si desea presentar apelaciones a COBRA, escriba a: **WageWorks (COBRA Appeals)** **P.O. Box 14390** **Lexington, Kentucky 40512-4390**
Designar a un representante autorizado para que presente apelaciones en su nombre	Llame al número que figura en su tarjeta de identificación del plan o llame a Servicios al Personal al **800-421-1362** para solicitar el formulario de representante autorizado del plan.

Lo que debe saber sobre reclamaciones y apelaciones

- Tiene derecho a apelar una decisión de inscripción o elegibilidad desfavorable que afecte su cobertura.
- Tiene derecho a apelar una decisión desfavorable sobre los beneficios solicitados, incluyendo las solicitudes de autorización previa.
- Tiene derecho a apelar una reclamación de beneficios que se haya rechazado en su totalidad o en parte.
- Puede designar a otra parte para que presente la apelación en su nombre al completar el formulario de representante autorizado del Plan.
- Una vez que se haga una decisión final de una apelación por una reclamación médica, de farmacia o de los Centros de Excelencia, usted puede tener derecho a solicitar una revisión externa independiente de la decisión si la reclamación se deniega por criterio médico o por la determinación de que la reclamación no está sujeto a las protecciones de facturación sorpresa.
- Las decisiones sobre inscripción, estado y preguntas sobre elegibilidad relacionadas con los periodos de espera de elegibilidad no son elegibles para revisiones externas, pero son elegibles para una revisión voluntaria conforme al Plan. Además, para los planes médicos, dentales y de la visión, las apelaciones rechazadas por motivos administrativos no médicos (p. ej., porque excedió los límites de visitas del Plan) son elegibles para una revisión voluntaria conforme al Plan.
- Tiene derecho a iniciar acciones legales si se rechaza una reclamación en una apelación, pero únicamente después de haber agotado los procedimientos de reclamaciones y apelaciones del Plan.
- **Debe enviar su solicitud de apelación a la dirección específica indicada anteriormente, incluida la Dirección interna. Si no envía su solicitud a esta dirección, el administrador del plan tardará en recibirla.**

Fechas límite para presentar una reclamación o iniciar acciones legales

Su reclamación debe enviarse al Plan dentro de los 12 meses. A menos que se especifique lo contrario en el capítulo que describe el beneficio correspondiente, o en este capítulo, las reclamaciones iniciales de beneficios conforme al Plan se deben presentar dentro de los 12 meses a partir de la fecha de servicio u otra fecha en la que surja el derecho a reclamar por primera vez. Debido a que los procedimientos para presentar una reclamación o una apelación varían de acuerdo con los diferentes planes de beneficios y administradores de terceros, consulte la sección correspondiente de este capítulo para obtener información detallada.

NOTA: El plazo para presentar reclamaciones que sucedieron antes del 1 de enero de 2025 es de 18 meses.

Debe cumplir todos los plazos de reclamación y apelación y "agotar" sus recursos administrativos antes de poder emprender otras acciones legales. Debe completar los procesos de reclamaciones y apelaciones requeridos que se describen en el capítulo titulado **Reclamaciones y apelaciones** antes de que inicie una acción legal o, en el caso de ciertas reclamaciones médicas, farmacéuticas, dentales o de Centros de Excelencia, antes de solicitar una revisión externa. No puede iniciar acciones legales por los beneficios si la reclamación o la apelación inicial no se realizan dentro de los plazos establecidos en los procedimientos descritos en este capítulo. Puede designar a otra parte para que realice una reclamación o apelación en su nombre al completar el formulario de representante autorizado del Plan.

Tiene un tiempo limitado para presentar una demanda en reclamación de beneficios. Si ha efectuado todos las reclamaciones y apelaciones requeridos y desea presentar una demanda, las acciones legales por beneficios deben iniciarse dentro de los 180 días después de la decisión final sobre una apelación (ya sea que dicha decisión haya sido tomada por el Plan o por los responsables de la revisión externa). No puede iniciar acciones legales una vez que finalice el periodo de 180 días. Si solicita una revisión voluntaria o una revisión externa, si corresponde, el tiempo que lleva la revisión voluntaria o la revisión externa no perjudicará los 180 días de los que dispone para iniciar acciones legales. No obstante, no es necesario que solicite que el Plan realice una revisión voluntaria o que se realice una revisión externa de la decisión sobre la apelación antes de iniciar acciones legales.

NO SE PUEDEN CEDER LOS BENEFICIOS

No puede ceder sus derechos legales, como el derecho a presentar una apelación, el derecho a solicitar copias de determinados documentos relacionados con el Plan, el derecho a presentar cualquier tipo de acción judicial en su nombre, incluidos, entre otros, las acciones judiciales para el pago de los beneficios, el derecho a presentar una acción judicial por incumplimiento de las obligaciones fiduciarias, el derecho a presentar una acción judicial para obtener una reparación equitativa, o el derecho a presentar una acción judicial para recuperar cualquier sanción legal, o sus derechos a cualquier pago en virtud de este Plan. No obstante, el Plan puede optar por remitir los pagos de beneficios directamente a los proveedores de atención médica respecto de los servicios cubiertos, pero solo para su comodidad y únicamente si autoriza al Plan a hacerlo. En virtud de este Plan, los proveedores de atención de la salud no son "participantes" ni "beneficiarios", ni se deberán considerar como tal, y no tienen derecho a recibir los beneficios del Plan ni a iniciar acciones legales o apelaciones en nombre de (o en lugar de) usted o sus dependientes cubiertos en ninguna circunstancia.

Cómo apelar una decisión sobre inscripciones o estados de elegibilidad

Esta sección describe el proceso de apelación que se aplica a las determinaciones de inscripción y elegibilidad.

Si no está de acuerdo con la determinación del Administrador del Plan en cuanto a su estado de inscripción o elegibilidad, tiene 180 días a partir del evento de inscripción de elegibilidad para apelar por escrito a Beneficios Totales de Recompensas, con atención a Apelaciones Internas, a la dirección que figura en la tabla **Recursos** al comienzo de este capítulo.

NOTA: El plazo para las inscripciones para eventos que hayan sucedido antes del 1 de enero de 2025 es de 365 días.

Los participantes de COBRA deben enviar la apelación, por escrito, a WageWorks a la dirección que figura en la tabla **Recursos** al comienzo de este capítulo.

Su apelación se procesará dentro de los 60 días a partir de la fecha de recepción (30 días en el caso de las apelaciones de COBRA), a menos que se necesite una prórroga.

El periodo de 60 días se puede extender si se determina que es necesaria una prórroga por situaciones ajenas al Plan. Si se requiere una prórroga o información adicional, se lo notificarán antes de que finalice el periodo de 60 días.

Las apelaciones por decisiones sobre inscripción o elegibilidad no reúnen los requisitos para someterse a revisiones externas, pero sí para someterse a revisiones voluntarias. Consulte la sección **Revisión voluntaria** más adelante en este capítulo.

Proceso de reclamaciones de beneficios médicos, farmacéuticos, de Centros de Excelencia, dentales y de la vista

En esta sección, se describe el proceso de reclamaciones que se seguirá solamente para los siguientes beneficios:

- Beneficios médicos, de farmacia y de Centros de Excelencia, excepto para los planes HMO y PPO; consulte **Procedimientos de opciones de reclamaciones y apelaciones del plan HMO** y **Procedimientos de opciones de reclamaciones y apelaciones del plan PPO** más adelante en este capítulo
- Beneficios dentales (a través de Delta Dental)
- Beneficios de la visión (a través de VSP) y
- Una rescisión de cobertura, que es una cancelación de cobertura que tiene efecto retroactivo. La anulación de la cobertura por no haber abonado a tiempo los aportes o las primas requeridas no es una rescisión y no está sujeta al proceso de reclamación.

Si en forma voluntaria decide notificar previamente al administrador de terceros ("TPA") sobre un servicio médico programado antes de recibir el tratamiento, y no se requiere la autorización previa para el servicio médico, la respuesta del

administrador de terceros no es vinculante en el Plan y no se encuentra sujeta a apelación. Sin embargo, si las condiciones o políticas del Plan, tal como las aplica su administrador de terceros, requiere que usted o su proveedor autoricen previamente los servicios y su solicitud de autorización previa es rechazada, esa decisión está sujeta a apelación. Consulte el capítulo **Plan médico** para obtener más información sobre las disposiciones de notificación previa voluntaria y de autorización previa obligatoria. Si desea averiguar si un servicio requiere autorización previa, comuníquese con su administrador de terceros.

Consulte los respectivos capítulos en ese Libro de Beneficios para Asociados para obtener información adicional sobre cómo presentar su reclamación inicial. En muchos casos, las reclamaciones iniciales serán presentados en su nombre por su proveedor de atención de la salud. Las reclamaciones iniciales serán determinadas por el TPA que figura en la siguiente tabla. A estos TPA se les ha delegado la autoridad para hacer determinaciones acerca de las reclamaciones. En algunos casos, el TPA puede contratar a una parte externa para hacer determinaciones acerca de las reclamaciones.

PERIODOS PARA LA DETERMINACIÓN DE RECLAMACIONES

El plazo de determinación de su reclamación depende del tipo de reclamación que presente.

Reclamaciones anteriores al servicio. Consulte la sección **Autorización previa** del capítulo **Plan médico** correspondiente a los servicios que requieren autorización previa. También debe consultar a su TPA para determinar si se requiere autorización previa para un servicio. Si se requiere autorización previa para un servicio específico, usted o su proveedor deben presentar una reclamación de aprobación para ese servicio antes de recibir el tratamiento, de lo contrario, es posible que no se pague su reclamación. Estos se llaman reclamaciones "anteriores al servicio".

Reclamaciones de atención de urgencia. Si su reclamación anterior al servicio es urgente, entonces se decidirá según los plazos correspondientes a la atención de reclamaciones de urgencia. Una reclamación es urgente si su determinación según un plazo normal podría poner en peligro la vida, la salud o la capacidad para recuperar el máximo de las funciones vitales o, según la opinión de un médico que conoce la afección médica, lo sometería a usted a un dolor intenso que no podría aliviarse en forma adecuada sin los cuidados o sin el tratamiento que son el motivo de la reclamación.

Reclamaciones posteriores al servicio. Si presenta una reclamación después de haber recibido los servicios, su reclamación se considera una reclamación posterior al servicio. Si su reclamación surge cuando hay una reducción en la atención actual, su reclamación es una reclamación de atención concurrente.

Reclamaciones de atención concurrente. Si su reclamación surge cuando hay una reducción de la atención en curso, como una reducción de la duración de una hospitalización previamente aprobada o una reducción del número de sesiones de fisioterapia previamente aprobadas, o si solicita una extensión de un tratamiento en curso, su reclamación se considera una "reclamación de atención concurrente."

ADMINISTRACIÓN DE RECLAMACIONES: MÉDICAS, DE FARMACIA, DENTALES Y DE LA VISTA DE RUTINA	
Médico • Para las reclamaciones de los Centros de Excelencia que no sean de formación de familia, consulte más abajo • Incluye los servicios en uno de los Centros de Excelencia no cubiertos conforme al programa de los Centros de Excelencia, y las reclamaciones por trasplante que no sean necesarios realizar en Mayo Clinic.	**Su administrador de terceros (TPA)** **Plan Premier, Contribution y Saver y beneficios de formación de familia bajo el programa de los Centros de Excelencia** (vea su tarjeta de identificación del plan) • Aetna Life Insurance Company (Aetna)* • BlueAdvantage Administrators of Arkansas (BlueAdvantage)* • UMR **Opciones de planes locales** • Plan local Mercy Arkansas—UMR • Plan local Banner, Aetna *Si su TPA es Aetna o BlueAdvantage y su lugar de trabajo está en AL, AK, AZ, CO, IL, IN, IA, KY, MN, MO, NC, SC, TN, TX, VA, WV o WI, las reclamaciones previas al servicio pueden ser determinados por Included Health o un tercero en nombre de Included Health. No obstante, debe ponerse en contacto con su TPA para cualquier solicitud antes del servicio ("autorización previa").
Farmacia	OptumRx
Dental	Delta Dental
De la vista	VSP
ADMINISTRACIÓN DE RECLAMACIONES: CENTROS DE EXCELENCIA Nota: Si está inscrito en un plan local, comuníquese con su asesor de atención médica para que se lo dirija al administrador correspondiente.	
Cirugía cardíaca	Su administrador de terceros (TPA)
Revisión de la historia clínica de cáncer	HealthSCOPE Benefits
Revisión de la historia clínica de la diálisis renal ambulatoria o de la ESRD	HealthSCOPE Benefits
Tratamiento y servicios para la formación de familia	Su administrador de terceros (TPA)
Reemplazo de cadera y rodilla	Contigo Health
Cirugía de columna	Contigo Health
Trasplante	HealthSCOPE Benefits
Cirugía para la pérdida de peso	Contigo Health

La tabla **Procesos y plazos de reclamaciones** de la página siguiente muestra los plazos para establecer determinaciones para estos tipos de reclamaciones.

PROCESOS Y PLAZOS DE RECLAMACIONES	
Reclamaciones urgentes Toda reclamación de atención de la salud o tratamiento para los cuales su determinación según un plazo normal podría poner en peligro la vida, la salud o la capacidad para recuperar el máximo de las funciones vitales o, según la opinión de un médico que conoce la afección médica, lo sometería a usted a un dolor intenso que no podría aliviarse en forma adecuada sin los cuidados o sin el tratamiento que son el motivo de la reclamación.	Se le notificará lo antes posible teniendo en cuenta las circunstancias médicas, pero a más tardar a las 72 horas posteriores a la recepción de la reclamación. La notificación se enviará independientemente de que la reclamación sea aprobada o rechazada. Se le puede notificar verbalmente, en cuyo caso se proporcionará una notificación por escrito dentro de los tres días posteriores a la notificación verbal. Si se determina que la reclamación urgente está incompleta, recibirá una notificación a este efecto dentro de las 24 horas posteriores a la recepción de la reclamación y, a partir de entonces, tendrá 48 horas para proporcionar información adicional. Si solicita una extensión de los beneficios de atención de urgencia más allá del periodo determinado inicialmente y si hace la solicitud por lo menos 24 horas antes de que se venza la determinación original, se lo notificará dentro de las 24 posteriores a la recepción del pedido.
Reclamaciones anteriores al servicio Reclamaciones de servicios aún no prestados y para los cuales el Plan requiere autorización previa.	Si su reclamación anterior al servicio se presenta correctamente, se enviará una determinación de reclamación dentro de un plazo razonable apropiado para las circunstancias médicas, pero a más tardar a los 15 días de recibida la reclamación. Si se necesita una extensión debido a asuntos que el Plan no puede controlar, este periodo se puede extender 15 días. Recibirá una notificación antes de la extensión que indica las circunstancias que requieren la extensión y la fecha para la cual el plan espera presentar una determinación. Si la extensión es necesaria para solicitar información adicional, la notificación de la extensión describirá la información requerida y usted tendrá por lo menos 45 días para presentar la información. El Plan luego tomará una determinación dentro de los 15 días después de la fecha en la que el Plan reciba su información o, si fuera anterior, de la fecha límite para presentar la información. Si su reclamación anterior al servicio se presenta incorrectamente, se le notificará dentro de los cinco días posteriores a la recepción de la reclamación.
Reclamaciones posteriores al servicio Reclamaciones de servicios ya prestados o para los cuales el Plan no requiere autorización previa.	Se enviará una notificación de rechazo de una reclamación posterior al servicio dentro de un plazo razonable, pero a más tardar a los 30 días de recibida la reclamación. Si se necesita una extensión debido a asuntos que el Plan no puede controlar, este periodo se puede extender 15 días. Recibirá una notificación antes de la extensión que indica las circunstancias que requieren la extensión y la fecha para la cual el plan espera presentar una determinación. Si la extensión es necesaria para solicitar información adicional, la notificación de la extensión describirá la información requerida y usted tendrá por lo menos 45 días para presentar la información. El Plan luego tomará una determinación dentro de los 15 días después de la fecha en la que el Plan reciba su información o, si fuera anterior, de la fecha límite para presentar la información.
Reclamaciones de atención concurrente Una reclamación relacionada con una reducción de servicios en curso o una reclamación de extensión de un tratamiento en curso.	Se le notificará con anticipación sobre cualquier decisión relacionada con la reducción o la cancelación de la cobertura de la atención actual para que pueda apelar la decisión y obtener una determinación antes de que la cobertura se reduzca o cancele, a menos que dichas acciones se deban a que se modificó o canceló el Plan.

NOTIFICACIÓN DE RECHAZO DE RECLAMACIONES

Si su reclamación es rechazada, dicho rechazo incluirá la siguiente información:

- Las razones específicas del rechazo
- Referencia a las disposiciones del Plan en las cuales se basó el rechazo
- Información relacionada con los plazos para la apelación;
- Una descripción de la información adicional necesaria para contemplar su reclamación y los motivos por los cuales dicha información es necesaria;
- Una declaración en la cual se establece que usted tiene derecho a obtener, cuando la solicite y sin cargo, una copia de las normas o pautas internas en las cuales se basaron para tomar esta determinación
- Si el rechazo se basa en una necesidad médica o limitaciones similares, una explicación de esta norma (o una declaración de que está disponible cuando se solicite); y
- Una notificación relacionada con su derecho a iniciar acciones legales después de un rechazo de apelación.

Para beneficios médicos, farmacéuticos, de Centros de Excelencia y de la visión, el rechazo también incluirá:

- Información suficiente para identificar la reclamación, incluida (si corresponde) la fecha del servicio, el proveedor de atención de la salud y el monto de la reclamación;
  - Si lo solicita por escrito, el Plan le suministrará los códigos de diagnóstico y tratamiento (y sus correspondientes significados) asociados a una reclamación o una apelación rechazados.
- El código del rechazo y su significado
- Una descripción de la norma del Plan para rechazar la reclamación
- Información sobre apelaciones internas y externas disponibles, incluido cómo iniciar una apelación, e
- Información de contacto de la correspondiente oficina de asistencia para el consumidor de seguros de salud o defensor del consumidor que lo asistirá en el proceso de apelaciones internas y externas.

ALGUNOS TIPOS DE CONFLICTOS DE PAGO NO SON “RECHAZOS” DE RECLAMACIONES

No todas las situaciones en las que exista un conflicto de pago entre el Plan y su proveedor de atención de la salud se considerarán una reclamación de beneficios en virtud de los procedimientos de reclamaciones que dan lugar a una notificación de rechazo o a un derecho de apelación. Si una decisión se limita a una cuestión sobre el importe que el Plan debe a un proveedor y no afecta el importe que usted puede deber al proveedor, el conflicto generalmente no entrará en estos procedimientos. Esto puede ocurrir, por ejemplo, cuando un proveedor de la red reclama el importe negociado pagado por el administrador de la red subcontratado o cuando un proveedor que no es parte de la red reclama un pago del administrador de la red subcontratado con respecto a un servicio por el que el proveedor tiene prohibido, según la ley estatal o federal, facturarle a usted el saldo de los importes no pagados. El proveedor puede reclamar por separado este pago al administrador de la red subcontratado o al Plan, pero no constituye una reclamación de sus beneficios del Plan en virtud de estos procedimientos.

Proceso de apelaciones internas

CÓMO APELAR UNA RECLAMACIÓN QUE SE RECHAZÓ DE FORMA PARCIAL O TOTAL

Si se rechaza una reclamación presentado por usted (o en su nombre), puede solicitar una apelación de la decisión. Para que se considere su apelación, esta debe:

- Presentarse por escrito
- Enviarse a la dirección correcta
- Presentarse en un plazo de 180 días a partir de la fecha de la denegación inicial (tenga en cuenta que para las reclamaciones médicas y dentales anteriores al 1 de enero de 2025, el plazo es de 365 días), y
- Contener cualquier información o documentación que usted desea que se tome en consideración.

Si su apelación implica una reclamación urgente, comuníquese con su TPA (administrador de terceros) para obtener información acerca de cómo presentar la apelación en forma oral.

Aetna, OptumRx y VSP permiten dos apelaciones (es decir, dos niveles de revisión). La segunda apelación debe presentarse dentro de los 60 días posteriores a la fecha del rechazo de la primera. Todos los otros TPA tienen un nivel de apelación.

Al realizar una apelación, debe enviar por escrito su reclamación para la revisión de la reclamación inicial al TPA que administra sus reclamaciones, tal como se indica en la tabla a continuación, o según se indique lo contrario en la carta de denegación.

El aviso de denegación de la reclamación proporcionará información específica sobre cómo apelar una reclamación denegada.

INFORMACIÓN DE CONTACTO PARA LAS APELACIONES

SERVICIOS MÉDICOS (Incluye los servicios realizados en un Centro de Excelencia pero que no están cubiertos por el programa de los Centros de Excelencia). *Si no puede localizar la dirección para las apelaciones en el aviso de denegación de la reclamación, llame a su TPA al número que aparece a continuación. Consulte su tarjeta de identificación del plan para saber el nombre de su TPA.*	
Aetna	**855-548-2387**
BlueAdvantage	**866-823-3790**
UMR (Planes Premier, Contribution y Saver)	**855-870-9177**
UMR (Plan local Mercy Arkansas):	**800-804-1272**
SERVICIOS DE LOS CENTROS DE EXCELENCIA *Tenga en cuenta que existe un proceso especial de reclamaciones y apelaciones para determinados beneficios de los Centros de Excelencia. Consulte los detalles más adelante en este capítulo.*	
Contigo Health • Cirugía de columna • Reemplazo de cadera y rodilla • Cirugía para la pérdida de peso	**Contigo Health** **Centers of Excellence: Walmart** **Attn: Appeals Coordinator** **300 Executive Pkwy Ste 100** **Hudson, Ohio 44236**
HealthSCOPE Benefits • Cirugía para la pérdida de peso en el Plan Local Mercy Arkansas • Revisión de los expedientes de cáncer • Revisión de los registros de riñón/enfermedad renal en etapa terminal	**HealthSCOPE Benefits** **P.O. Box 2359** **Little Rock, Arkansas 72203**
Su administrador de terceros (TPA) • Tratamiento y servicios para la formación de familia • Cirugía cardíaca	Vea su tarjeta de identificación del plan
FARMACIA	
OptumRx	**OptumRx** **Attn: Appeals Coordinator** **P.O. Box 2975** **Mission, Kansas 66201**
DENTAL	
Delta Dental of Arkansas	**Delta Dental of Arkansas Appeals Committee** **P.O. Box 15965** **Little Rock, Arkansas 72231-5965**
DE LA VISTA	
VSP	**VSP** **Member Appeals** **3333 Quality Drive** **Rancho Cordova, California 95670**

NOTA: Algunos tipos de beneficios ofrecidos a través de los Centros de Excelencia, incluidos los trasplantes, la cirugía de columna y el reemplazo de cadera y rodilla, están sujetos a procedimientos de apelación especiales, como se describe más adelante en este capítulo. Si desea apelar una decisión relacionada con un beneficio ofrecido a través de una de las instalaciones de los Centros de Excelencia, consulte dichos procedimientos.

Su apelación se llevará a cabo independientemente de la determinación inicial y estará a cargo de una persona que no sea quien tomó la decisión sobre su reclamación inicial. No se permitirá la postergación de la determinación inicial, lo que significa que la apelación será una determinación independiente con respecto a la reclamación. Usted tendrá la oportunidad de enviar comentarios por escrito, documentos u otra información que respalden su apelación. Tiene derecho a solicitar copias, sin cargo, de todos los documentos, archivos u otra información relacionada con su reclamación. El TPA, en nombre del Plan, le proporcionará toda prueba nueva o adicional o los fundamentos considerados en el marco

de su reclamación, con tiempo suficiente antes de la fecha de la determinación de las apelaciones, a fin de darle una oportunidad razonable de responder.

Si su reclamación involucra una cuestión de criterio médico, el Plan consultará a un profesional de atención de la salud calificado con la capacitación y la experiencia apropiadas en el campo de la medicina involucrado. Si se consultó a un profesional de atención de la salud para la determinación inicial, la apelación se consultará con un profesional de atención de la salud diferente. Cuando lo solicite, el Plan le proporcionará la identificación de todo experto médico cuyo asesoramiento se obtuvo en nombre del Plan en conexión con su apelación.

La decisión final sobre una apelación se tomará dentro de los plazos especificados en el cuadro que se encuentra a continuación, según el tipo de reclamación:

PROCESO Y PLAZOS DE APELACIONES	
Reclamaciones urgentes	Se le notificará la determinación lo antes posible, teniendo en cuenta las circunstancias médicas, pero antes de las 72 horas posteriores a la recepción de la reclamación (36 horas para cada una de las dos apelaciones de Aetna o Optum).
Reclamaciones anteriores al servicio	Se le notificará la determinación dentro de un plazo razonable, teniendo en cuenta las circunstancias médicas, pero antes de los 30 días posteriores a la recepción del reclamo (15 días para cada una de las dos apelaciones de Aetna o Optum).
Reclamaciones posteriores al servicio	Se le notificará la determinación dentro de un plazo razonable, pero antes de los 60 días posteriores a la recepción del reclamo (30 días para cada una de las dos apelaciones de Aetna, Optum o VSP).

Si su reclamación se rechaza en la apelación, recibirá una notificación de rechazo que incluirá:

- Las razones específicas del rechazo
- Referencia a las disposiciones del Plan en las cuales se basó el rechazo
- Una declaración que establezca su derecho a solicitar copias, sin cargo, de todos los documentos, archivos u otra información relacionada con su reclamación
- Una declaración en la cual se establece que usted tiene derecho a obtener, cuando la solicite y sin cargo, una copia de las normas o pautas internas en las cuales se basaron para tomar esta determinación
- Si el rechazo se basa en una necesidad médica o limitación similar, una explicación de esta norma (o una declaración de que está disponible cuando se solicite)
- Una descripción de cualquier procedimiento de revisión voluntario disponible; y
- Una notificación relacionada con su derecho a iniciar acciones legales después de un rechazo de apelación.

Para beneficios médicos, farmacéuticos y de Centros de Excelencia, el rechazo también incluirá lo siguiente:

- Información suficiente para identificar la reclamación, incluida la fecha del servicio, el proveedor de atención de la salud y el monto de la reclamación (si corresponde)
  - Si lo solicita por escrito, el Plan le suministrará los códigos de diagnóstico y tratamiento (y sus correspondientes significados) asociados a una reclamación o una apelación rechazados.
- El código del rechazo y su significado
- Una descripción de la norma del Plan para rechazar la reclamación
- Información sobre apelaciones internas y externas disponibles, incluido cómo iniciar una apelación, e
- Información de contacto de la correspondiente oficina de asistencia para el consumidor de seguros de salud o defensor del consumidor que lo asistirá en el proceso de apelaciones internas y externas.

Procedimientos de apelación especiales para los Centros de Excelencia

Los beneficios para trasplantes, cirugía de columna vertebral y reemplazo de cadera o rodilla en el marco del programa de los Centros de Excelencia, están sujetos a procedimientos especiales de reclamación y apelación. Estos procedimientos especiales se describen a continuación. Si está presentando una reclamación de excepción o una apelación por el rechazo de una reclamación relacionada con uno de estos beneficios, revise atentamente estos procedimientos.

Su reclamación se considerará como una reclamación urgente o anterior al servicio. Consulte la tabla **Proceso y plazos de apelaciones** anteriormente en este capítulo para obtener información detallada sobre los plazos en los cuales el Administrador del Plan le notificará acerca de su determinación en respuesta a su solicitud.

SERVICIOS DE TRASPLANTE: SOLICITUD DE EXCEPCIÓN DE LA RED PARA LA COBERTURA FUERA DEL PROGRAMA DE LOS CENTROS DE EXCELENCIA

Tal como se describió en el capítulo **Plan médico**, todos los receptores de trasplantes conforme al programa de los Centros de Excelencia se deben someter a un examen previo al trasplante por Mayo Clinic. Mayo Clinic recomendará servicios de trasplante en Mayo Clinic. Puede solicitar una excepción para que le realicen un trasplante en un centro que no sea Mayo Clinic. Si se concede la excepción, el AMP pagaría los servicios de trasplante cubiertos bajo condiciones que de otra forma fuesen aplicables. En esta sección se describen los procedimientos que debe seguir para solicitar una excepción para que el AMP pague los servicios de trasplante cubiertos en un centro distinto al de Mayo Clinic, según las condiciones aplicables.

Solicitud de excepción previa al servicio para someterse a un trasplante en un centro que no sea Mayo Clinic

Puede presentar una reclamación de excepción previa al servicio (una reclamación "previa al servicio") para recibir un trasplante en un centro distinto a Mayo Clinic y hacer que el AMP pague los beneficios de los servicios cubiertos según las condiciones aplicables de otro modo, en el caso de que exista un riesgo significativo de que el viaje a Mayo Clinic pueda provocar la pérdida de la vida, o cuando Mayo Clinic determine que no recomendará ni realizará un trasplante porque no es un tratamiento médico adecuado o porque usted no es un candidato apropiado.

Envíe su solicitud de excepción previa al servicio por escrito a:

Por correo electrónico a: **ghappeal@wal-mart.com**
Por correo postal: **Mail Stop 3610–Benefits Total Rewards Team**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

Una Organización de Revisión Independiente designada por el Administrador del Plan examinará su solicitud. La Organización de Revisión Independiente no incluirá asociados de Walmart, Mayo Clinic ni un TPA del Plan. La Organización de Revisión Independiente revisará los expedientes médicos relevantes que revisó o generó Mayo Clinic, y el resto de los materiales que usted presente. También considerará su afección, tratamientos alternativos, pruebas y estudios científicos, opiniones de otros profesionales médicos, la naturaleza experimental o de investigación de los procedimientos propuestos y el posible beneficio que el trasplante tendría.

Si va a presentar una solicitud de excepción previa al servicio por los servicios prestados en otra instalación diferente de Mayo Clinic porque existe un riesgo importante que indique que el traslado a Mayo Clinic podría provocar la pérdida de la vida, debe presentarlo cuanto antes. Si va a presentar una solicitud de excepción previa al servicio debido a que Mayo Clinic determinó que el trasplante no es un tratamiento médico adecuado, el Plan debe recibir su solicitud en el plazo de 120 días calendario a partir del rechazo inicial del trasplante por Mayo Clinic.

Si la solicitud es urgente, la Organización de Revisión Independiente tomará su determinación dentro de las 72 horas posteriores a la recepción de la solicitud (de lo contrario, la Organización de Revisión Independiente tomará su determinación dentro de los 15 días posteriores a la recepción de la solicitud). Si se determina que la solicitud de excepción previa al servicio urgente está incompleta, recibirá una notificación dentro de las 24 horas posteriores a la recepción de dicha solicitud y tendrá 48 horas para proporcionar información adicional.

En lo que respecta a las solicitudes no urgentes, la fecha límite para decidir la solicitud puede extenderse 15 días y la Organización de Revisión Independiente enviará una notificación que explique dicha extensión, si es necesario. Si es necesaria una extensión para solicitar información adicional, la notificación de la extensión describirá la información requerida y usted tendrá por lo menos 45 días para presentar la información. La Organización de Revisión Independiente tomará una determinación dentro de los 15 días después de la fecha en la que la Organización de Revisión Independiente reciba su información o, si fuera anterior, de la fecha límite para presentar la información.

Solicitud de excepción posterior al servicio para someterse a un trasplante en un centro que no sea Mayo Clinic

Si ya ha recibido un trasplante porque requería un trasplante inmediato debido a sus circunstancias, sin el cual probablemente habría sufrido la pérdida de la vida, puede solicitar que el AMP pague los beneficios de un trasplante recibido en un centro distinto a Mayo Clinic en los términos que sean aplicables, presentando una reclamación posterior al servicio.

Envíe su solicitud escrita de excepción posterior al servicio para un trasplante en una instalación que no sea Mayo Clinic a:

Por correo electrónico a: **ghappeal@wal-mart.com**
Por correo postal a: **Mail Stop 3610–Benefits Total Rewards Team**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

Una Organización de Revisión Independiente designada por el Administrador del Plan examinará su solicitud de excepción posterior al servicio. La Organización de Revisión Independiente no incluirá asociados de Walmart, Mayo Clinic ni un TPA del Plan. La Organización de Revisión Independiente revisará los

expedientes médicos relevantes que revisó o generó Mayo Clinic, y todo otro material que usted presente, y considerará diversos factores, incluidos su condición, tratamientos alternativos, pruebas y estudios científicos, opiniones de otros profesionales médicos, la naturaleza de investigación o experimental de los procedimientos propuestos y el posible beneficio que la intervención quirúrgica tendría.

Debe presentar su solicitud de excepción dentro de los 120 días calendario luego de la fecha de servicio.

Si presenta una solicitud de excepción posterior al servicio, la Organización de Revisión Independiente tomará una determinación dentro de los 30 días posteriores a la recepción de dicha solicitud posterior al servicio. La fecha límite para decidir el reclamo puede extenderse 15 días y la Organización de Revisión Independiente enviará una notificación que explique dicha extensión, si es necesario. Si es necesaria una extensión para solicitar información adicional, la notificación de la extensión describirá la información requerida y usted tendrá por lo menos 45 días para presentar la información. La Organización de Revisión Independiente tomará una determinación dentro de los 15 días después de la fecha en la que la Organización de Revisión Independiente reciba su información o, si fuera anterior, de la fecha límite para presentar la información.

Apelación interna de la denegación de una solicitud de excepción previa al servicio o posterior al servicio para someterse a un trasplante en un centro que no sea Mayo Clinic

Si su solicitud de excepción previa al servicio se deniega, dispondrá de 180 días para apelar la denegación y solicitar a una Organización de Revisión Independiente que realice una revisión interna de esta. El aviso de denegación proporcionará información sobre cómo solicitar una apelación.

O bien, puede enviar su apelación a:

Por correo electrónico a: **ghappeal@wal-mart.com**
Por correo postal a: **Mail Stop 3610–Benefits Total Rewards Team**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

La Organización de Revisión Independiente resolverá la apelación. La Organización de Revisión Independiente no incluirá asociados de Walmart, Mayo Clinic ni un TPA del Plan. Su apelación se llevará a cabo independientemente de la determinación inicial y estará a cargo de una persona que no sea quien tomó la decisión sobre su solicitud de excepción previa al servicio inicial. No se permitirá la postergación de la determinación inicial. Lo que significa que la apelación será una determinación independiente con respecto a la solicitud inicial. Usted tendrá la oportunidad de enviar comentarios por escrito, documentos u otra información que respalden su apelación. Tiene derecho a solicitar copias, sin cargo, de todos los documentos, archivos u otra información relacionada con su solicitud.

La Organización de Revisión Independiente tomará una decisión sobre una solicitud de apelación urgente dentro de las 72 horas y de una apelación no urgente dentro de los 30 días de recibirla.

Si su apelación interna se deniega, puede apelar al proceso de apelación externa que se describe más adelante en este capítulo si la denegación se basó en el criterio médico.

Los trasplantes de córnea y de intestino se decidirán de acuerdo con los procedimientos regulares de reclamación y apelación médica que se describieron anteriormente en este capítulo.

Consulte **Fechas límite para presentar una reclamación o iniciar acciones legales** anteriormente en este capítulo en lo referido a la fecha límite para presentar una acción legal.

CIRUGÍA DE LA COLUMNA VERTEBRAL Y PRÓTESIS DE CADERA Y RODILLA: SOLICITUD DE EXCEPCIÓN DE LA RED PARA LA COBERTURA FUERA DEL PROGRAMA DE LOS CENTROS DE EXCELENCIA

Tal como se describe en el capítulo **Plan médico**, la cirugía de columna y el reemplazo de cadera y rodilla que son elegibles para realizarse en una instalación de los Centros de Excelencia deben tener autorización previa por el administrador del programa y se deben llevar a cabo a una instalación de los Centros de Excelencia a fin de que se paguen los beneficios cubiertos del Centro de Excelencia. Puede solicitar una excepción para que le realicen una intervención en un centro que no sea un Centro de excelencia. Si se concede la excepción, el AMP pagaría los servicios cubiertos bajo condiciones que de otra forma fuesen aplicables. En esta sección se describen los procedimientos para solicitar una excepción para que el AMP pague los servicios cubiertos realizados en un centro que no sea un Centro de excelencia en las condiciones aplicables.

Solicitud de excepción previa al servicio para recibir servicios de un centro no perteneciente a los Centros de Excelencia

Puede presentar una reclamación de excepción previa al servicio (una reclamación “previa al servicio”) para el AMP para pagar los beneficios para los servicios cubiertos facilitados en una instalación que no sea de los Centros de Excelencia conforme a los términos que de otra forma serían aplicables si existe un riesgo importante que indique que el traslado podría provocar una parálisis o la pérdida de la vida o si la instalación del Centro de excelencia determina que el procedimiento no es un tratamiento médico adecuado o que el paciente no es un candidato adecuado para someterse a la cirugía.

Envíe por escrito su solicitud de excepción previa al servicio solicitado para la cirugía de columna o de reemplazo de cadera o rodilla a la siguiente dirección:

Centros de Excelencia: Walmart
Attn: Appeals Coordinator
300 Executive Pkwy Ste 100
Hudson, Ohio 44236

Contigo Health, el administrador de los Centros de Excelencia para la cirugía de columna vertebral y el reemplazo de cadera y rodilla, considerará sus solicitudes de excepción previa al servicio. Contigo Health utilizará una Organización de Revisión Independiente que no incluirá a ningún asociado de Walmart ni ninguna instalación de los Centros de Excelencia para la cirugía de columna ni el reemplazo de cadera o rodilla, o un TPA del Plan. La Organización de Revisión Independiente revisará los expedientes médicos pertinentes que revisó o generó el correspondiente Centro de excelencia, y todo otro material que usted presente, y considerará varios factores, entre los que se incluyen su afección, tratamientos alternativos, pruebas y estudios científicos, opiniones de otros profesionales médicos, la naturaleza experimental o de investigación de los procedimientos propuestos y el posible beneficio que tendría el procedimiento quirúrgico.

Si va a presentar una solicitud de excepción anterior al servicio para los servicios en una instalación que no pertenezca a los Centros de Excelencia porque existe un riesgo importante que indique que el traslado podría provocar una parálisis o la pérdida de la vida, debe presentarlo cuanto antes. Si va a presentar una reclamación de excepción anterior al servicio porque una instalación de los Centros de Excelencia determinó que la cirugía no es un tratamiento médico adecuado, el Plan debe recibir su reclamación dentro de los 120 días calendario luego del rechazo inicial por parte de la instalación de los Centros de Excelencia.

Si la solicitud de excepción anterior al servicio reclamo es urgente, la Organización de Revisión Independiente diseñada por Contigo Health tomará su determinación dentro de las 72 horas posteriores a la recepción del reclamo (de lo contrario, la Organización de Revisión Independiente tomará su determinación dentro de los 15 días posteriores a la recepción del reclamo). Si se determina que la solicitud de excepción previa al servicio urgente está incompleta, recibirá una notificación dentro de las 24 horas posteriores a la recepción de dicha solicitud y tendrá 48 horas para proporcionar información adicional.

En lo que respecta a los reclamos no urgentes, la fecha límite para decidir el reclamo puede extenderse 15 días, y Contigo Health enviará una notificación que explique dicha extensión. Si es necesaria una extensión para solicitar información adicional, la notificación de la extensión describirá la información requerida y usted tendrá por lo menos 45 días para presentar la información. La Organización de Revisión Independiente tomará una determinación dentro de los 15 días después de la fecha en la que Contigo Health reciba su información o, si fuera anterior, de la fecha límite para presentar la información.

Solicitud de excepción posterior al servicio para recibir servicios de un centro que no sea uno de los Centros de Excelencia

Si ya recibió tratamiento quirúrgico debido a que sus circunstancias exigían una cirugía inmediata, sin la cual podría haber muerto o sufrido una parálisis, puede solicitar que el AMP pague los beneficios para los servicios cubiertos que recibió en una instalación que no pertenece a los Centros de Excelencia bajo términos que de otra forma estarían cubiertos (una reclamación “posterior al servicio”).

Envíe su solicitud por escrito para obtener una excepción posterior al servicio a los términos de cobertura del Plan para la cirugía de columna o el reemplazo de cadera o rodilla a la siguiente dirección:

Por correo electrónico a: **ghappeal@wal-mart.com**
Por correo postal a: **Mail Stop 3610–Benefits Total Rewards Team**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

Una Organización de Revisión Independiente designada por el Administrador del Plan examinará su solicitud de excepción posterior al servicio. La Organización de Revisión Independiente no incluirá a los asociados de Walmart, a la instalación de los Centros de Excelencia para la cirugía de columna o el reemplazo de cadera o rodilla, ni al TPA del Plan. La Organización de Revisión Independiente revisará los expedientes médicos pertinentes que revisó o generó el correspondiente Centro de excelencia, y todo otro material que usted presente, y considerará varios factores, entre los que se incluyen su afección, tratamientos alternativos, pruebas y estudios científicos, opiniones de otros profesionales médicos, la naturaleza experimental o de investigación de los procedimientos propuestos y el posible beneficio que tendría el procedimiento quirúrgico.

Debe presentar su solicitud de excepción dentro de los 120 días calendario luego de la fecha de servicio.

Si presenta una solicitud de excepción posterior al servicio, la Organización de Revisión Independiente tomará una determinación dentro de los 30 días posteriores a la recepción de dicha solicitud posterior al servicio. La fecha límite para decidir el reclamo puede extenderse 15 días y la Organización de Revisión Independiente enviará una notificación que explique dicha extensión, si es necesario. Si es necesaria una extensión para solicitar información adicional, la notificación de la extensión describirá la información requerida y usted tendrá por lo menos 45 días para presentar la información. La Organización de Revisión Independiente tomará una determinación dentro de los 15 días después de la fecha en la que la Organización de Revisión Independiente reciba su información o, si fuera anterior, de la fecha límite para presentar la información.

Apelación interna de la denegación de una solicitud de excepción previa o posterior al servicio para recibir servicios de una instalación no perteneciente a los Centros de Excelencia

Si su reclamación se rechaza (ya sea una reclamación anterior al servicio considerado por Contigo Health o una reclamación posterior al servicio considerado por una Organización de Revisión Independiente), tendrá 180 días para apelar el rechazo que una Organización de Revisión Independiente realice una revisión interna del rechazo. El aviso de denegación proporcionará información sobre cómo solicitar una apelación.

O bien, puede enviar su apelación a:

Por correo electrónico a: **ghappeal@wal-mart.com**
Por correo postal a: **Mail Stop 3610–Benefits Total Rewards Team**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

La Organización de Revisión Independiente resolverá la apelación. La Organización de Revisión Independiente no incluirá a los asociados de Walmart, a la instalación de los Centros de Excelencia para la cirugía de columna o el reemplazo de cadera o rodilla, ni al TPA del Plan. Su apelación se llevará a cabo independientemente de la determinación inicial y estará a cargo de una persona que no sea quien tomó la decisión sobre su solicitud de excepción inicial. No se permitirá la postergación de la determinación inicial. Lo que significa que la apelación será una determinación independiente con respecto a la solicitud inicial. Usted tendrá la oportunidad de enviar comentarios por escrito, documentos u otra información que respalden su apelación. Tiene derecho a solicitar copias, sin cargo, de todos los documentos, archivos u otra información relacionada con su solicitud.

La Organización de Revisión Independiente decidirá si la solicitud necesita una apelación urgente de una solicitud de excepción anterior al servicio dentro de las 72 horas luego de la recepción, una apelación no urgente de una solicitud de excepción anterior al servicio dentro de los 30 días luego de la recepción y una apelación de una solicitud de excepción posterior al servicio dentro de los 60 días luego de la recepción.

Si su apelación interna se deniega, puede apelar al proceso de apelación externa que se describe más adelante en este capítulo si la denegación se basó en el criterio médico.

Consulte **Fechas límite para presentar una reclamación o iniciar acciones legales** anteriormente en este capítulo en lo referido a la fecha límite para presentar una acción legal.

Revisión voluntaria

En las siguientes situaciones, usted puede solicitar una revisión voluntaria de una apelación rechazada. La revisión voluntaria es opcional. *No está obligado a solicitar una revisión voluntaria para que se considere que ha agotado los recursos administrativos.*

CÓMO SOLICITAR UNA REVISIÓN VOLUNTARIA DE SU APELACIÓN RECHAZADA PARA DETERMINACIONES DEL ESTADO DE INSCRIPCIÓN O ELEGIBILIDAD (INCLUIDA LA LEY COBRA)

Si tiene información adicional que no figuraba en su apelación, puede pedir una revisión voluntaria de la decisión sobre su apelación dentro de los 180 días posteriores a la recepción de la carta de rechazo de la apelación. Los mismos criterios y tiempos de respuesta que se aplicaron a su apelación se aplican por lo general a este nivel de revisión voluntario.

Envíe una solicitud de apelación voluntaria por escrito sobre el estado de la inscripción o de elegibilidad a:

Por correo electrónico a: **ghappeal@wal-mart.com**
Por correo postal a: **Mail Stop 3610—Benefits Total Rewards Team**
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

Consulte **Fechas límite para presentar una reclamación o iniciar acciones legales** anteriormente en este capítulo en lo referido a la fecha límite para presentar una acción legal.

SOLICITAR UNA REVISIÓN VOLUNTARIA DE UNA APELACIÓN DENEGADA POR MOTIVOS ADMINISTRATIVOS: APELACIONES MÉDICAS, DENTALES Y DE LA VISTA

Usted puede solicitar una revisión voluntaria de la decisión sobre su apelación de una reclamación de beneficio médico, dental o de la vista si la apelación fue rechazada por un motivo administrativo, tal como un exceso de la cantidad de visitas permitidas, y no por un motivo de criterio médico. Usted debe presentar su solicitud dentro de 180 días a partir de la fecha de la carta de rechazo de la apelación. Los mismos criterios y tiempos de respuesta que se aplicaron a su apelación se aplican por lo general a este nivel de revisión voluntario.

Envíe una solicitud de apelación voluntaria por escrito por rechazo administrativo a:

Por correo electrónico a: **ghappeal@wal-mart.com**
Por correo postal a: **Mail Stop 3610—Benefits Total Rewards Team**
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

Proceso de apelaciones externas para beneficios médicos, farmacéuticos o de Centros de Excelencia

Puede tener derecho a apelar de nuevo su reclamación en un proceso de revisión externa independiente si su apelación interna para los beneficios médicos, de farmacia o de los Centros de Excelencia del Plan se deniega por criterio médico o por la determinación de que la reclamación no está sujeta a las protecciones de facturación sorpresa. El aviso de denegación contendrá información sobre el proceso de apelaciones externo.

La apelación externa será llevada a cabo por una Organización de Revisión Independiente que no tenga afiliación con el Plan. Si esta Organización de Revisión Independiente anula la decisión del Plan, la decisión de la Organización de Revisión Independiente será vinculante para el Plan y se aplicará de inmediato, aunque el Plan podrá solicitar una revisión posterior por parte de un tribunal en los casos que corresponda. Su notificación de rechazo de la apelación interna incluirá información sobre su derecho a presentar una solicitud de revisión externa e información de contacto. Usted

debe presentar la solicitud de revisión externa dentro de los cuatro meses de haber recibido la determinación final sobre la apelación interna. La presentación de una reclamación de revisión externa no afectará su capacidad de iniciar acciones legales en un tribunal. Cuando presente una solicitud de revisión externa, se le pedirá que autorice la divulgación de los registros médicos cuya consulta podría necesitarse a los fines de tomar una decisión sobre la revisión externa.

Envíe por escrito una solicitud de apelación médica externa (incluidas las solicitudes de excepción relacionadas con los beneficios de los Centros de Excelencia) a:

Por correo electrónico a: **ghappeal@wal-mart.com**
Por correo postal a: **Mail Stop 3610—Benefits Total Rewards Team**
Attn: External Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

Envíe una solicitud de apelación farmacéutica externa por escrito a:

OptumRx
Attn: Appeals Coordinator
P.O. Box 2975
Mission, Kansas 66201

Otros derechos relacionados con los beneficios médicos, de farmacia, de Centros de Excelencia, dental, de la vista y por discapacidad a corto plazo

DERECHO DEL PLAN A SOLICITAR ARCHIVOS MÉDICOS

El Plan tiene derecho a solicitar archivos médicos para cualquier individuo cubierto.

EL DERECHO DEL PLAN A RECUPERAR EL EXCESO DE PAGO

Los pagos se realizan de acuerdo con las disposiciones del Plan. Si se determina que el pago se realizó por un cargo no elegible o que otro plan o seguro se consideró primario, o que se ha producido cualquier otra circunstancia que dio lugar a que el Plan pague beneficios mayores a los permitidos o requeridos según los términos del Plan, el Plan tiene derecho a recuperar el pago excesivo. El Plan (o el administrador de terceros u otro proveedor de servicios que actúe en nombre del Plan) procurará recuperar el pago excesivo de la parte a quien se le realizó el pago. No obstante, el Plan se reserva el derecho de solicitar la recuperación del pago excesivo de los participantes, beneficiarios o dependientes. Además, el Plan tiene derecho a involucrar a una agencia de cobros externa para recuperar los pagos excesivos a nombre del Plan si los esfuerzos de cobro no tienen éxito. El Plan también puede iniciar acciones legales para hacer cumplir sus derechos de recuperar los pagos excesivos.

Si los pagos excesivos se realizan a un proveedor, el Plan (o los administradores de terceros que actúen en nombre del Plan) puede reducir, compensar o rechazar los beneficios, en el monto del pago excesivo, por los servicios que de otra manera estarían cubiertos para las reclamaciones actuales o futuros con el proveedor en nombre de los participantes, beneficiarios o dependientes del Plan. Si un proveedor a quien se le realizó un pago excesivo tiene pacientes que participan en otros planes de salud y bienestar administrados por el administrador de terceros, este puede reducir o compensar los pagos adeudados al proveedor correspondientes a los otros planes de salud por el monto del pago excesivo.

DERECHO DEL PLAN A REALIZAR AUDITORÍAS

El Plan tiene derecho a realizar auditorías de sus reclamaciones, incluidos las reclamaciones de los proveedores médicos. El Plan (o el correspondiente administrador de terceros) puede reducir o rechazar los beneficios por los servicios que de otra manera estarían cubiertos para todos las reclamaciones actuales o futuras ante el proveedor que se brindaron a su nombre o de un participante a través de otro plan de salud y bienestar administrado por el administrador de terceros en función de los resultados de una auditoría. El Plan también puede reducir o rechazar los beneficios por servicios que de otra manera estarían cubiertos para todos las reclamaciones actuales o futuros que presente.

DERECHO DEL PLAN A DESCONTAR DEL SUELDO O DEL SALARIO

En la medida en que el Plan pueda cobrarle a usted o a sus dependientes los beneficios pagados anteriormente, en su totalidad o en parte, por ejemplo, por beneficios pagados en exceso o a los que no tenía derecho según las condiciones del Plan, se considerará, en virtud de su inscripción en el Plan, que usted ha acordado que la compañía puede deducir tales importes de su sueldo o salario y pagarlo al Plan hasta que la recuperación sea completa. Si se inscribe para la cobertura del Plan, se asumirá que usted ha prestado consentimiento para las deducciones de su sueldo aplicables a dicha cobertura. Además, si usted no se inscribe ni se reinscribe durante la Inscripción Anual, el Plan asumirá que usted ha prestado consentimiento para la reinscripción automática que se describe en el capítulo **Elegibilidad, inscripción y fechas de vigencia**, incluidas las deducciones del sueldo que correspondan.

Derechos de subrogación y reembolso del Plan

NOTA: Este apartado se aplica a los beneficios del Plan que se financian a través de los activos de la compañía. Estos beneficios se mencionan generalmente en el *Libro de beneficios para asociados* como beneficios autofinanciados, o beneficios autoasegurados, para indicar que no están asegurados mediante un contrato de seguro emitido por una aseguradora. Los aseguradores de los beneficios asegurados pueden tener derechos de subrogación y reembolso independientes aplicables a los beneficios que aseguran. Consulte la póliza respectiva y el certificado de cobertura aplicable a cualquier beneficio asegurado en el que pueda estar inscrito.

Si usted o un dependiente cubierto (una persona cubierta) sufre una lesión o cualquier otro daño debido a la conducta de otra persona y el Plan paga los beneficios financiados por la compañía como resultado de dicha lesión o daño, el Administrador del Plan tiene derecho a recuperar por parte de la persona cubierta o de cualquier parte responsable de compensar a la persona cubierta por sus enfermedades o lesiones, los pagos que realiza en nombre de la persona cubierta. El término legal que se utiliza para hacer referencia a este derecho de recuperación es "subrogación". El Plan gozará de un derecho de retención de preferencial contra cualquier importe que la persona cubierta recupere por parte de otra parte responsable o aseguradora por el monto total de los beneficios que se paguen a la persona cubierta o en su beneficio como resultado de la lesión o daño de un tercero, y el Plan tendrá derecho a compensar dichos montos de beneficios contra beneficios futuros exigibles en virtud del Plan.

El Plan tiene derecho a realizar cualquiera de las siguientes acciones para hacer valer su gravamen y derecho de reembolso y recuperación:

- Reducir o rechazar beneficios que de lo contrario paga el Plan, y
- Recuperar o subrogar el 100 % de los beneficios que pagó o pagará el Plan por las personas cubiertas, hasta el punto de contemplar cada uno de los siguientes pagos:
  - Cualquier sentencia, liquidación o pago que se haya realizado o que se esté por realizar a causa de un accidente o mala práctica (excepto si la mala práctica provoca una paraplejía o cuadriplejía, quemaduras graves que provoquen un grado de incapacidad para todo el cuerpo de al menos el 50 %, determinado por una organización de revisión independiente de conformidad con las directrices de la Asociación Médica Americana para la evaluación de la incapacidad permanente, discapacidad mental o física total y permanente, o la muerte), independientemente de la forma en que se califique la sentencia, el acuerdo o el pago, incluidos los pagos de cualquier otro seguro, ya sea que proporcione cobertura a terceros o a titulares
  - Cualquier cobertura o beneficio de seguro de automóvil o casa rodante, incluida la cobertura de automovilistas no asegurados o asegurados por menos del valor real
  - Pagos o coberturas de seguro médico, comercial o de responsabilidad civil, y
  - Honorarios de los abogados.

El gravamen del Plan existe cuando el Plan paga cualquier beneficio a o en favor de una persona cubierta. Si una persona cubierta presenta una solicitud de quiebra, dicha persona acepta que el gravamen del Plan existía antes de la creación de la masa de la quiebra.

Recuerde además que:

- El término "persona cubierta" hace referencia a cualquier participante (de acuerdo con la definición de ERISA) o dependiente de un participante que tiene derecho a recibir beneficios del Plan.
- El Plan tiene máxima prioridad de derecho a la reducción, al reembolso y a la subrogación
- El Plan tiene el derecho a recuperar el interés sobre el importe que el Plan pagó a causa del accidente
- El Plan tiene derecho a un reembolso del 100 % en una suma única
- El Plan no está sujeto a ninguna ley estatal o doctrina equitativa, incluida la doctrina del fondo común, lo cual exigiría que el Plan reduzca su cobertura a cualquier porción de honorarios y costos de abogados de una persona cubierta
- El Plan no se hace responsable de los gastos, costos y honorarios de abogados de la persona cubierta
- El derecho de reducción, reembolso y subrogación se basa en las disposiciones del Plan vigentes al momento del fallo, pago o liquidación
- El derecho de reducción, reembolso y subrogación del Plan se aplica a cualquier fondo recuperado de otra parte, por parte de los herederos de cualquier persona cubierta o en su nombre, y
- El derecho prioritario del Plan a una reducción, reembolso y subrogación no se reducirá debido a la negligencia de la persona cubierta.

El plan no procurará reducción, reembolso ni subrogación en los casos en que la lesión o la enfermedad que sea la base de la recuperación de costos por parte de la persona cubierta por cualquier tercero tenga como consecuencia:

- Paraplejía o tetraplejía
- Quemaduras graves que causan un grado de discapacidad para todo el cuerpo de al menos el 50 %, según lo determinado por una Organización de Revisión Independiente de conformidad con las directrices de la Asociación Médica Americana para la evaluación de la discapacidad permanente.
- Discapacidad mental o física total y permanente, o
- Fallecimiento

El Administrador del Plan tiene la autoridad, a su entera discreción, de decidir limitar o no continuar con los derechos del Plan con respecto a la reducción, el reembolso o la subrogación. Para obtener más información, comuníquese con el Administrador del Plan.

El hecho de que una persona cubierta tenga o no una "discapacidad mental o física total y permanente" se decidirá sobre la base de criterios desarrollados y aplicados por el Administrador del Plan, a su entera discreción. Una manera de demostrar la discapacidad física o mental total y permanente es que la persona cubierta demuestre que tiene derecho a los beneficios de ingresos por discapacidad del Seguro Social, o que ha satisfecho los requisitos para tener derecho a los ingresos por discapacidad del Seguro Social. El Administrador del Plan considerará las reclamaciones por discapacidad mental y física, incluso si la persona cubierta no reúne las condiciones para recibir beneficios de ingresos por discapacidad de Seguridad Social, conforme a los criterios desarrollados por el Administrador del Plan.

Incluso en circunstancias en las que no se prohíbe que el Plan procure reducción, reembolso o subrogación en función de las excepciones descritas anteriormente, el derecho del Plan a reducción, reembolso o subrogación se limitará a no más del 50 % del monto total recuperado por la persona cubierta, o en nombre de ella, de cualquier tercero (que no se reducirá por costos u honorarios de abogados de la persona cubierta). De acuerdo con el Plan, todas las personas cubiertas y sus representantes deben informar al Plan si se ven involucradas en un incidente que cause tal derecho de reducción, reembolso o subrogación. Las personas aseguradas deben cooperar con el Plan y firmar los documentos que el administrador, actuando en nombre del Plan, considere necesarios para proteger los derechos de reducción, reembolso o subrogación del Plan. Las personas cubiertas no deberán hacer nada que obstaculice, retrase, impida o ponga en peligro el derecho prioritario de reducción, reembolso o subrogación del Plan. Si no se cumple con esta disposición, el Plan tendrá derecho a retener los beneficios que se adeuden conforme al Plan. Esto es adicional a todos y cada uno de los demás derechos que el Plan tiene en virtud de sus derechos de reducción, reembolso y subrogación.

Los derechos del Plan a la reducción, el reembolso y la subrogación se aplican independientemente de cualquier asignación o designación de la liquidación o la adjudicación aplicable (por ejemplo, alivio del dolor y el sufrimiento, o beneficios médicos) e independientemente de las reclamaciones o causas de acción específicas que se liquidan o adjudican. Los derechos del Plan se aplican independientemente de si la persona cubierta ha sido resarcida o compensada totalmente por las lesiones de la persona cubierta y sin tener en cuenta ninguna ley estatal o doctrina equitativa, como la doctrina de resarcimiento, que limitaría el derecho de recuperación del Plan en función de si la persona cubierta ha sido resarcida, siendo la intención que el derecho de recuperación del Plan sea un derecho de recuperación del primer pago.

Además, el Plan tiene derecho a presentar una demanda en nombre de la persona cubierta por la afección relacionada con los gastos médicos para recuperar los beneficios que pagó o que pagará el Plan. Asimismo, el Plan puede hacer valer sus derechos de reducción, reembolso y subrogación contra cualquier fondo, causante de daños, parte responsable o coberturas de seguro disponibles, incluidas las coberturas de motorista no asegurado, sin culpa o con seguro insuficiente, en la máxima medida permitida por la ley.

Para ayudar a que el Plan haga cumplir su derecho a la reducción, la recuperación, el reembolso y la subrogación, una persona cubierta o su representante designado deben, a pedido y a criterio del Plan:

- Tomar las medidas necesarias para que el Plan pueda ejercer sus derechos de recuperación.
- Brindar información; o
- Proporcionar al Plan cualquier información solicitada relacionada con la reclamación en cuestión, incluida la información con respecto a otros seguros, juicios, pagos o acuerdos.

La falta de colaboración con el Plan y el incumplimiento de tales solicitudes pueden dar lugar a la retención o recuperación por parte del Plan de los beneficios, servicios, pagos o créditos que se adeudan o se pagan conforme al Plan.

Reclamaciones para los beneficios y derecho a apelar decisiones sobre reducciones, reembolsos y subrogaciones

La decisión del Plan de procurar reducción, reembolso o subrogación es una determinación de beneficios conforme al Plan y se la puede apelar de acuerdo con los procedimientos que aparecen a continuación.

A los fines de los procedimientos de reclamaciones que se especifican a continuación, una "reclamación de beneficios" se refiere al pedido por parte de un participante, beneficiario o dependiente ("reclamante") de tener los beneficios provistos conforme al Plan no reducidos por la aplicación del derecho del Plan a la reducción, el reembolso o la subrogación.

RECLAMACIÓN INICIAL DE BENEFICIOS

Si un reclamante recibe una notificación en la que se indica qué beneficios están sujetos a reducción, reembolso o subrogación, y el reclamante considera que el caso encuadra dentro de una de las excepciones o limitaciones al derecho del Plan a la reducción, el reembolso o la subrogación, puede presentar una reclamación de beneficios ante el Plan.

También puede designar a un representante autorizado para que presente reclamaciones de beneficios o apelaciones en su nombre.

Para que se tome en consideración una reclamación inicial de beneficios, este debe:

- Presentarse por escrito
- Enviarse a la dirección correcta
- Presentarse dentro de los 12 meses a partir de la fecha de la notificación de que un beneficio está sujeto a reducción, reembolso o subrogación
- Identificar la excepción o la limitación al derecho del Plan a reducción, reembolso o subrogación que el reclamante considera que se aplica a su caso, y
- Incluir documentación que ayude al Plan a tomar su decisión (por ejemplo, archivos médicos u hospitalarios, cartas de médicos, etc.).

Envíe por escrito una reclamación de revisión de la reclamación inicial de beneficios a:

Por correo electrónico a: **ghappeal@wal-mart.com**
Por correo postal a: **Mail Stop 3610—Benefits Total Rewards Team**
Attn: Subrogation Review
508 SW 8th Street
Bentonville, Arkansas 72716-3610

Dentro de un plazo prudencial, pero a más tardar 30 días después de que se realice la reclamación inicial de beneficios, el Plan le notificará por escrito la decisión que tome. Si la reclamación de beneficios se rechaza en su totalidad o en parte, la notificación incluirá la siguiente información:

- Las razones específicas del rechazo
- Referencia a las disposiciones del Plan en las cuales se basó el rechazo
- Una descripción de cualquier material o información adicional necesaria que sustenten la reclamación de beneficios y una explicación de por qué es necesario dicho material o dicha información
- Una declaración en la cual se establece que el reclamante tiene derecho a obtener, cuando la solicite y sin cargo, una copia de las normas o pautas internas en las cuales se basó la determinación del Plan
- Una descripción de los procedimientos de apelación del Plan y de los límites de tiempo para apelar, y
- Una notificación relacionada con el derecho del reclamante de iniciar acciones legales después del rechazo de una apelación.

El periodo de 30 días se puede extender 15 días si se determina que es necesaria una prórroga por situaciones ajenas al Plan. El Plan notificará al reclamante antes de que finalice el periodo de 30 días si se requiere una prórroga o información adicional. Si se le solicita que proporcione información adicional, el reclamante tendrá 45 días a partir de la fecha de la notificación para proporcionarla. El momento de tomar una determinación se suspenderá hasta que el reclamante proporcione la información solicitada (o hasta la fecha límite para proporcionar la información, si fuera anterior).

DERECHO A APELAR UNA RECLAMACIÓN RECHAZADA

Si una reclamación relacionada con una decisión de reducción, reembolso o subrogación se rechaza de forma total o parcial, el reclamante puede solicitar una apelación de la decisión. Para que se considere la apelación, esta debe:

- Presentarse por escrito
- Enviarse a la dirección correcta
- Presentarse dentro de los 180 días posteriores a la fecha del rechazo inicial, y
- Contener cualquier información o documentación adicional que el reclamante desee que se tome en consideración.

Envíe una solicitud de apelación por escrito a:

Por correo electrónico a: **ghappeal@wal-mart.com**
Por correo postal a: **Mail Stop 3610—Benefits Total Rewards Team**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3610

La apelación se llevará a cabo independientemente de la decisión inicial y estará a cargo de una persona que no sea la parte que decidió la reclamación inicial de beneficios. El reclamante tiene derecho a pedir copias, sin cargo, de todos los documentos, archivos u otra información relevante para su reclamación de beneficios. El reclamante también tiene derecho a presentar comentarios, documentos, archivos y otra información por escrito, que el Plan tendrá en cuenta al tomar su decisión sobre la apelación. Al decidir acerca de una reclamación de beneficios que se basa en un criterio médico, de forma total o parcial, el fiduciario de reclamaciones del Plan consultará a un profesional de atención de la salud que tenga la capacitación y la experiencia apropiadas en el campo de la medicina asociado con el criterio médico. El profesional de atención de la salud será una persona a quien no se haya consultado en relación con la decisión del Plan sobre la reclamación de beneficios inicial ni un subordinado de dicho profesional de atención de la salud. Si se obtiene el asesoramiento de un profesional de atención de la salud para decidir sobre una apelación y el reclamante solicita el nombre de dicho profesional, se le proporcionará la información solicitada independientemente de si el Plan se basó en dicho asesoramiento. El Plan debe notificar por escrito al reclamante acerca de su decisión sobre la revisión en el plazo de 60 días a partir de que el Plan reciba su apelación.

Si la reclamación de beneficios se rechaza durante la apelación, el Plan proporcionará una notificación de rechazo, que incluirá:

- Las razones específicas para el rechazo de su reclamo
- Referencia específica a las cláusulas del Plan en las cuales se basó el rechazo
- Una declaración que describe el derecho del reclamante a pedir copias, sin cargo, de todos los documentos, archivos u otra información relevante para su reclamación de beneficios
- Una declaración en la cual se establece que el reclamante tiene derecho a obtener, cuando la solicite y sin cargo, una copia de las normas o pautas internas en las cuales se basó la determinación
- Una descripción de los procedimientos de revisión voluntaria disponibles, de haberlos, y
- Una notificación relacionada con el derecho del reclamante de iniciar acciones legales después del rechazo de una apelación.

UNA RECLAMACIÓN DE BENEFICIOS ES LA ÚNICA FORMA DE SOLICITAR UNA EXCEPCIÓN AL DERECHO DE REDUCCIÓN Y RECUPERACIÓN DEL PLAN

El único método por el que un reclamante puede solicitar al Plan que no reduzca los beneficios en virtud de los derechos de reducción y recuperación del Plan es presentar una reclamación de beneficios, siguiendo el proceso descrito anteriormente. El reclamante debe completar el proceso obligatorio de apelaciones y reclamaciones que se describe en estos procedimientos para reclamaciones antes de iniciar una acción legal. El reclamante no puede iniciar acciones legales por beneficios si su apelación o reclamación inicial de beneficios no se realiza dentro de los plazos establecidos en estos procedimientos de reclamaciones. Toda acción legal por los beneficios debe ser iniciada por el reclamante dentro de los 180 días después de la decisión de apelación. No puede iniciar acciones legales pasado el periodo de 180 días.

Procedimientos de opciones de reclamaciones y apelaciones del plan HMO

En algunos lugares, Walmart ofrece cobertura de seguro de salud a través de una Organización de Mantenimiento de la Salud (HMO) como parte del Plan de Salud y Bienestar para Asociados. Si participa en una HMO, esta le proporcionará un folleto con los beneficios que, junto con este documento, servirá como descripción resumida del Plan para la cobertura de la HMO y describirá los procedimientos de reclamaciones y apelaciones. Para obtener más información, comuníquese con su HMO.

Procedimientos de opciones de reclamaciones y apelaciones del plan PPO

En algunos lugares, Walmart ofrece el Plan PPO como parte del Plan de salud y bienestar para asociados. Si participa en el Plan PPO, Aetna, el administrador de terceros del Plan, le entregará un folleto con los beneficios que, junto con este documento, servirá como descripción resumida del Plan para la cobertura del Plan PPO y describirá los procedimientos de reclamaciones y apelaciones. Para obtener más información, comuníquese con Aetna.

Proceso de reclamaciones para el seguro contra accidentes y por enfermedades graves

Las reclamaciones del seguro contra accidentes y por enfermedades graves deben enviarse dentro de los 60 días de ocurrido el accidente o comenzada la enfermedad grave que están cubiertos, o en cuanto sea razonablemente posible, a la siguiente dirección:

Allstate Benefits
Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488

Así mismo, puede facilitar un aviso de la reclamación de la siguiente manera: En línea: **allstatebenefits.com/mybenefits**
Por teléfono: **800-514-9525**
Por fax: **877-423-8804**

Asegúrese de incluir la siguiente información de la persona cubierta:

- Nombre
- Número de identificación de Walmart (WIN), y
- Fecha en que se produjo o comenzó la enfermedad cubierta o el accidente.

Puede solicitar un formulario de reclamación a Allstate Benefits o ingresar a **One.Walmart.com** o **AllstateBenefits.com/Walmart** para obtener una copia. Si no recibe un formulario de reclamación dentro de los 15 días de su reclamación, puede enviar una notificación de la reclamación a Allstate Benefits y proporcionar a Allstate Benefits una declaración de la naturaleza y la magnitud del siniestro.

Allstate Benefits tiene derecho a recuperar cualquier pago en exceso que se haya hecho debido a un fraude o a un error que cometan al procesar una reclamación. Usted o su beneficiario deberán reembolsar a Allstate Benefits todos los montos adeudados. Si usted o su beneficiario no pueden reembolsar financieramente a Allstate Benefits al pagar una suma global, Allstate Benefits colaborará con usted o con su beneficiario para desarrollar un método razonable de reembolso.

SEGURO CONTRA ACCIDENTES

Cuando usted presenta una reclamación a Allstate Benefits, la determinación de la reclamación se hará dentro de un periodo de tiempo razonable, pero no más tarde de 90 días después de que Allstate Benefits reciba la reclamación. Si Allstate Benefits determina que se necesita una extensión debido a circunstancias especiales, este plazo puede extenderse 90 días más. En tal caso, usted recibirá un aviso por escrito de la extensión antes de que finalice el periodo de 90 días, el cual contiene detalles de las circunstancias que requieren la extensión y la fecha en la que Allstate Benefits espera tomar una decisión.

Si su reclamación se rechaza, recibirá un aviso de rechazo que consistirá en una explicación por escrito, que incluirá:

- Las razones específicas del rechazo
- Referencia a las disposiciones específicas del Plan en las cuales se basó el rechazo
- Una descripción del material o la información adicional, si los hubiese, que sean necesarios para sustentar la reclamación y las razones por las que ese material o esa información son necesarios, e
- Información sobre los procedimientos de revisión de reclamaciones y los plazos de apelación, incluida una declaración respecto de que tiene derecho a presentar una demanda tras una denegación en apelación.

El comprobante escrito debe entregarse a Allstate Benefits dentro de los 90 días siguientes al accidente cubierto. Si no se puede proporcionar un comprobante escrito dentro de ese plazo, Allstate no reducirá ni negará ninguna reclamación por esta razón, siempre y cuando el comprobante se presente tan pronto como sea razonablemente posible. Independientemente del caso, el comprobante requerido deberá entregarse a Allstate Benefits en un plazo máximo de 15 meses a partir del momento indicado, a menos que la persona cubierta esté legalmente incapacitada.

Su beneficiario debe cooperar razonablemente durante cualquier investigación y/o determinación de una reclamación. Esto incluye dar autorización para la divulgación de historiales médicos y otra información.

Allstate Benefits tiene derecho, a sus expensas, a que cualquier persona cubierta sea examinada por un médico de su elección, tantas veces como sea razonablemente necesario mientras una reclamación esté pendiente. Asimismo, Allstate Benefits puede hacer que se realice una autopsia mientras la reclamación está pendiente, cuando la ley lo permita.

CÓMO APELAR UNA RECLAMACIÓN DE SEGURO POR ACCIDENTES QUE SE RECHAZÓ EN SU TOTALIDAD O EN PARTE

Puede apelar cualquier rechazo de una reclamación para beneficios presentando un pedido por escrito con:

Allstate Benefits
P.O. Box 41488
Jacksonville, Florida 32203-1488

Su apelación debe presentarse dentro de un plazo de 60 días a partir de la recepción del aviso escrito de la denegación de una reclamación. También puede acompañar su apelación con comentarios, documentos, archivos e información que considere que respaldan su reclamación, aún si no presentó antes tal documentación. Usted puede solicitar, sin cargo, todos los documentos que sean relevantes (según lo establece ERISA) para su reclamación. Puede tener representación durante el procedimiento de revisión.

La decisión final sobre la apelación se tomará dentro de un plazo razonable, pero a más tardar 60 días después de recibir su apelación por escrito. Si Allstate Benefits determina que se necesita una extensión debido a circunstancias especiales, este plazo puede extenderse 60 días más. En tal caso, usted recibirá un aviso por escrito de la extensión antes de que finalice el periodo de 60 días, el cual contiene detalles de las circunstancias que requieren la extensión y la fecha en la que Allstate Benefits espera tomar una decisión.

Si se rechaza su apelación, recibirá una notificación por escrito sobre el rechazo que incluirá:

- Las razones específicas del rechazo
- Referencia a las disposiciones específicas del Plan en las cuales se basó el rechazo
- Una declaración que establece que usted tiene derecho a recibir, si lo solicita y sin cargo, acceso razonable a todos los documentos, archivos y otra información relevante para su reclamación de beneficios y a obtener copias de dicha documentación
- Una descripción de los procedimientos de revisión voluntaria ofrecidos por el Plan y su derecho a obtener información sobre tales procedimientos, y
- Una declaración sobre su derecho a presentar una acción en virtud del artículo 502 (a) de ERISA.

Si se rechaza su reclamación, tiene derecho a presentar una acción en un tribunal federal de acuerdo con la sección 502(a) de la ley ERISA, pero únicamente después de haber cumplido con los procedimientos de reclamaciones y apelaciones del Plan. Consulte **Fechas límite para presentar una reclamación o iniciar acciones legales** anteriormente en este capítulo en lo referido a la fecha límite para presentar una acción legal.

SEGURO POR ENFERMEDADES GRAVES

Cuando usted presenta una reclamación a Allstate Benefits, la determinación de la reclamación se hará dentro de un periodo de tiempo razonable, pero no más tarde de 30 días después de que Allstate Benefits reciba la reclamación. Si Allstate Benefits determina que se necesita una prórroga debido a situaciones ajenas al Plan, este periodo se puede extender a un periodo adicional de 15 días. En tal caso, usted recibirá un aviso por escrito de la extensión antes de que finalice el periodo de 30 días, el cual contiene detalles de las circunstancias que requieren la extensión y la fecha en la que Allstate Benefits espera tomar una decisión. Si la extensión es necesaria para solicitar información adicional, la notificación de la extensión describirá la información requerida y usted tendrá por lo menos 45 días para presentar la información. Allstate Benefits tomará su decisión dentro de un plazo de 15 días a partir de la fecha en que reciba la información o, en caso de que sea antes, la fecha límite para presentarla.

Si se rechaza su reclamación, el rechazo consistirá en una explicación escrita que incluirá lo siguiente:

- Las razones específicas del rechazo
- Referencia a las disposiciones específicas del Plan en las cuales se basó el rechazo
- Una descripción del material o la información adicional, si los hubiese, que sean necesarios para sustentar la reclamación y las razones por las que ese material o esa información son necesarios
- Una descripción de los procedimientos de revisión de las reclamaciones y los plazos aplicables para tales procedimientos, incluida una declaración de su derecho a iniciar acciones legales conforme a la Sección 502(a) de la ley ERISA después de un rechazo de su reclamación
- La divulgación de cualquier norma, directriz o protocolo interno en el que se haya basado la denegación de la reclamación o una declaración de que tiene derecho a obtener, previa solicitud y de forma gratuita, tal información, y
- Si la denegación se basa en la necesidad médica o el tratamiento experimental o limitaciones similares, una explicación del criterio científico o clínico para la determinación o una declaración de que tiene derecho a obtener, previa solicitud y de forma gratuita, tal información.

Se debe entregar un comprobante escrito a Allstate Benefits dentro de los 90 días siguientes a cada enfermedad grave cubierta. Si no se puede proporcionar un comprobante escrito dentro de ese plazo, Allstate no reducirá ni negará ninguna reclamación por esta razón, siempre y cuando el comprobante se presente tan pronto como sea razonablemente posible. Independientemente del caso, el comprobante requerido deberá entregarse a Allstate Benefits en un plazo máximo de 15 meses a partir del momento indicado, a menos que la persona cubierta esté legalmente incapacitada.

Su beneficiario debe cooperar razonablemente durante cualquier investigación y/o determinación de una reclamación. Esto incluye dar autorización para la divulgación de historiales médicos y otra información.

Allstate Benefits tiene derecho, a sus expensas, a que cualquier persona cubierta sea examinada por un médico de su elección, tantas veces como sea razonablemente necesario mientras una reclamación esté pendiente. Asimismo, Allstate Benefits puede hacer que se realice una autopsia mientras la reclamación está pendiente, cuando la ley lo permita.

CÓMO APELAR UNA RECLAMACIÓN DE SEGURO POR ENFERMEDADES GRAVES QUE SE RECHAZÓ EN SU TOTALIDAD O EN PARTE

Puede apelar cualquier rechazo de una reclamación para beneficios por enfermedades graves presentando un pedido por escrito con Allstate.

Allstate Benefits
Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488
Attention: Appeals

Su apelación debe presentarse dentro de un plazo de 180 días a partir de la recepción del aviso escrito de la denegación de una reclamación. También puede acompañar su apelación con comentarios, documentos, archivos e información que considere que respaldan su reclamación, aún si no presentó antes tal documentación. Usted puede solicitar, sin cargo, todos los documentos que sean relevantes (según lo establece ERISA) para su reclamación. La apelación la llevará a cabo una persona distinta de la que tomó la decisión inicial. No se permitirá la postergación de la determinación inicial. Puede tener representación durante el procedimiento de revisión.

Si la reclamación involucra una cuestión de criterio médico, Allstate Benefits consultará a un profesional de atención de la salud que tenga las calificaciones, la capacitación y la experiencia apropiadas en el campo de la medicina involucrado. Si se consultó a un profesional de atención de la salud para la determinación inicial, la apelación se consultará con un profesional de atención de la salud diferente. Si lo solicita, Allstate Benefits le proporcionará la identificación de cualquier experto médico cuyo asesoramiento se haya obtenido en relación con la apelación.

La decisión final sobre la apelación se tomará dentro de un plazo razonable, pero a más tardar 60 días después de recibir su apelación por escrito.

Si se rechaza su apelación, recibirá una notificación por escrito sobre el rechazo que incluirá:

- Las razones específicas del rechazo
- Referencia a las disposiciones específicas del Plan en las cuales se basó el rechazo
- Una declaración que establece que usted tiene derecho a recibir, si lo solicita y sin cargo, acceso razonable a todos los documentos, archivos y otra información relevante para su reclamación de beneficios y a obtener copias de dicha documentación
- Una descripción de los procedimientos de revisión voluntaria ofrecidos por el Plan y su derecho a obtener información sobre tales procedimientos
- La divulgación de cualquier norma, directriz o protocolo interno en el que se haya basado la denegación de la reclamación o una declaración de que tiene derecho a obtener, previa solicitud y de forma gratuita, tal información
- Si la denegación se basa en la necesidad médica o el tratamiento experimental o limitaciones similares, una explicación del criterio científico o clínico para la determinación o una declaración de que tiene derecho a obtener, previa solicitud y de forma gratuita, tal información, y
- Una declaración sobre su derecho a presentar una acción en virtud del artículo 502 (a) de ERISA.

Si se rechaza su reclamación, tiene derecho a presentar una acción en un tribunal federal de acuerdo con la sección 502(a) de la ley ERISA, pero únicamente después de haber cumplido con los procedimientos de reclamaciones y apelaciones del Plan. Consulte **Fechas límite para presentar una reclamación o iniciar acciones legales** anteriormente en este capítulo en lo referido a la fecha límite para presentar una acción legal.

Proceso de reclamaciones para el seguro de vida pagado por la compañía, seguro de vida opcional para asociados y para dependientes, seguro contra accidentes durante viajes de negocios y seguro por AD&D

Las reclamaciones por el seguro de vida pagado por la compañía, seguro de vida opcional para asociados y para dependientes, seguro contra accidentes durante viajes de negocios y seguro por muerte accidental y desmembramiento (AD&D) se pueden iniciar llamando por teléfono a Prudential al **877-740-2116**. Consulte el capítulo correspondiente para saber qué información debe facilitar a Prudential al presentar una reclamación. Las reclamaciones de beneficios asegurados por Prudential también pueden presentarse enviando la reclamación a la siguiente dirección:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

Las reclamaciones de beneficios conforme al seguro de vida deben presentarse en los 90 días siguientes a la fecha de la pérdida.

Las reclamaciones de beneficios conforme al seguro por accidentes en viajes de negocios deben presentarse en los 365 días siguientes a la fecha de la pérdida.

Las reclamaciones de beneficios bajo el seguro de muerte accidental y desmembramiento deben presentarse en los 90 días siguientes a la fecha de la pérdida.

SEGURO DE VIDA, POR ACCIDENTE EN VIAJE DE NEGOCIOS O POR MUERTE ACCIDENTAL Y DESMEMBRAMIENTO

Cuando presente una reclamación de seguro de vida a Prudential, se hará una determinación la reclamación en un plazo de 45 días. Este plazo puede extenderse 30 días más si es necesario por causas ajenas a Prudential. Dentro del periodo inicial de 45 días si se necesita una extensión adicional, se le proporcionará un aviso por escrito de la extensión, el motivo de la extensión y la fecha en la que Prudential espera tomar una decisión sobre su reclamación. Este plazo puede extenderse 30 días adicionales más allá de la extensión original de 30 días si es necesario debido a asuntos fuera del control de Prudential. Se le proporcionará un aviso por escrito de la extensión adicional, el motivo de esta y la fecha en la que Prudential espera tomar una decisión sobre la reclamación dentro del primer periodo de extensión de 30 días si se necesita una extensión adicional. No obstante, si se extiende el plazo debido a que usted no ha presentado la información necesaria para tomar una decisión sobre la reclamación, el plazo para que Prudential determine el

beneficio quedará suspendido desde la fecha en que se le envíe el aviso de la prórroga hasta la fecha en que usted responda a la reclamación de información adicional.

Si su reclamación de beneficios se deniega, ya sea total o parcialmente, usted o su representante autorizado recibirán un aviso por escrito de Prudential sobre su denegación. El aviso se redactará de forma que usted pueda entenderlo y deberá incluir:

- Las razones específicas para el rechazo de su reclamo
- Referencia a las disposiciones específicas del plan en las cuales se basó la determinación de beneficio
- Una descripción de cualquier material adicional o información necesaria para que usted sustente la reclamación y una explicación de por qué es necesario dicha información
- Una descripción de los procedimientos de apelaciones de Prudential y los plazos aplicables; y
- Si una determinación adversa de beneficios se basa en una necesidad médica o en un tratamiento experimental o en una exclusión o límite similar, se proporcionará gratuitamente, previa solicitud, una explicación del criterio científico o clínico para la determinación.

PRESENTAR UNA APELACIÓN PARA UNA RECLAMACIÓN DE SEGURO DE VIDA, POR ACCIDENTE EN VIAJE DE NEGOCIOS O POR MUERTE ACCIDENTAL Y DESMEMBRAMIENTO QUE HAYA SIDO DENEGADO TOTAL O PARCIALMENTE

Puede apelar cualquier rechazo de una reclamación para beneficios presentando un pedido por escrito con:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

Si su reclamación de beneficios se deniega o si no recibe una respuesta a su reclamación dentro del plazo correspondiente (en cuyo caso la reclamación de beneficios se considera denegado), usted o su representante pueden apelar su reclamación denegada por escrito a Prudential dentro de un plazo de 180 días a partir de la recepción del aviso de denegación por escrito o 180 días a partir de la fecha en que dicho reclamación se considere denegado. Puede presentar comentarios con sus apelaciones por escrito, documentos, archivos y cualquier otra información relacionada con su reclamación. Si lo solicita, también tendrá acceso y derecho a obtener copias de todos los documentos, registros e información pertinentes para su reclamación de forma gratuita.

Prudential llevará a cabo una revisión exhaustiva de la información contenida en el expediente de reclamación y de cualquier información nueva que se presente para apoyar la apelación, utilizando personas que no hayan participado en la determinación inicial del beneficio. Esta revisión no otorgará ninguna deferencia a la determinación inicial del beneficio.

Prudential tomará una determinación sobre su reclamación de apelación dentro de los 45 días posteriores a la recepción de su reclamación de apelación. Este periodo se puede extender hasta otros 45 días si Prudential determina que existen circunstancias especiales que requieren una prórroga. En el plazo inicial de 45 días se le facilitará un aviso por escrito de la extensión, el motivo de esta y la fecha en que Prudential espera tomar una decisión. No obstante, si se extiende el plazo debido a que usted no ha presentado la información necesaria para tomar una decisión sobre la apelación, el plazo para determinar el beneficio quedará suspendido desde la fecha en que se le envíe el aviso de la prórroga hasta la fecha en que usted responda a la solicitud de información adicional.

Si se rechaza la apelación en su totalidad o en parte, recibirá una notificación por escrito de Prudential sobre el rechazo. El aviso se redactará de forma que el solicitante pueda entenderlo y deberá incluir:

- Las razones específicas para la determinación desfavorable
- Referencia a las disposiciones específicas del plan en las cuales se basó la determinación
- Una declaración que establece que usted tiene derecho a recibir, si lo solicita y sin cargo, acceso razonable a todos los documentos, archivos y otra información relevante para su reclamación de beneficios y a obtener copias de dicha documentación
- Una descripción de los procedimientos de revisión de Prudential y los plazos aplicables
- Una declaración en la cual se establece que usted tiene derecho a obtener, cuando la solicite y sin cargo, una copia de las normas o pautas internas en las cuales se basaron para tomar la determinación; y
- Una declaración que describa los procedimientos de apelación ofrecidos por el plan.

Si no se lo informa de una decisión sobre la apelación dentro de los plazos mencionados anteriormente, la reclamación debe considerarse rechazada en la apelación.

Consulte **Fechas límite para presentar una reclamación o iniciar acciones legales** anteriormente en este capítulo en lo referido a la fecha límite para presentar una acción legal.

SEGUNDA APELACIÓN VOLUNTARIA DE LAS RECLAMACIONES POR SEGURO DE VIDA, POR ACCIDENTE EN VIAJE DE NEGOCIOS O POR MUERTE ACCIDENTAL Y DESMEMBRAMIENTO

Si la apelación de su reclamación de beneficios se deniega o si no recibe una respuesta a su apelación dentro del plazo correspondiente (en cuyo caso la apelación se considera denegada), usted o su representante pueden presentar una segunda apelación voluntaria de su denegación por escrito a Prudential en un plazo de 180 días a partir de la fecha cuando recibió el aviso por escrito de denegación o de 180 días a partir de la fecha en que tal reclamación se considere denegada. *No está obligado a solicitar una revisión voluntaria para que se considere que ha agotado los recursos administrativos.* Consulte **Fechas límite para presentar una reclamación o iniciar acciones legales** anteriormente en este capítulo en lo referido a la fecha límite para presentar una acción legal.

Puede presentar comentarios con su segunda apelación por escrito, documentos, archivos y cualquier otra información relacionada con su reclamación. Si lo solicita, también tendrá acceso y derecho a obtener copias de todos los documentos, registros e información pertinentes para su reclamación de forma gratuita.

Prudential tomará una determinación sobre su segunda apelación dentro de los 45 días posteriores a la recepción de su reclamación de apelación. Este periodo se puede extender hasta otros 45 días si Prudential determina que existen

circunstancias especiales que requieren una prórroga. En el plazo inicial de 45 días se le facilitará un aviso por escrito de la extensión, el motivo de esta y la fecha en que Prudential espera tomar una decisión. No obstante, si se extiende el plazo debido a que usted no ha presentado la información necesaria para tomar una decisión sobre la apelación, el plazo para determinar el beneficio quedará suspendido desde la fecha en que se le envíe el aviso de la prórroga hasta la fecha en que usted responda a la solicitud de información adicional.

Si la reclamación para la apelación se deniega total o parcialmente por segunda vez, recibirá un aviso por escrito de Prudential sobre la denegación. El aviso se redactará de una manera que el solicitante pueda entender e incluirá la misma información que se incluyó en la primera carta de determinación adversa. Si no se lo informa de una decisión sobre la apelación dentro de los plazos mencionados anteriormente, la reclamación debe considerarse rechazada en la apelación.

Proceso de reclamaciones y apelaciones para las reclamaciones por la cobertura de discapacidad a corto plazo

NOTA: Esta sección describe el proceso de reclamación y recurso del plan de discapacidad a corto plazo a tiempo completo pagado por hora (básico y mejorado). Para obtener información sobre las reclamaciones y las apelaciones de los planes de discapacidad a corto plazo para los asociados asalariados y los conductores de camión, consulte los capítulos respectivos.

PRESENTAR UNA RECLAMACIÓN DE BENEFICIOS POR DISCAPACIDAD A CORTO PLAZO CONFORME AL PLAN DE DISCAPACIDAD A CORTO PLAZO PARA ASOCIADOS A TIEMPO COMPLETO PAGADOS POR HORA

Si queda discapacitado, debe presentar de manera oportuna su reclamación para recibir los beneficios. Un retraso en la presentación podría dar lugar al pago retrasado del beneficio, a la interrupción de su salario o al rechazo de su reclamación. El calendario y el proceso que debe seguir para presentar una reclamación de beneficios por discapacidad a corto plazo dependen de si el plan de discapacidad a corto plazo está disponible en su localidad (es decir, si se encuentra en un estado o localidad que ofrezca beneficios obligatorios por ley). Consulte las **Instrucciones para presentar una reclamación** en la siguiente página para obtener información sobre cómo presentar su reclamación.

PASO 1: Póngase en contacto con Sedgwick para solicitar una licencia. Independientemente del proceso que siga para presentar una reclamación de discapacidad a corto plazo ante el Plan, deberá ponerse en contacto con Sedgwick a través de **One.Walmart.com/LOA > mySedgwick** o llamando al **800-492-5678** para solicitar una licencia de ausencia en cuanto sepa que va a faltar al empleo debido a una enfermedad, lesión o embarazo. Sedgwick le enviará un paquete inicial en el que se encontrará la información que necesita y se describirán las medidas que debe tomar.

La política de licencia de ausencia no es un beneficio que se ofrece conforme al Plan ni es administrado como parte del Plan, por lo que no se aborda aquí detalladamente. Consulte **One.Walmart.com** para obtener información específica sobre la política de licencias de ausencia. La aprobación de una licencia conforme a la política de licencias de Walmart no significa que se apruebe automáticamente su reclamación de discapacidad a corto plazo. Para obtener más detalles, consulte **Cuándo comienzan los beneficios** en el capítulo **Discapacidad a corto plazo para asociados a tiempo completo pagados por hora**.

PASO 2: Presentar una reclamación de discapacidad a corto plazo o de beneficios obligatorios por ley. Su reclamación de beneficios por discapacidad a corto plazo no puede procesarse completamente hasta que haya dejado de trabajar. Notifique a su gerente si su enfermedad o lesión está relacionada con su trabajo en Walmart a fin de iniciar una reclamación por la compensación para trabajadores.

NOTA: La fecha de presentación de su reclamación es la fecha en la que presenta su reclamación de discapacidad a Sedgwick. Para que Sedgwick comience a revisar su reclamación, debe haber dejado de trabajar por completo. Si presenta su reclamación antes del primer día de ausencia, Sedgwick comenzará a procesar su reclamación a partir del primer día de ausencia. Si presenta su reclamación el primer día de licencia o posteriormente, Sedgwick iniciará la revisión a partir de la fecha comunicada.

Para presentar una reclamación a Sedgwick, puede llamar al **800-492-5678** o presentarlo por correo a la siguiente dirección:

Sedgwick Claims Management Services, Inc.
P.O. Box 14748
Lexington, Kentucky 40512-4748

Si se encuentra en un estado o localidad que ofrece un beneficio obligatorio, debe presentar su reclamación en el estado o localidad correspondiente. Consulte la tabla de la siguiente página para saber dónde y cuándo presentar su reclamación.

INSTRUCCIONES PARA PRESENTAR RECLAMACIONES

Su estado o localidad puede tener periodos de presentación únicos, lo que podría excluir los beneficios correspondientes a periodos anteriores a la fecha de su solicitud de beneficios. Le recomendamos encarecidamente que solicite los beneficios requerido por ley en su estado o localidad sin demora.

Estado o localidad	Elegibilidad	Administración de reclamaciones	Instrucciones de presentación
CA, RI	No tiene derecho a la cobertura de discapacidad a corto plazo básica o mejorada de Walmart Derecho a la maternidad, como complemento de los beneficios obligatorios por ley	Estado donde se ofrece el beneficio obligatorio por ley Sedgwick para maternidad	**CA:** Visite **edd.ca.gov** o llame al **800-480-3287** para obtener instrucciones **RI:** Visite **www.dlt.ri.gov/tdi** o llame al **401-462-8420** para obtener instrucciones Para obtener beneficios de maternidad, presente una reclamación ante Sedgwick dentro de los 90 días posteriores a la fecha en que su discapacidad haya comenzado; deberá facilitar la carta de determinación del estado que incluya los detalles de los beneficios. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.
HI, NJ	No tiene derecho a la cobertura de discapacidad a corto plazo básica o mejorada de Walmart Derecho a la maternidad, como complemento de los beneficios obligatorios por ley	Lincoln Sedgwick para maternidad	**HI:** Presente una reclamación a Sedgwick en un plazo de 90 días a partir de la fecha de inicio de su discapacidad y Sedgwick la remitirá a Lincoln. **NJ:** Presente una reclamación a Sedgwick en un plazo de 30 días a partir de la fecha de inicio de su discapacidad y Sedgwick la remitirá a Lincoln. Para el beneficio de maternidad, presente una reclamación con Sedgwick dentro de los 90 días de la fecha en que comienza la discapacidad. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.
CO, CT, MA, OR, WA **Washington D. C.**	Si es elegible para el plan de discapacidad a corto plazo de Walmart como complemento a los beneficios obligatorios por ley	Estado o distrito de beneficios obligatorios por ley Sedgwick para beneficios complementarios y de maternidad	**CO:** Visite **famli.colorado.gov** o llame al **866-263-2654** para obtener instrucciones **CT:** Visite **ctpaidleave.org** o llame al **877-499-8606** para obtener instrucciones **MA:** Visite **paidleave.mass.gov** o llame al **833-344-7365** para obtener instrucciones **OR:** Visite **paidleave.oregon.gov** o llame al **833-854-0166** para obtenerinstrucciones **WA:** Visite **paidleave.wa.gov** o llame al **833-717-2273** para obtener instrucciones **D.C.:** Visite **dcpaidfamilyleave.dc.gov** o llame al **202-899-3700** para obtener instrucciones **Sedgwick:** Presente una reclamación ante Sedgwick dentro de los 90 días posteriores a la fecha en que su discapacidad haya comenzado; deberá facilitar la carta de determinación del estado o distrito que incluya los detalles de los beneficios estatales o del distrito. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.
NY	Si es elegible para el plan de discapacidad a corto plazo de Walmart como complemento a los beneficios obligatorios por ley	Lincoln Sedgwick para beneficios complementarios y de maternidad	Presente una reclamación a Sedgwick en un plazo de 30 días a partir de la fecha de inicio de su discapacidad y Sedgwick la remitirá a Lincoln. Para el beneficio de maternidad, presente una reclamación con Sedgwick dentro de los 90 días de la fecha en que comienza la discapacidad. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.
Todos los demás	Si es elegible para el plan de discapacidad a corto plazo de Walmart	Sedgwick	Presente una reclamación con Sedgwick dentro de los 90 días de la fecha en que comienza la discapacidad. Es posible que Sedgwick desestime las reclamaciones que se presenten trascurridos los 90 días de la fecha en que comienza la discapacidad, a menos que la aseguradora determine que hay una buena causa para la presentación tardía.

PASO 3: Informe al consultorio de su médico que se pondrá en contacto para solicitar información. Infórmele a su médico que se comunicarán con él para que complete un certificado médico y para pedirle que proporcione información médica, incluida la siguiente:

- Diagnóstico
- Fecha y duración prevista de la discapacidad
- Restricciones y limitaciones
- Conclusiones de exámenes cognitivos y/o físicos y resultados de pruebas
- Plan de tratamiento, y
- Notas de las consultas médicas.

Debe firmar un formulario que autorice a su médico a divulgar esta información. (Este formulario se incluirá en el paquete inicial que reciba de Sedgwick. Sin embargo, si presenta su reclamación en línea, se acepta una firma electrónica).

PASO 4: Realice un seguimiento con su médico para asegurarse de que la información haya sido enviada a Sedgwick. Cualquier retraso en el envío de la información a Sedgwick podría tener como resultado un retraso, o rechazo, en el procesamiento de su reclamación y el pago de los beneficios.

Las reclamaciones se determinan dentro de los plazos y requisitos establecidos en este capítulo. Tiene derecho a apelar una reclamación rechazada. Consulte **Cómo apelar una reclamación de discapacidad a corto plazo que se rechazó en su totalidad o en parte** que se ha denegado total o parcialmente más adelante en este capítulo.

Es posible que se le exija una prueba por escrito de su discapacidad o información médica adicional antes de que se apruebe su reclamación.

DETERMINACIÓN INICIAL DE LA RECLAMACIÓN

Consulte la tabla en la página anterior para informarse sobre las fechas límite de presentación. Una vez que se presentó una reclamación, se tomará una decisión en un periodo de no más de 45 días a partir de la recepción de la reclamación correctamente presentado. El tiempo para la decisión se puede extender hasta dos periodos de 30 días adicionales siempre que, antes de cualquier periodo de prórroga, se le notifique por escrito que se necesita una extensión debido a asuntos que están fuera de su control, se identifiquen esos asuntos y se le proporcione la fecha en la que se presentará su decisión. Si su reclamación se extiende debido a que usted no presenta información necesaria para la determinación de su reclamación, el tiempo de decisión se puede anunciar a partir de la fecha en la cual se le envía la notificación de la prórroga hasta la fecha en que se recibe su respuesta. Si se aprueba su reclamación, la decisión contendrá información suficiente para informarle de forma razonable sobre esa decisión.

Toda determinación de beneficio desfavorable se hará por escrito y contendrá lo siguiente:

- Razones específicas para la decisión
- Referencia específica a las disposiciones del Plan en la cual se basa la decisión
- Un análisis de la decisión, incluida una explicación de lo básico para estar en desacuerdo o no seguida de lo siguiente:
  - Las opiniones que presente ante los profesionales de atención médica del Plan que lo tratan y los profesionales vocacionales que lo evaluaron
  - Las opiniones de los expertos médicos o vocacionales cuyo consejo se obtuvo por cuenta del Plan en conexión con su determinación de beneficio desfavorable, independientemente de si se basó en el consejo para tomar la determinación del beneficio, y
  - Una determinación de discapacidad sobre usted realizada por la Administración de Seguridad Social y presentada por usted ante el Plan.
- Las reglas internas específicas, pautas, protocolos, estándares u otros criterios similares del Plan en los que se basaron para tomar la determinación desfavorable o, alternativamente, una declaración de que estas reglas, pautas, protocolos, estándares u otros criterios similares del Plan no existen
- Si la determinación de beneficio desfavorable se basa en una necesidad médica, un tratamiento experimental o una exclusión o límite similar, una explicación del veredicto científico o clínico para la determinación, que aplique los términos del Plan a sus circunstancias médicas, o una declaración de que esa explicación se proporcionará de forma gratuita a pedido
- Una descripción de cualquier material adicional o información necesaria para que usted sustente la reclamación y una explicación de por qué es necesario dicho material o información
- Una declaración que establece que usted tiene derecho a recibir, si lo solicita y sin cargo, acceso razonable a todos los documentos, archivos y otra información relevante para su reclamación de beneficios y a obtener copias de dicha documentación
- Una descripción de los procedimientos de revisión y límites de tiempo aplicables a tales procedimientos, y
- Una declaración que establece que tiene derecho a iniciar acciones civiles conforme a la Sección 502(a) de ERISA (incluida una descripción de cualquier periodo de limitaciones contractuales que se aplique y la fecha en la que el periodo de limitaciones contractuales vence).

CÓMO APELAR UNA RECLAMACIÓN DE DISCAPACIDAD A CORTO PLAZO QUE SE RECHAZÓ EN SU TOTALIDAD O EN PARTE

NOTA: Si su reclamación de beneficios por discapacidad a corto plazo es denegada porque Sedgwick no ha recibido documentación médica objetiva que respalde su reclamación, o la documentación facilitada no respalda su reclamación, dispondrá de un periodo de gracia de 30 días calendario a partir de la fecha de la carta de denegación para presentar información médica objetiva a Sedgwick para su revisión sin necesidad de presentar una apelación. Una vez que termine el periodo de gracia, si su reclamación sigue rechazada y desea apelar, debe enviar una apelación formal oral o por escrito a Sedgwick o Lincoln (según corresponda) dentro de los 180 días luego del rechazo.

En el caso de los asociados de estados o localidades con programas obligatorios por ley en California, Colorado, Connecticut, Massachusetts, Oregón, Rhode Island, Washington D.C. y el estado de Washington, debe presentar su apelación de una determinación relativa a una reclamación de beneficios obligatorios directamente al gobierno estatal o local. Para obtener más información, incluidos los plazos de presentación, llame al número de teléfono correspondiente que figura en la tabla **Recursos** al comienzo del capítulo **Discapacidad a corto plazo para asociados a tiempo completo pagados por hora**.

Si su apelación se refiere a una reclamación denegada por Sedgwick o Lincoln y desea apelar, debe presentar una apelación escrita u oral a Sedgwick o una apelación escrita a Lincoln (según corresponda) dentro de los 180 días de la denegación a la siguiente dirección, según corresponda:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

Recursos para asociados en Hawái, Nueva Jersey y Nueva York: Envíe su apelación a la entidad apropiada que figura a continuación, dependiendo de sus circunstancias particulares:

BENEFICIO	DIRIJA SU APELACIÓN A
Apelaciones por discapacidad a corto plazo mejorados y licencia familiar con goce de sueldo de Nueva York	**Group Benefits Claims Appeal Unit** **Lincoln Financial Group** **Group – Charlotte WM** **Attn: Appeal Review Unit** **P.O. Box 2578** **Omaha, Nebraska 68172-9688**
Apelaciones contra la Ley de beneficios por discapacidad de Nueva York	**Workers' Compensation Board** **Disability Benefits Bureau** **P.O. Box 9029** **Endicott, NY 13761-9029**
Apelaciones contra el Seguro de Discapacidad Temporal de Nueva Jersey	**New Jersey Department of Labor and Workforce Development** **Division of Temporary Disability Insurance** **Private Plan Compliance** **P.O. Box 957** **Trenton, NJ 08625-0957**

Su apelación se llevará a cabo independientemente de la determinación inicial y estará a cargo de una persona que no sea quien tomó la decisión sobre su reclamación inicial ni un subordinado de la persona que tomó la decisión sobre su reclamación inicial. No se permitirá la postergación de la determinación inicial. Usted tendrá la oportunidad de enviar comentarios por escrito, documentos u otra información que respalden su apelación. Tiene derecho a solicitar copias, sin cargo, de todos los documentos, archivos u otra información relacionada con su reclamación. El administrador de terceros, en nombre del Plan, le proporcionará toda prueba nueva o adicional o los fundamentos considerados en el marco de su reclamación, con tiempo suficiente antes de la fecha de la determinación de las apelaciones, a fin de darle una oportunidad razonable de responder.

Si su reclamación involucra una cuestión de criterio médico, un administrador de terceros en nombre del Plan consultará a un profesional de atención de la salud que tenga las calificaciones, la capacitación y la experiencia apropiadas en el campo de la medicina involucrado. Si se consultó a un profesional de atención de la salud para la determinación inicial, la apelación se consultará con un profesional de atención de la salud diferente. Cuando lo solicite, el administrador de terceros en nombre del Plan le proporcionará la identificación de todo experto médico cuyo asesoramiento se obtuvo en nombre del Plan en conexión con su apelación.

Sedgwick o Lincoln (según corresponda) tomarán una determinación sobre su apelación dentro de los 45 días posteriores a la recepción de su solicitud de apelación. Este periodo se puede extender hasta 45 días adicionales si se determina que circunstancias especiales requieren una prórroga. Si se requiere una prórroga, se lo notificarán antes de que finalice el periodo de 45 días. Si se le pide que suministre información adicional, tendrá 45 días a partir de la fecha en que se lo notifica para que proporcione la información y se suspenderá el tiempo para tomar una determinación hasta que proporcione la información que se le solicitó (o la fecha límite para presentar la información, si es anterior).

Si se rechaza su apelación en su totalidad o en parte, recibirá una notificación por escrito sobre el rechazo que incluirá:

- Las razones específicas para la determinación desfavorable
- Referencia a las disposiciones específicas del plan en las cuales se basó la determinación
- Un análisis de la decisión, incluida una explicación de lo básico para estar en desacuerdo o no seguida de lo siguiente:
  - Las opiniones presentadas por usted a los profesionales del Plan de atención de la salud que lo tratan y los profesionales vocacionales que lo evaluaron
  - Las opiniones de los expertos médicos o vocacionales cuyo consejo se obtuvo por cuenta del Plan en conexión con su determinación de beneficio desfavorable, independientemente de si se basó en el consejo para tomar la determinación del beneficio, y
  - Una determinación de discapacidad sobre usted realizada por la Administración de Seguridad Social y presentada por usted ante el Plan.
- Las reglas internas específicas, pautas, protocolos, estándares u otros criterios similares del Plan en los que se basaron para tomar la determinación desfavorable o, alternativamente, una declaración de que estas reglas, pautas, protocolos, estándares u otros criterios similares del Plan no existen
- Si la determinación de beneficio desfavorable se basa en una necesidad médica, un tratamiento experimental o una exclusión o límite similar, una explicación del veredicto científico o clínico para la determinación, que aplique los términos del Plan a sus circunstancias médicas, o una declaración de que esa explicación se proporcionará de forma gratuita, a pedido
- Una declaración que establece que usted tiene derecho a recibir, si lo solicita y sin cargo, acceso razonable a todos los documentos, archivos y otra información relevante para su reclamación de beneficios y a obtener copias de dicha documentación, y
- Una declaración que establece que tiene derecho a iniciar acciones civiles conforme a la Sección 502(a) de ERISA (incluida una descripción de cualquier periodo de limitaciones contractuales que se aplique y la fecha en la que el periodo de limitaciones contractuales vence).

Consulte **Fechas límite para presentar una reclamación o iniciar acciones legales** anteriormente en este capítulo en lo referido a la fecha límite para presentar una acción legal.

Consulte **Cómo apelar una decisión sobre inscripciones o estados de elegibilidad** anteriormente en este capítulo para obtener información sobre la apelación de las decisiones de elegibilidad.

En el caso de los asociados asalariados y los conductores de camión, consulte el capítulo **Plan de discapacidad a corto plazo para asociados asalariados** o **Plan de discapacidad a corto plazo para conductores de camión**, según corresponda, para obtener información detallada sobre el proceso de apelaciones para dichos planes.

AUTORIDAD DEL ADMINISTRADOR DE RECLAMACIONES POR DISCAPACIDAD A CORTO PLAZO

Sedgwick o Lincoln (según corresponda) tendrán la autoridad discrecional única y exclusiva para interpretar las disposiciones sobre discapacidad a corto plazo del Plan con respecto a todas las reclamaciones de beneficios por discapacidad a corto plazo debidamente presentadas por un participante o beneficiario del Plan, sujeto a los requisitos de ERISA. La determinación de Sedgwick o Lincoln (según corresponda) sobre la revisión de una apelación se realizará de manera justa y coherente de forma que se pueda garantizar la independencia e imparcialidad de las personas involucradas en el proceso de toma de decisiones, de acuerdo con los términos del Plan, y su decisión será definitiva, sujeta únicamente a la determinación de un tribunal de jurisdicción competente de que su decisión fue arbitraria o caprichosa.

SEGUNDA APELACIÓN VOLUNTARIA DE UNA RECLAMACIÓN POR BENEFICIOS CONFORME AL PLAN DE DISCAPACIDAD A CORTO PLAZO PARA ASOCIADOS PAGADOS POR HORA A TIEMPO COMPLETO

Si es un asociado pagado por hora a tiempo completo cuya cobertura por discapacidad a corto plazo es administrada a través de Sedgwick y su apelación se rechaza, puede realizar una segunda apelación voluntaria de su rechazo oralmente o por escrito a Sedgwick. Debe presentar su segunda apelación dentro de los 180 días luego de recibir la notificación escrita del rechazo. Puede presentar comentarios por escrito, documentos, archivos y cualquier otra información relacionada con su reclamación. Por lo general, los mismos criterios y tiempos de respuesta que se aplicaron a su primera apelación se aplican a esta segunda apelación voluntaria, tal como se describe anteriormente.

Las segundas apelaciones voluntarias para beneficios por discapacidad a corto plazo se deben enviar a:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

Consulte **Fechas límite para presentar una reclamación o iniciar acciones legales** anteriormente en este capítulo en lo referido a la fecha límite para presentar una acción legal.

Proceso de reclamaciones y apelaciones para las reclamaciones por la cobertura de discapacidad a largo plazo

Las reclamaciones de reembolso del plan de discapacidad a largo plazo deben dirigirse a:

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

Si tiene una reclamación aprobada de discapacidad a corto plazo, Sedgwick la transferirá automáticamente a Lincoln para su consideración. También puede llamar a Lincoln al **877-353-6404** para solicitar un formulario de reclamación en cuanto sepa que necesitará utilizar su beneficio por discapacidad a largo plazo, pero a más tardar 30 días después de que el beneficio por discapacidad a largo plazo comenzaría. De no ser posible, deberá llamar a Lincoln en cuanto sea razonablemente posible para hacerlo. Lincoln le proporcionará información adicional sobre cómo completar su reclamación.

Si usted eligió el plan de discapacidad a largo plazo para conductores de camión y se le pidió que presentara evidencia de buena salud, pero su evidencia no fue aprobada, puede presentar una apelación por escrito a Lincoln Financial Group. Comuníquese con Lincoln Financial Group para conocer los procedimientos específicos relativos a la apelación de una decisión de evidencia de buena salud, incluidos los requisitos de tiempo. Envíe su apelación por correo electrónico a **EOIQuestions@lfg.co**. o por correo postal a:

Lincoln Financial Group
ATTN: Medical Underwriting
P.O. Box 2870
Omaha, NE 68103-2870

Una vez que se haya presentado una reclamación, Lincoln le notificará su decisión sobre la misma dentro de un periodo razonable de tiempo, pero no más de 45 días después de la recepción de su reclamación debidamente presentada. El tiempo para la decisión se puede extender hasta dos periodos de 30 días adicionales siempre que, antes de cualquier periodo de prórroga, se le notifique por escrito que se necesita una extensión debido a asuntos que están fuera del control de Lincoln, se identifiquen esos asuntos y se le proporcione la fecha en la que se presentará su decisión. Si su reclamación se extiende debido a que usted no presenta información necesaria para la determinación de su reclamación, el tiempo de decisión se puede anunciar a partir de la fecha en la cual se le envía la notificación de la prórroga hasta la fecha en que se recibe su respuesta. Si se aprueba su reclamación, la decisión contendrá información suficiente para informarle de forma razonable sobre esa decisión.

Toda determinación de beneficio desfavorable se hará por escrito y contendrá lo siguiente:

- Razones específicas para la decisión
- Referencia específica a las disposiciones del Plan en la cual se basa la decisión
- Un análisis de la decisión, incluida una explicación de lo básico para estar en desacuerdo o no seguida de lo siguiente:
  - Las opiniones que presente ante los profesionales de atención médica del Plan que lo tratan y los profesionales vocacionales que lo evaluaron
  - Las opiniones de los expertos médicos o vocacionales cuyo consejo se obtuvo por cuenta del Plan en conexión con su determinación de beneficio desfavorable, independientemente de si se basó en el consejo para tomar la determinación del beneficio, y
  - Una determinación de discapacidad sobre usted realizada por la Administración de Seguridad Social y presentada por usted ante el Plan.
- Las reglas internas específicas, pautas, protocolos, estándares u otros criterios similares del Plan en los que se basaron para tomar la determinación desfavorable o, alternativamente, una declaración de que estas reglas, pautas, protocolos, estándares u otros criterios similares del Plan no existen
- Si la determinación de beneficio desfavorable se basa en una necesidad médica, un tratamiento experimental o una exclusión o límite similar, una explicación del veredicto científico o clínico para la determinación, que aplique los términos del Plan a sus circunstancias médicas, o una declaración de que esa explicación se proporcionará de forma gratuita, a pedido
- Una descripción de cualquier material adicional o información necesaria para que usted sustente la reclamación y una explicación de por qué es necesario dicho material o información
- Una declaración que establece que usted tiene derecho a recibir, si lo solicita y sin cargo, acceso razonable a todos los documentos, archivos y otra información relevante para su reclamación de beneficios y a obtener copias de dicha documentación
- Una descripción de los procedimientos de revisión y límites de tiempo aplicables a tales procedimientos, y
- Una declaración que establece que tiene derecho a iniciar acciones civiles conforme a la Sección 502(a) de ERISA (incluida una descripción de cualquier periodo de limitaciones contractuales que se aplique y la fecha en la que el periodo de limitaciones contractuales vence).

CÓMO APELAR UNA RECLAMACIÓN DE DISCAPACIDAD A LARGO PLAZO QUE SE RECHAZÓ EN SU TOTALIDAD O EN PARTE

Si se rechaza su reclamación para obtener los beneficios de discapacidad a largo plazo y desea apelar, debe enviar una apelación por escrito a Lincoln dentro de los 180 días posteriores al rechazo.

Su apelación se llevará a cabo independientemente de la determinación inicial y estará a cargo de una persona que no sea quien tomó la decisión sobre su reclamación inicial ni un subordinado de la persona que tomó la decisión sobre su reclamación inicial. No se permitirá la postergación de la determinación inicial. Usted tendrá la oportunidad de enviar comentarios por escrito, documentos u otra información que respalden su apelación. Tiene derecho a solicitar copias, sin cargo, de todos los documentos, archivos u otra información relacionada con su reclamación. Lincoln le proporcionará toda prueba nueva o adicional o los fundamentos considerados en el marco de su reclamación, con tiempo suficiente antes de la fecha de la determinación de las apelaciones, a fin de darle una oportunidad razonable de responder.

Si su reclamación involucra una cuestión de criterio médico, Lincoln consultará a un profesional de atención de la salud que tenga las calificaciones, la capacitación y la experiencia apropiadas en el campo de la medicina involucrado. Si se consultó a un profesional de atención de la salud para la determinación inicial, la apelación se consultará con un profesional de atención de la salud diferente. Si lo solicita, Lincoln le proporcionará la identificación de cualquier experto médico cuyo asesoramiento se haya obtenido en relación con su apelación. Lincoln tomará una determinación sobre su apelación dentro de los 45 días a partir de la recepción de su solicitud de apelación. Este periodo se puede extender hasta 45 días adicionales si se determina que circunstancias especiales requieren una prórroga. Si se requiere una prórroga, se lo notificarán antes de que finalice el periodo de 45 días. Si se le pide que suministre información adicional, tendrá 45 días a partir de la fecha en que se lo notifica para que proporcione la información y se suspenderá el tiempo para tomar una determinación hasta que proporcione la información que se le solicitó (o la fecha límite para presentar la información, si es anterior).

Si se rechaza su apelación de forma parcial o total, recibirá una notificación por escrito sobre el rechazo que incluirá:

- Las razones específicas para la determinación desfavorable
- Referencia a las disposiciones específicas del plan en las cuales se basó la determinación
- Un análisis de la decisión, incluida una explicación de lo básico para estar en desacuerdo o no seguida de lo siguiente:
  - Las opiniones presentadas por usted a los profesionales de Lincoln de atención de la salud que lo tratan y los profesionales vocacionales que lo evaluaron.
  - Las opiniones de los expertos médicos o vocacionales cuyo consejo se obtuvo por cuenta del Plan en conexión con su determinación de beneficio desfavorable, independientemente de si se basó en el consejo para tomar la determinación del beneficio, y
  - Una determinación de discapacidad sobre usted realizada por la Administración de Seguridad Social y presentada por usted ante el Plan.
- Las reglas internas específicas, pautas, protocolos, estándares u otros criterios similares del Plan en los que se basaron para tomar la determinación desfavorable o, alternativamente, una declaración de que estas reglas, pautas, protocolos, estándares u otros criterios similares del Plan no existen
- Si la determinación de beneficio desfavorable se basa en una necesidad médica, un tratamiento experimental o una exclusión o límite similar, una explicación del veredicto científico o clínico para la determinación, que aplique los términos del Plan a sus circunstancias médicas, o una declaración de que esa explicación se proporcionará de forma gratuita, a pedido
- Una declaración que establece que usted tiene derecho a recibir, si lo solicita y sin cargo, acceso razonable a todos los documentos, archivos y otra información relevante para su reclamación de beneficios y a obtener copias de dicha documentación, y
- Una declaración que establece que tiene derecho a iniciar acciones civiles conforme a la Sección 502(a) de ERISA (incluida una descripción de cualquier periodo de limitaciones contractuales que se aplique y la fecha en la que el periodo de limitaciones contractuales vence).

Consulte **Fechas límite para presentar una reclamación o iniciar acciones legales** anteriormente en este capítulo en lo referido a la fecha límite para presentar una acción legal.

Consulte **Cómo apelar una decisión sobre inscripciones o estados de elegibilidad** anteriormente en este capítulo para obtener información sobre la apelación de las decisiones de elegibilidad.

Mis recursos de salud mental

No es necesario que presente una reclamación de beneficios de Mis recursos de salud mental. Puede acceder al sitio web de Lyra o ponerse en contacto con Lyra por teléfono en cualquier momento mientras siga siendo elegible. Sin embargo, si tiene preguntas sobre sus beneficios o no está de acuerdo con los beneficios que le ofrecen, puede llamar a Servicios al Personal al **800-421-1362** o presentar una reclamación por escrito a la siguiente dirección:

Mail Stop 3610–Benefits Total Rewards Team
Attn: Custodian of Records
508 SW 8th Street
Mail Stop #3610
Bentonville, Arkansas 72716-3610

Las reclamaciones y las apelaciones se determinan según los plazos y los requisitos para los procedimientos de presentación de reclamaciones de beneficios médicos que se establecen anteriormente en el capítulo.

Seguro médico durante viajes de negocios internacionales

Por lo general, los formularios para reclamaciones no se requieren para los servicios de GeoBlue. Sin embargo, si tiene alguna pregunta sobre sus beneficios o no está de acuerdo con los beneficios que le ofrecen, puede comunicarse con GeoBlue o presentar una reclamación. Para enviar una reclamación por correo electrónico o por fax, descargue un formulario de reclamación y consulte las instrucciones detalladas en el Centro para Miembros en **geo-blue.com**. Envíe su reclamación por correo electrónico a **claims@geo-blue.com** o por fax al **610-482-9623**.

También puede enviar reclamaciones por correo postal. Descargue un formulario de reclamación del Centro para Miembros en geo-blue.com y envíe el formulario completo a:

GeoBlue
Claims Department
P.O. Box 1748
Southeastern, Pennsylvania 19399-1748

Las reclamaciones y las apelaciones se determinarán conforme a los plazos y los requisitos establecidos en la póliza de GeoBlue. Comuníquese con GeoBlue en cualquier momento llamando al **888-412-6403**. Fuera de los EE. UU., llame por cobrar al: **610-254-5830**.

Información legal

Información legal

El *Libro de beneficios para asociados* de 2025 contiene capítulos separados que, en conjunto, constituyen la Descripción resumida del plan (SPD, por sus siglas en inglés) del Plan de Salud y Bienestar de los Asociados de Walmart Inc. (el Plan). En concreto, el DOCUP del Plan (*Libro de beneficios para asociados* de 2025) incluye los siguientes capítulos:

- **Elegibilidad, inscripción y fechas de vigencia**
- **Elegibilidad, inscripción y fechas de vigencia para los asociados en Hawái**
- **Plan médico**
- **Beneficio de farmacia**
- **Plan dental**
- **Plan de la visión**
- **Recursos de asistencia para los asociados (excepto Help Now)**
- **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)**
- **Plan de discapacidad a corto plazo para asociados a tiempo completo pagados por hora**
- **Plan de discapacidad a largo plazo**
- **Discapacidad a largo plazo para conductores de camión**
- **Seguro de vida pagado por la compañía**
- **Seguro de vida opcional para asociados**
- **Seguro de vida opcional para dependientes**
- **Seguro contra accidentes durante viajes de negocios**
- **Seguro contra accidentes**
- **Seguro por muerte accidental y desmembramiento (AD&D)**
- **Seguro por enfermedades graves**
- **Reclamaciones y apelaciones**

En este capítulo **Información legal** de la SPD, encontrará información administrativa importante y datos sobre sus derechos como participante del Plan.

RECURSOS

Encuentre lo que necesita	En línea	Otros recursos
Comuníquese con el administrador del Plan		Escriba a: **Mail Stop 3610–Plan Administrator** **Administrative Committee** **Associates' Health and Welfare Plan** **508 SW 8th Street** **Mail Stop #3610** **Bentonville, Arkansas 72716-3610** **NOTA:** Debe enviar su solicitud a la dirección específica indicada anteriormente, incluida la Dirección interna. Si no envía su solicitud a esta dirección, el administrador del plan tardará en recibirla. Llame al **(479) 621-2058**
Respuestas a las preguntas sobre la notificación de privacidad de la HIPAA	Envíe su pregunta a **AHWPrivacy@walmart.com**	Llame a Servicios al Personal al **800-421-1362.**
Respuestas a las preguntas sobre los planes de medicamentos recetados de Medicare	Visite **medicare.gov**	**800-MEDICARE** (**800-633-4227**) Los usuarios de TTY deben llamar al **877-486-2048**
Respuestas a las preguntas sobre Medicaid/CHIP	Visite **insurekidsnow.gov**	**877-KIDSNOW** (**877-543-7669**)

Lo que debe saber sobre la información legal para el Plan de salud y bienestar para asociados

- Como participante del Plan, usted tiene ciertos derechos y protecciones conforme a la Ley de Garantía de los Ingresos de Jubilación para los Empleados (ERISA) de 1974 y sus enmiendas.
- La notificación de privacidad de la HIPAA que figura en este capítulo describe cómo se puede utilizar y revelar su información médica y cómo puede obtener acceso a esta información.
- La **Medicare y la cobertura de medicamentos recetados** sección que se encuentra en este capítulo explica las opciones que tiene dentro de la cobertura de medicamentos recetados de Medicare y lo puede ayudar a decidir si quiere inscribirse o no.
- En la notificación de Medicaid/Programa de Seguros de Salud para Niños (CHIP) se explican los derechos a la inscripción especial y a la asistencia para primas para individuos elegibles para estos programas.

Plan de Salud y Bienestar para Asociados

Walmart Inc. mantiene el Plan para el beneficio exclusivo de sus asociados y familiares elegibles. El Plan proporciona beneficios de salud y bienestar a través de los siguientes programas de beneficios:

- Beneficios médicos autoasegurados, incluidos los beneficios de farmacia*
- Seguro médico (incluido HMO)**
- Beneficios dentales autoasegurados
- Seguro de la visión
- Programa de asistencia para empleados autoasegurados (recursos de asistencia para los asociados, excepto Help Now)
- Plan de discapacidad a corto plazo autoasegurado para asociados a tiempo completo pagados por hora
- Seguro por discapacidad a largo plazo
- Seguro de vida pagado por la compañía
- Seguro de vida opcional para asociados
- Seguro de vida opcional para dependientes
- Seguro contra accidentes durante viajes de negocios
- Seguro contra accidentes
- Seguro contra muerte accidental o desmembramiento
- Seguro por enfermedades graves

Cada uno de los programas de beneficios (excepto el seguro médico) se resume en el capítulo respectivo de esta SPD. El seguro médico (incluido HMO) se resume en un folleto de certificado de seguro emitido por una compañía de seguros, un resumen preparado específicamente para ese programa de beneficios. Estos resúmenes también forman parte de la SPD del Plan.

Los términos y condiciones del Plan se exponen en esta SPD, en el Documento de cobertura del Plan de salud y bienestar para asociados (Documento de cobertura), y en las pólizas de seguro y otros documentos del programa de bienestar incorporados en el Documento de cobertura. El Documento de cobertura, junto con este libro y otros documentos incorporados, constituyen el instrumento escrito conforme a los cuales se establece y se mantiene el Plan. Una modificación de un documento incorporado, incluida esta SPD se considera una modificación del Plan.

*Los beneficios médicos autoasegurados incluyen las siguientes opciones de planes: Plan Premier, Plan Contribution, Plan Saver y los Planes Locales.

**El seguro médico incluye las siguientes opciones de plan: PPO Plan, los HMO.

Información de identificación del plan

Patrocinador del plan:
Walmart Inc.
702 SW 8th Street
Bentonville, Arkansas 72716-0295

Número de identificación del empleador (EIN) del patrocinador del plan: 71-0415188

Número del Plan: 501

Tipo de plan: seguro de bienestar, que incluye el seguro médico, dental, de la vista, el programa de asistencia al empleado, el seguro de discapacidad a corto plazo, seguro de discapacidad a largo plazo, el seguro de vida pagado por la compañía, el seguro de vida opcional para asociados y dependientes, el seguro contra accidentes en viajes de negocios, el seguro por accidentes, el seguro por muerte accidental y desmembramiento (AD&D) y el seguro por enfermedad grave.

Tipo de administración: el Plan es administrado por el Administrador del Plan. El administrador del plan tiene la facultad de delegar una parte o la totalidad de su responsabilidad fiduciaria en una parte externa. El Administrador del Plan ha delegado la responsabilidad fiduciaria para determinar las reclamaciones de beneficios y las apelaciones en virtud de los componentes de beneficios autofinanciados a los administradores de terceros. En el caso de los beneficios asegurados, las compañías de seguros tienen la responsabilidad fiduciaria de determinar las reclamaciones de beneficios y las apelaciones. El capítulo **Reclamaciones y apelaciones** de esta SPD, se identifica el administrador de la red subcontratado específico, incluidas las compañías de seguros que administran las reclamaciones y las apelaciones para los respectivos beneficios.

El Administrador del Plan (o sus delegados, incluidos los administradores de terceros y compañías aseguradoras que deciden sobre las reclamaciones y las apelaciones) tiene el criterio absoluto para interpretar y definir las disposiciones del Plan, sacar conclusiones de hecho, corregir errores y suplir omisiones. Todas las decisiones e interpretaciones del Administrador del Plan (o su delegado) adoptadas conforme al Plan serán finales, concluyentes y vinculantes para todas las personas y no se pueden anular a menos que un tribunal las considere arbitrarias e inusuales. Los beneficios se pagarán solamente si el Administrador del Plan (o su delegado) determina a su exclusivo criterio que el reclamante tiene derecho a ellos.

Administrador del plan y fiduciario designado:
Mail Stop 3610–Plan Administrator
Administrative Committee
Associates' Health and Welfare Plan
508 SW 8th Street
Mail Stop #3610
Bentonville, Arkansas 72716-3610

Fiduciario designado (para los beneficios médicos, de farmacia, dental y de discapacidad a corto plazo autofinanciados): para cada uno de los programas de beneficios con componentes autofinanciados, el administrador de terceros aplicable es un fiduciario designado en lo que respecta a las decisiones de si se pagará una reclamación de beneficios conforme al Plan.

Fiduciario designado (para el seguro médico, de la vista, de vida pagado por la compañía, de vida opcional para asociados, de vida opcional para dependientes, de accidente por viaje de negocios, de discapacidad a largo plazo, por accidente, por AD&D y de enfermedad grave): para cada uno de los programas de beneficios de los componentes asegurados, la compañía de seguros aplicable es un fiduciario designado con respecto a las decisiones relativas a si se pagará una reclamación de beneficios en virtud del contrato de seguro.

Depositario del plan:
J. P. Morgan
4 New York Plaza, 15th Floor
New York, New York 10004-2413

Agente para el aviso de procesos legales: Corporation Trust Company
1209 Orange Street Corporation Trust Center
Wilmington, Delaware 19801

Las notificaciones legales también pueden estar a cargo del Depositario o Administrador del Plan.

Año del plan: 1 de enero al 31 de diciembre

Financiación del Plan

Walmart Inc. puede financiar los beneficios del Plan a partir de sus activos generales o a través de aportes hechos al Fondo de Salud y Bienestar para Asociados de Walmart Inc. Los aportes también pueden ser solicitados por los asociados en una suma determinada por Walmart Inc. a su criterio. Todos los bienes del Plan, incluidos los aportes de asociados y los dividendos o ingresos del Plan estarán disponibles para pagar los beneficios suministrados conforme al Plan o los gastos del Plan, incluidas las primas de seguros.

Modificación o cancelación del plan

Walmart se reserva el derecho según su exclusivo criterio a modificar o finalizar cualquier beneficio conforme al Plan, en cualquier momento y por cualquier motivo, ya sea que se relacione con un participante o beneficiario actual, pasado o futuro del Plan. El Plan solo podrá modificarse de conformidad con los términos del Documento de cobertura.

Ni el Plan ni los beneficios que se describen en este *Libro de beneficios para asociados* de 2025 se pueden enmendar en forma oral. Todas las declaraciones y representaciones orales no tendrán fuerza ni efecto, ni siquiera si son realizadas por el Administrador del Plan, un asociado administrativo de Walmart o un representante del centro de llamadas de beneficios, o un administrador de terceros. Asimismo, las declaraciones escritas de cualquier persona, incluido cualquier material generado por IA en cualquier sistema de Walmart, no enmiendan ni modifican el Plan. Solo las declaraciones escritas relativas a la interpretación de los términos vigentes del Plan por parte del Administrador del Plan y las modificaciones adoptadas de conformidad con los términos del Documento de cobertura serán vinculantes.

Sus derechos conforme a ERISA

Como participante del Plan, usted tiene ciertos derechos y protecciones conforme a la Ley de Garantía de los Ingresos de Jubilación para los Empleados (ERISA) de 1974 y sus enmiendas. La ley ERISA establece que todos los participantes del Plan tienen derecho a lo siguiente:

RECIBIR INFORMACIÓN SOBRE SU PLAN Y SUS BENEFICIOS

Usted tiene derecho a:

- Revisar, sin cargo, en la oficina del Administrador del Plan y en otras instalaciones específicas, como lugares de trabajo y salones de sindicato, todos los documentos que rigen el Plan, incluidos los contratos de seguros, acuerdos de negociaciones colectivos y una copia del último informe anual (serie del Formulario 5500) que presentó el Plan ante el Ministerio de Trabajo de los Estados Unidos, disponible en la Sala de Información Pública de la Administración de Seguridad de los Beneficios del Empleado.
- Obtener, previa solicitud por escrito al Administrador del Plan, copias de los documentos que rigen el funcionamiento del Plan, incluidos los contratos de seguros y los convenios colectivos de trabajo, copias del último informe anual (serie del Formulario 5500) y una Descripción Resumida del Plan actualizada. El Administrador puede cobrar un costo razonable por las copias.
- Recibir un resumen del informe financiero anual del Plan. La ley exige que el Administrador del Plan entregue una copia de este informe anual a cada participante.

CONTINUACIÓN DE LA COBERTURA DEL PLAN DE SALUD GRUPAL

Usted tiene derecho a continuar la cobertura de atención de la salud para usted, su cónyuge y sus dependientes si hay una pérdida de cobertura conforme al Plan como resultado de un evento calificador. Es posible que usted o sus dependientes tengan que pagar por dicha cobertura. Consulte este *Libro de beneficios para asociados* de 2025 y los documentos que rigen el Plan sobre las normas que determinan la continuación de los derechos de cobertura de COBRA. (Consulte el capítulo **Ley COBRA (Ley Ómnibus Consolidada de Reconciliación Presupuestaria)** para obtener más información.)

Se le debe otorgar un certificado de cobertura acreditable, sin cargo, del plan o del emisor de seguro de salud cuando pierde cobertura conforme al plan, cuando tiene derecho a elegir la continuación de la cobertura de COBRA o cuando cesa la continuación de la cobertura de COBRA, si la solicita antes de perder la cobertura o si la solicita en un periodo de hasta 24 meses después de perder la cobertura.

El componente de beneficios médicos del Plan no tiene exclusión por afección preexistente.

ACCIONES PRUDENTES DE LOS FIDUCIARIOS DEL PLAN

Además de crear derechos para los participantes del Plan, la ley ERISA impone deberes sobre las personas que son responsables del funcionamiento del Plan. Las personas que administran su Plan, llamadas "fiduciarios" del Plan, tienen el deber de llevar a cabo su tarea con prudencia e interesándose por usted y por los otros participantes y beneficiarios del Plan. Nadie, ni siquiera su empleador, su gremio ni cualquier otra persona puede despedirlo o discriminarlo de ninguna manera para evitar que obtenga sus beneficios o ejerza sus derechos bajo la ERISA.

Si su reclamación por un beneficio se rechaza o ignora en parte o totalmente, tiene derecho a saber a qué se debe esta decisión, a obtener copias gratis de documentos que se relacionan con tal decisión y a apelar cualquier negación, todo dentro de ciertos plazos.

Conforme a la ley ERISA, existen pasos que puede seguir para hacer valer los derechos expuestos anteriormente. Por ejemplo:

- Si solicita materiales al Plan y no los recibe dentro de los 30 días, puede presentar una demanda en un tribunal federal. En ese caso, el tribunal puede exigir al Administrador del Plan que le suministre los materiales y le pague hasta $110 por día hasta que reciba los materiales, a menos que los materiales no se hayan enviado por razones ajenas al Administrador.
- Si rechazan o ignoran en parte o totalmente su reclamación de beneficios, puede iniciar una demanda en un tribunal estatal o federal. Por lo general, debe completar el proceso de apelaciones antes de iniciar acciones legales contra el Plan. Sin embargo, se recomienda consultar a su abogado para determinar cuándo es adecuado iniciar acciones legales contra el Plan.
- Si no está de acuerdo con la decisión del plan o desconoce la misma con respecto al estado calificado de una orden de relación familiar u orden médica de subsidio de menores, puede presentar una demanda en un tribunal federal.
- Si los fiduciarios del Plan hicieran un mal uso del dinero del Plan o si usted es discriminado por hacer valer sus derechos, puede solicitar la ayuda del Departamento de Trabajo de los EE. UU. o puede iniciar acciones legales en un tribunal federal.

El tribunal decidirá quién debe pagar los gastos judiciales y honorarios de abogados. Si usted gana, el tribunal puede ordenar a la persona que usted demandó que pague tales gastos y honorarios. Si usted pierde, el tribunal puede ordenarle que pague los costos y honorarios; por ejemplo, si descubre que su reclamación es improcedente.

AYUDA CON SUS PREGUNTAS

Si tiene alguna pregunta sobre su Plan, debe ponerse en contacto con el Administrador del Plan. Si tiene alguna pregunta sobre esta declaración o sobre sus derechos conforme a la ley ERISA o necesita ayuda para obtener documentos del Administrador del Plan, comuníquese con la Oficina de Administración de Seguridad de Beneficios del Empleado más cercana, del Departamento de Trabajo de EE. UU., que se incluyen en su directorio telefónico o con:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U. S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

También puede obtener ciertas publicaciones sobre sus derechos conforme a la ley ERISA llamando a la línea gratuita de las publicaciones de la Administración de Seguridad de Beneficios del Empleado al **866-444-3272** o ingresando en **dol.gov/ebsa**.

Utilización de datos de asociados y participantes

Se utilizarán datos como su domicilio, correo electrónico, número de teléfono, información sobre dependientes y otros detalles que facilite durante una sesión de inscripción para inscribirlo en el Plan. Únicamente con el fin de operar eficazmente el Plan, incluido el suministro de información importante sobre sus beneficios, Walmart Inc. puede compartir la información que usted proporcione durante la inscripción con el Plan o con los proveedores de servicios del Plan, según sea razonablemente necesario y según lo permita la ley. Consulte el **Aviso de privacidad de la información de asociados de Walmart** para obtener detalles adicionales.

El Plan puede compartir los datos relativos a sus beneficios entre los proveedores de servicios del Plan únicamente con el fin de proporcionar los beneficios del Plan, según lo permita la ley. Walmart Inc., el Plan o los proveedores de servicios del Plan pueden ponerse en contacto con usted en relación con sus beneficios en la dirección de correo electrónico o el número de teléfono personal que usted haya proporcionado.

Notificación sobre las prácticas de privacidad de la HIPAA

Este aviso se actualizó el 15 de mayo de 2023

ESTA NOTIFICACIÓN SE APLICA AL PLAN MÉDICO PARA ASOCIADOS (AMP), AL PLAN DENTAL Y A MIS RECURSOS DE SALUD MENTAL DENOMINADOS CONJUNTAMENTE LOS "PLANES".

COMPROMISO DE LOS PLANES CON SU PRIVACIDAD

A instancias de esta notificación, donde figuren "nosotros" o "nuestro", se hace referencia a los Planes. Walmart también proporciona beneficios para algunos asociados a través de una organización de mantenimiento de la salud (Health Maintenance Organization, HMO), un Plan PPO totalmente asegurado y un plan de seguro médico de accidente durante viajes de negocios internacionales totalmente asegurado. Para estas opciones de beneficios, el asegurador del Plan de HMO o PPO, o el plan de seguro médico de accidente durante viajes de negocios internacionales es responsable de proteger su información de salud conforme a las regulaciones de la HIPAA, así como de proporcionarle su propia notificación de las prácticas de privacidad.

Los planes se encargan de mantener la privacidad de su información de salud durante el tiempo que el Plan mantenga su información de salud o durante cincuenta años después de su fallecimiento. Mediante la administración de los planes, creamos registros sobre usted y los beneficios que le proporcionamos. Esta notificación le informará sobre las maneras en que podemos usar y divulgar su información de salud. También describe sus derechos y determinadas obligaciones que tenemos con respecto al uso y la divulgación de la información de salud. La ley nos exige:

- Preservar la privacidad de su información médica, también conocida como Información médica protegida (PHI);

- Proporcionarle esta notificación
- Cumplir con las disposiciones de esta notificación, y
- Notificarlo si se infringe su PHI sin seguridad.

El Plan se reserva el derecho de modificar las prácticas de privacidad y de hacer que toda modificación se aplique a la PHI que obtuvimos sobre usted antes de realizadas las modificaciones. Si se realiza una revisión material de esta notificación, le haremos llegar la nueva notificación. Para obtener una copia impresa de la notificación vigente, comuníquese con los Planes a través de la información de contacto que figura al final de esta notificación. La notificación más reciente también se encuentra disponible en One.Walmart.com.

ESTA NOTIFICACIÓN DESCRIBE CÓMO SE PUEDE UTILIZAR Y REVELAR SU INFORMACIÓN MÉDICA Y CÓMO PUEDE TENER ACCESO A ELLA. REVÍSELA CON ATENCIÓN. Usted tiene ciertos derechos conforme a la Ley de Transportabilidad y Responsabilidad de Seguros de Salud (HIPAA). La HIPAA regula en qué momento y de qué modo su información sobre salud médica, conservada por el AMP, el plan dental y Mis recursos de salud mental, puede ser utilizada y divulgada y de qué manera puede usted tener acceso a esta información. Comparta una copia de ella con los miembros de su familia cubiertos por el AMP, el plan dental y Mis recursos de salud mental.

CÓMO PUEDEN USAR Y DIVULGAR SU PHI EL AMP, EL PLAN DENTAL Y MIS RECURSOS DE SALUD MENTAL

La ley permite que usemos y divulguemos su información médica protegida (PHI) para determinados fines sin su permiso o autorización. A continuación, se presentan ejemplos de cada una de estas circunstancias:

1. **Para tratamientos.** Se nos permite usar o divulgar su PHI si los fines están relacionados con un tratamiento. Por ejemplo, podemos compartir su PHI con médicos, enfermeros y otros profesionales que participan en sus cuidados.
2. **Para pagos.** Se nos permite usar o divulgar su PHI para permitir el pago del tratamiento que recibe conforme a los Planes. Por ejemplo, podemos contactar a su médico para certificar que usted ha recibido tratamiento (y por qué rango de beneficios) y solicitar detalles relacionados con su tratamiento para determinar si sus beneficios cubrirán su tratamiento (o pagarán los costos). Además, podemos usar y divulgar su PHI para obtener el pago de terceros que pueden ser responsables de tales costos, como familiares u otras compañías de seguros.
3. **Para operaciones relacionadas con la atención de la salud.** Podemos usar o divulgar su PHI para aplicarla en nuestras operaciones relacionadas con la atención de la salud. Por ejemplo, nuestros administradores de reclamaciones en algunos estados o los mismos Planes pueden usar su PHI para llevar a cabo actividades de planificación y gestión de costos. Toda información que utilicemos o divulguemos para suscribir esos fines no incluirán ninguna PHI que sea información genética.
4. **Para el patrocinador de los Planes.** Los Planes pueden usar o divulgar su PHI a Walmart, el Patrocinador del Plan. El Patrocinador de los Planes utilizará su PHI únicamente según sea necesario para administrar los Planes. La ley solo permite que los Planes divulguen su PHI a Walmart, en calidad de Patrocinador de los Planes, si Walmart certifica, entre otros aspectos, que solo la utilizará o divulgará según lo permite el Plan, que limitará el acceso a ella a los empleados de Walmart cuyo trabajo sea administrar el Plan y que no la usará para actividades relacionadas con el empleo.
5. **Para programas y servicios relacionados con la atención de la salud.** Los Planes pueden contactarlo para brindarle información acerca de alternativas de tratamiento u otros beneficios y servicios relacionados con su atención de la salud que pueden ser de su interés.
6. **A personas relacionadas con su atención o con el pago de su atención.** Los Planes pueden divulgar a terceros su información médica protegida que esté relacionada con la atención de la salud que usted recibe (incluidos a sus familiares, amigos cercanos o a una persona identificada en el Plan como involucrada en este aspecto), siempre y cuando usted esté de acuerdo. Si usted no se encuentra presente para aceptar o denegar la divulgación de su PHI a terceros, los Planes pueden usar su criterio profesional para determinar si hacerlo es beneficioso para usted. Si se decide que hacerlo es en su mayor beneficio, los Planes pueden divulgar la menor cantidad de PHI necesaria para alcanzar el objetivo. Además, usted tiene el derecho a solicitar que los Planes limiten la divulgación de su PHI a individuos específicos del ámbito de la atención de la salud que usted recibe.

OTROS USOS O FORMAS DE DIVULGACIÓN DE SU INFORMACIÓN MÉDICA PROTEGIDA SIN AUTORIZACIÓN

La ley nos permite divulgar su PHI sin su permiso o autorización en las siguientes circunstancias:

1. **Cuando así lo exige la ley.** Los Planes usarán y divulgarán su PHI cuando nos lo exija la ley federal, estatal o local.
2. **Para prevención de riesgos de la salud pública.** El Plan puede divulgar su PHI para su aplicación en actividades de salud pública, tales como actividades que apuntan a prevenir o controlar enfermedades, prevenir lesiones, informar sobre reacciones a medicamentos o problemas con determinados productos e informar sobre el maltrato o abandono de niños, personas mayores y adultos dependientes.
3. **Para actividades de supervisión de atención de la salud.** Los Planes pueden divulgar su PHI a un organismo que supervise la atención de la salud para actividades autorizadas por ley. Estas actividades de supervisión, que son necesarias para que el gobierno controle el sistema de atención médica, incluyen investigaciones, inspecciones, auditorías y concesión de permisos de ausencia.
4. **Para acciones legales y conflictos.** Los Planes pueden usar o divulgar su PHI en respuesta a una orden administrativa o judicial si usted se ve implicado en una acción legal o procedimiento similar. También podemos divulgar su PHI en respuesta a una requisitoria prejudicial de pruebas, citación u otro proceso legal promovido por otra parte implicada en el conflicto, pero únicamente si recibimos garantías satisfactorias de la parte que busca la información de que se han hecho los esfuerzos razonables para informarle de la requisitoria, permitirle objetar en un tribunal u obtener una orden a fin de proteger la información que ha solicitado dicha parte.

5. **A efectos del cumplimiento de la ley.** Los Planes pueden divulgar su PHI si una autoridad judicial la solicita en determinadas circunstancias, que incluyen, entre otras, las siguientes:
   - Con relación a un delito en determinadas situaciones, si nos resulta imposible obtener el consentimiento de la persona
   - Con relación a una muerte que sospechamos pudo haber sido consecuencia de un acto delictivo
   - Con relación a un acto delictivo perpetrado en nuestras oficinas
   - En respuesta a una orden de allanamiento, una citación, una orden judicial, una orden de comparecencia o un proceso legal similar
   - Para identificar o ubicar a un sospechoso, a un testigo material, a un fugitivo o a una persona desaparecida
   - En una emergencia, para dar aviso de un delito (lo cual incluye la ubicación de las víctimas del delito o la descripción, identidad o ubicación de la persona que cometió el delito), y
   - En los casos en los que una agencia encargada del cumplimiento de la ley haya solicitado PHI a los fines de identificar o ubicar a una persona, la HIPAA permite que, si se cumplen determinadas situaciones, los planes divulguen a dicha agencia información limitada tal como el nombre, la dirección, el número de Seguro Social, el tipo de sangre ABO, el tipo de lesión, la fecha y la hora del tratamiento o el fallecimiento y características físicas distintivas.
6. **Para evitar una amenaza grave para la salud o la seguridad.** Los Planes pueden usar o divulgar su PHI cuando resulte necesario para minimizar o prevenir una amenaza grave para su salud y su seguridad o la salud y la seguridad de otra persona o de la comunidad. En estos casos, solo divulgaremos información a las personas u organizaciones que pueden ayudar a prevenir la amenaza.
7. **Para cumplir funciones militares.** Los Planes pueden divulgar su PHI si usted es miembro del ejército de los Estados Unidos o de las fuerzas armadas extranjeras (incluso excombatientes) a los fines de garantizar la ejecución correcta de una misión militar solamente si la autoridad militar correcta ha publicado en el Registro Federal la información adecuada.
8. **Para la seguridad nacional.** Los Planes pueden divulgar su PHI a funcionarios Federales para actividades de inteligencia y seguridad nacional autorizadas por ley. También podemos divulgar su PHI a funcionarios federales para proteger al presidente, otros funcionarios o presidentes extranjeros, o bien para llevar a cabo investigaciones.
9. **Presidiarios.** Los planes pueden divulgar su PHI a instituciones correccionales o autoridades judiciales si está preso o bajo la custodia de un organismo judicial. En estos casos, se divulga la información por las siguientes razones: a fin de que la institución le brinde servicios de atención de la salud; para la seguridad y protección de la institución; para proteger su salud y su seguridad o la salud y la seguridad de otras personas.
10. **Para programas de compensación de trabajadores.** Los planes pueden divulgar su información médica para programas de compensación de trabajadores y otros programas similares.
11. **Para servicios relacionados con el fallecimiento.** Los Planes pueden divulgar su PHI tras su fallecimiento a un médico forense, director fúnebre o centro de donación de órganos, según sea necesario para permitirles cumplir sus funciones.
12. **Investigación.** La HIPAA les permite a los Planes divulgar PHI a los fines de investigación aprobada por el gobierno. Es política de los Planes no divulgar PHI a los fines de investigación y no divulgará su PHI para tales fines a menos que sea necesario divulgarla de conformidad con la ley.
13. **Notas de psicoterapia.** Siempre se requiere una autorización para usar o divulgar las notas de psicoterapia a un tercero a menos que el uso o la divulgación estén permitidos de conformidad con las regulaciones de la HIPAA. Los usos o las divulgaciones permitidos incluyen: uso para tratamiento, pago u operaciones de atención médica; uso por el originador de las notas para tratamiento; uso por los Planes para defenderse en una demanda que usted inicie; cuando sea requerido por el secretario del Departamento de Salud y Servicios Humanos; cuando dicha divulgación sea requerida por ley; para actividades de supervisión de atención de la salud según esté permitido de conformidad con las regulaciones; divulgación a una persona que puede prevenir razonablemente un daño grave a una persona o al público; y la divulgación a un examinador médico o médico forense a los fines de identificar una persona fallecida, determinar la causa de muerte u otros fines permitidos por la ley. Aunque las regulaciones permiten a las entidades cubiertas usar y divulgar notas de psicoterapia para la capacitación de profesionales o estudiantes de la salud, los Planes no participan en dichos ejercicios de capacitación y no pueden divulgar la información para tales fines.
14. **Víctimas de abuso, negligencia o violencia doméstica.** Los Planes pueden divulgar su PHI si hay una creencia razonable de que usted es víctima de abuso, negligencia o violencia doméstica. Dicha divulgación está permitida conforme a la ley HIPAA solamente si lo exige la ley o con su permiso o en la medida en la que la divulgación esté expresamente autorizada por ley y solamente si, al mejor criterio del Plan, la divulgación es necesaria para prevenir un daño grave a usted u otras víctimas potenciales.
15. **Actividades de supervisión de la salud e investigaciones conjuntas.** El Plan debe divulgar PHI solicitada de agencias de supervisión de la salud a los fines de auditorías autorizadas legalmente, investigaciones que incluyen investigaciones conjuntas, inspecciones, concesión de licencias, acciones disciplinarias u otras actividades de supervisión de entidades autorizadas.
16. **Esfuerzos de socorro en desastres.** Los Planes pueden usar o divulgar su PHI para notificar a un integrante de la familia o a otra persona involucrada en su atención su ubicación, condición general o muerte, o a una entidad pública o privada autorizada por la ley o su estatuto para asistir en los esfuerzos de socorro en desastres a hacer dicha notificación.

USOS Y DIVULGACIÓN QUE REQUIEREN DE SU AUTORIZACIÓN

Los Planes solicitarán su autorización escrita en caso de necesitar usar o divulgar su PHI para otras situaciones, que incluyen la mayoría de los usos y las divulgaciones de las notas de psicoterapia (excepto en las situaciones descritas más arriba), los usos y las divulgaciones de PHI para fines comerciales, y los usos o las divulgaciones que son una venta de la PHI. Tras su autorización, el Plan no condicionará su elegibilidad para participar en el Plan o el pago de los beneficios conforme al Plan, excepto cuando la ley lo permita. Si usted nos otorga una autorización escrita para usar o divulgar su PHI, puede revocar dicha autorización en cualquier momento por escrito. Si usted revoca su autorización, ya no utilizaremos ni divulgaremos su PHI por las razones que se describen en la autorización, salvo en las que hemos tomado medidas basándonos en su autorización antes de que recibiéramos su revocación por escrito.

LEYES DE PRIVACIDAD ESTATALES MÁS ESTRICTAS

Conforme a las Reglamentaciones de Privacidad de la HIPAA, el Plan debe acatar las legislaciones estatales, de haberlas, que también son aplicables y no vayan en contra de la HIPAA (por ejemplo, donde las leyes estatales sean más estrictas). El Plan mantiene una política para garantizar el cumplimiento de estas leyes.

SUS DERECHOS CON RELACIÓN A SU INFORMACIÓN MÉDICA PROTEGIDA (PHI)

Usted tiene los siguientes derechos en relación con la PHI que mantenemos en nuestro poder:

1. **Derecho a solicitar comunicaciones confidenciales.** Tiene derecho a solicitar que los Planes se comuniquen con usted por asuntos concernientes a su salud y otros temas relacionados por medios específicos o en lugares determinados si considera que su vida puede correr peligro si se envía la información a su hogar. Por ejemplo, puede pedir que se lo contacte en el trabajo y no en su casa. Para solicitar un tipo de comunicación confidencial, debe enviar una solicitud por escrito a la dirección que figura al final de esta sección y especificar el método de contacto solicitado o el lugar donde desea que se lo contacte. Para que consideremos la posibilidad de dar lugar a su solicitud de comunicación confidencial, su solicitud por escrito debe establecer con claridad que su vida podría correr peligro si esta información se divulga total o parcialmente.
2. **Derecho a solicitar restricciones.** Tiene derecho a solicitar una restricción en el uso o en la divulgación de su PHI a los fines de tratamientos, pagos u operaciones de atención de la salud. Si bien no estamos obligados a acceder a su solicitud excepto en circunstancias limitadas, en caso de que efectivamente accedamos, estamos obligados conforme a este acuerdo, salvo cuando la ley exija lo contrario, en casos de emergencias o cuando la información sea necesaria para brindarle tratamiento. Para solicitar una restricción a nuestro uso o divulgación de su PHI, debe enviar su solicitud por escrito a la dirección que figura al final de esta sección. Su solicitud debe describir en forma clara y concisa: (a) la información que desea que se restrinja; (b) si desea que el Plan Médico para Asociados, el plan dental o Mis recursos de salud mental se limiten en cuanto a su uso, su divulgación o ambos; (c) a quién desea que se apliquen estas restricciones.
3. **Derecho a revisar y copiar la información.** Salvo en circunstancias limitadas, tiene derecho a revisar y copiar la PHI que puede utilizarse para tomar decisiones que lo involucran. Generalmente, esto incluye registros médicos y de facturación. Para revisar o copiar su PHI, debe enviar su solicitud por escrito a la dirección que figura al final de esta sección. Los Planes deben proporcionarle directamente, a usted o el individuo que designe, acceso a la PHI electrónica en el formulario electrónico y formato que solicite, si se puede ejecutar inmediatamente o, en caso contrario, en un formato electrónico que pueda leerse según lo acordado entre usted y el Plan. Los planes pueden cobrar una tarifa por el costo de la copia, el envío postal, las tareas realizadas y los insumos relacionados con su solicitud. En determinadas circunstancias limitadas, podemos denegar su solicitud para inspeccionar y/o copiar, en cuyo caso puede presentar una solicitud al Plan a la dirección que figura en la siguiente columna para que se revise la denegación.
4. **Derecho a solicitar enmiendas.** Tiene derecho a solicitar que modifiquemos su PHI si considera que es incorrecta o que está incompleta. Para solicitar una enmienda, debe enviar una solicitud por escrito a la dirección que figura al final de esta sección. Debe incluir un motivo que respalde su solicitud de enmiendas. Podemos rechazar su solicitud si nos pide modificar PHI que: (a) es precisa y completa; (b) no forma parte de la PHI guardada por el Plan o para el Plan; (c) no forma parte de la PHI que usted está autorizado a revisar y copiar; o (d) no fue creada por el Plan, salvo que la persona o el organismo que creó la PHI no pueda modificarla. Incluso si rechazamos su solicitud de enmiendas, usted tiene derecho a presentar una declaración de desacuerdo con respecto a toda información en sus registros que considere incompleta o incorrecta. Si lo solicita, esta información formará parte de sus registros médicos: la adjuntaremos a sus registros y la incluiremos cada vez que divulguemos esta información o declaración que usted considera incompleta o incorrecta.
5. **Derecho a un informe sobre la divulgación de información.** Tiene derecho a solicitar un informe sobre la divulgación de su información. El informe sobre la divulgación de información es una lista de determinados casos en que divulgamos su PHI, para fines que no están relacionados con tratamientos, pagos, operaciones de atención de la salud y otras excepciones conforme a la ley o conforme a su autorización. Para solicitar un informe sobre la divulgación de información, debe enviar una solicitud por escrito a la dirección que figura al final de esta sección. Debe especificar el periodo, el cual no debe superar los seis años anteriores a su solicitud. Le notificaremos el costo involucrado en el cumplimiento con su solicitud y usted podrá elegir retirar o modificar su solicitud en ese momento.
6. **Notificación impresa.** Tiene derecho a solicitar una copia impresa de esta notificación, incluso si accedió a recibirla en formato electrónico.

Si considera que se han violado sus derechos a la privacidad, puede presentar un reclamo ante el Plan Médico para Asociados, el plan dental o Mis recursos de salud mental, o bien ante el secretario del Departamento de Salud y Servicios Humanos de los Estados Unidos. Para presentarnos un reclamo, debe enviarlo por escrito a la dirección que figura al final de esta sección. Ni Walmart ni los Planes tomarán

represalias contra usted por presentar un reclamo. No se tomarán represalias contra usted ni se le discriminará, ni se le negará ningún servicio, pago ni privilegio porque haya presentado un reclamo ante el Plan Médico para Asociados, el plan dental, Mis recursos de salud mental, o el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Si tiene preguntas sobre esta notificación o desea ejercer los derechos descritos en esta notificación, comuníquese con:

Mail Stop 3610–Benefits Total Rewards Team
Attn: HIPAA Compliance Team
508 SW 8th Street
Mail Stop #3610
Bentonville, Arkansas 72716-3610

Envíe sus preguntas por correo electrónico a:
AHWPrivacy@walmart.com
Teléfono: **800-421-1362**

Medicare y la cobertura de medicamentos recetados

Lea detenidamente esta notificación sobre Medicare y la cobertura de medicamentos recetados y consérvela en un lugar donde pueda encontrarla.

Esta notificación contiene información sobre su cobertura actual de medicamentos recetados con el Plan médico para asociados (el AMP) y la opción de cobertura de medicamentos recetados de Medicare. Esta información puede ayudarlo a decidir si desea adherirse a un plan de medicamentos de Medicare. Si está considerando la posibilidad de adherirse, debe comparar su cobertura actual, incluso qué medicamentos tienen cobertura y a qué costo, con la cobertura y los costos de los planes que ofrecen cobertura para medicamentos recetados de Medicare en su área. Al final de esta notificación encontrará información sobre dónde puede obtener ayuda para tomar decisiones acerca de su cobertura de medicamentos recetados.

Existen dos aspectos importantes que debe conocer sobre su cobertura actual y la cobertura de medicamentos recetados de Medicare:

- La cobertura de medicamentos recetados de Medicare comenzó a estar disponible en 2006 para todas las personas que cuentan con Medicare. Puede gozar de esta cobertura si se adhiere a un Plan de Medicamentos Recetados de Medicare o a un Plan de Ventajas de Medicare (por ejemplo, una HMO o una PPO) que ofrecen cobertura para medicamentos recetados. Todos los planes de medicamentos de Medicare ofrecen como mínimo un nivel de cobertura estándar establecido por Medicare. Algunos planes también pueden ofrecer mayor cobertura a cambio de una prima mensual más alta. Para fines del *Libro de beneficios para asociados*, cualquiera de los planes de medicamentos de Medicare cubiertos por este aviso se consideran planes de la Parte D.
- El AMP ha determinado se espera que la cobertura de medicamentos recetados que se ofrecen en todas las opciones de autofinanciación del AMP pague tanto como la cobertura estándar de medicamentos recetados de Medicare y, por lo tanto, se considera una cobertura acreditable, en promedio y para todos los participantes del Plan. Si se inscribe en una de estas opciones, puede conservar su cobertura actual y no pagar una prima más alta (una multa) si luego decide inscribirse en el plan de medicamentos Parte D de Medicare.

¿CUÁNDO PUEDE ADHERIRSE A UN PLAN DE MEDICAMENTOS DE MEDICARE?

Puede adherirse a un plan de medicamentos de Medicare cuando adquiera elegibilidad por primera vez para Medicare y cada año entre el 15 de octubre y el 7 de diciembre.

No obstante, si pierde su cobertura atribuible actual de medicamentos recetados, sin que medie culpa de su parte, también será elegible para un periodo de inscripción especial (SEP) de dos (2) meses para adherirse a un plan de medicamentos de Medicare.

¿CUÁNDO PAGARÁ UNA PRIMA MÁS ALTA (MULTA) PARA ADHERIRSE A UN PLAN DE MEDICAMENTOS DE MEDICARE?

También debe saber que, si está inscrito en una opción del AMP y abandona o pierde su cobertura del AMP y no se inscribe en un plan de medicamentos de Medicare dentro de los 63 días continuos siguientes a la finalización de su cobertura del AMP actual, puede pagar una prima más alta (una penalización) para inscribirse en el plan de medicamentos de Medicare más adelante.

Si usted pasa 63 días corridos o más desde el final del último mes en que fue inicialmente elegible para adherirse al plan de medicamentos de Medicare, pero no se adhirió sin una cobertura acreditable de medicamentos recetados, su prima mensual aumentaría como mínimo el 1 % de la prima mensual básica para beneficiarios de Medicare por cada mes que no tuvo esa cobertura. Por ejemplo, si pasa 19 meses sin cobertura acreditable, su prima siempre debe ser, al menos, un 19 % más alta que la prima básica para beneficiarios de Medicare. Es posible que tenga que pagar esta prima más alta (una multa) por el tiempo que tenga una cobertura de medicamentos recetados de Medicare. Además, es posible que tenga que esperar hasta el siguiente periodo de inscripción anual de Medicare, que empieza en octubre, para adherirse.

¿QUÉ SUCEDE CON SU COBERTURA ACTUAL SI DECIDE ADHERIRSE A UN PLAN DE MEDICAMENTOS DE MEDICARE?

Si decide adherirse a un plan de medicamentos de Medicare, su cobertura actual con AMP se verá afectada. Las directrices del plan le impiden inscribirse en el AMP si está inscrito en un plan de medicamentos de Medicare. Además, si su dependiente está inscrito en un plan de medicamentos de Medicare y usted no lo está, usted es elegible para inscribirse en el AMP, pero su dependiente no será elegible para tal cobertura.

Si opta por inscribirse en un plan de medicamentos de Medicare y abandona la cobertura del AMP, tenga en cuenta que usted y sus dependientes podrán volver a inscribirse, pero

solamente durante la Inscripción anual o debido a un evento de cambio de elección, siempre y cuando no siga inscrito en un plan de medicamentos de Medicare.

Si se inscribe en un plan de medicamentos de Medicare y decide, en un plazo de 60 días, volver a cambiar a una opción de plan bajo el AMP, tendrá que llamar a Servicios al Personal al **800-421-1362** para volver a inscribirse. Para obtener información, consulte el capítulo **Elegibilidad, inscripción y fechas de vigencia** .

PARA OBTENER MÁS INFORMACIÓN SOBRE ESTA NOTIFICACIÓN O SU COBERTURA DE MEDICAMENTOS RECETADOS

Llame a Servicios al Personal al **800-421-1362** para obtener información adicional. Nota:

- Recibirá este aviso cada año antes del siguiente periodo en el que puede inscribirse en un plan de medicamentos de Medicare.
- Si realizamos alguna modificación al plan que afecte su cobertura acreditable conforme al AMP, recibirá otra notificación.
- Si desea obtener una copia de esta notificación en cualquier momento, puede solicitarla a Servicios al Personal al **800-421-1362**.

PARA OBTENER MÁS INFORMACIÓN SOBRE LAS OPCIONES QUE TIENE BAJO LA COBERTURA DE MEDICAMENTOS RECETADOS DE MEDICARE

Puede obtener más información detallada sobre los planes de Medicare que ofrecen cobertura para medicamentos recetados en el manual "*Medicare & You*" (Medicare y usted) de Medicare. También puede ser contactado directamente por los planes de medicamentos recetados de Medicare. Todos los años, Medicare le enviará una copia del manual por correo.

Para obtener más información sobre la cobertura de medicamentos recetados de Medicare:

- Visite **medicare.gov**.
- Llame a su programa estatal de asistencia para seguros de salud para obtener ayuda personalizada (al número de teléfono que aparece en el manual "*Medicare & You*").
- Llame al **800-MEDICARE**(**800-633-4227**). Los usuarios de TTY deben llamar al **877-486-2048**.

Si tiene ingresos y recursos limitados puede obtener ayuda adicional para pagar el plan de medicamentos recetados de Medicare disponible. Para obtener más información sobre esta ayuda adicional, visite el sitio de la Administración de Seguridad Social en **socialsecurity.gov** o llame al **800-772-1213** (TTY **800-325-0778**).

RECUERDE

Conserve este aviso de cobertura acreditable. Si decide adherirse a uno de los planes de medicamentos de Medicare, es posible que deba presentar una copia de esta notificación cuando se adhiera para demostrar que ha mantenido una cobertura atribuible o no, y por lo tanto, que debe pagar una prima más alta (una multa) o no.

Asistencia para el pago de primas conforme a Medicaid y el Programa de Seguros de Salud para Niños (CHIP)

Si usted o sus hijos son elegibles para Medicaid o CHIP, y usted es elegible para una cobertura de salud de Walmart Inc., es posible que su estado tenga un programa de asistencia para primas que puede ayudarlo a pagar la cobertura mediante el uso de los fondos de sus programas de Medicaid o CHIP. Si usted o sus hijos no son elegibles para tener Medicaid o CHIP, usted no será elegible para estos programas de asistencia con primas, pero tal vez pueda adquirir una cobertura de seguro individual a través del mercado de seguro de salud. Para obtener más información, visite **healthcare.gov**.

Si usted o sus dependientes ya están inscritos en Medicaid o CHIP y usted vive en uno de los estados que se mencionan en la siguiente página, comuníquese con la oficina de Medicaid o CHIP de su estado para averiguar si disponen de asistencia con primas.

Si usted o sus dependientes NO están actualmente inscritos en Medicaid o en el CHIP, y considera que usted o cualquiera de sus dependientes son elegibles para uno de estos programas, comuníquese con la oficina de Medicaid o del CHIP de su estado, llame al **877-KIDS NOW** o visite **insurekidsnow.gov** para averiguar cómo inscribirse. Si usted reúne los requisitos, pregunte en su estado si existe un programa que podría ayudarlo a pagar las primas del Plan.

Si usted o sus dependientes son elegibles para un programa de asistencia para primas de Medicaid o CHIP, así como elegible para el Plan de Walmart, Inc., el Plan está obligado a permitirle a usted y a sus dependientes inscribirse en el Plan si todavía no está inscrito. Esto se llama oportunidad de "inscripción especial" y usted debe solicitar la cobertura dentro de los 60 días posteriores a que se haya determinado que es elegible para la asistencia para primas. Si tiene preguntas acerca de la inscripción en el plan de su empleador, comuníquese con el Departamento de Trabajo a través del sitio web **askebsa.dol.gov** o llamando al **866-444-EBSA** (**3272**).

Si usted vive en uno de los siguientes estados, podría ser elegible para recibir asistencia para pagar las primas del plan de salud del empleador. La siguiente lista de estados es actual desde el 31 de julio de 2024. Para obtener más información sobre la elegibilidad, comuníquese con su estado.

ALABAMA – Medicaid
Sitio web: **http://myakhipp.com**
Teléfono: **855-692-5447**

ALASKA – Medicaid
Programa de pago de primas del seguro de salud de Alaska
Sitio web: **http://myakhipp.com**
Teléfono: **866-251-4861**
Correo electrónico: **CustomerService@MyAKHIPP.com**
Elegibilidad: **https://health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS – Medicaid
Sitio web: **http://myarhipp.com**
Teléfono:**855-MyARHIPP** (**855-692-7447**)

CALIFORNIA – Medicaid
Pago de primas del seguro de salud (HIPP)
Sitio web: **https://www.dhcs.ca.gov/hipp**
Teléfono: **916-445-8322**
Fax: **916-440-5676**
Correo electrónico: **hipp@dhcs.ca.gov**

COLORADO – Health First Colorado (Medicaid) y Plan de salud para niños Plus (CHP+)
Sitio web de Health First Colorado:
https://www.healthfirstcolorado.com
Centro de Contacto para miembros de Health First Colorado:
800-221-3943 Servicio de retransmisión estatal **711**
CHP+: **https://hcpf.colorado.gov/child-health-plan-plus**
Centro de atención al cliente de CHP+: **800-359-1991** / Servicio de retransmisión estatal **711**
Programa de compra de seguros médicos (HIBI):
https://www.mycohibi.com
Servicio de atención al cliente de HIBI: **855-692-6442**

FLORIDA – Medicaid
Sitio web: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Teléfono: **877-357-3268**

GEORGIA – Medicaid
Sitio web de GA HIPP: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Teléfono: **678-564-1162**, oprima **1**
Sitio web de GA-CHIPRA: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Teléfono: **678-564-1162**, oprima **2**

INDIANA – Medicaid
Pago de primas del seguro de salud
Y el resto de Medicaid
Sitio web: **https://www.in.gov/medicaid**
http://www.in.gov/fssa/dfr
Teléfono: **800-403-0864**
Teléfono de atención para los miembros: **800-457-4584**

IOWA MEDICAID Y CHIP (Hawki)
Página web de Medicaid: **https://hhs.iowa.gov/programs/welcome-iowa-medicaid**
Teléfono del Medicaid: **800-338-8366**
Sitio web de Hawki: **https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki**
Teléfono de Hawki: **800-257-8563**
Página web de HIPP: **https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp**
Teléfono de HIPP: **888-346-9562**

KANSAS – Medicaid
Sitio web: **http://www.kancare.ks.gov**
Teléfono de HIPP: **800-967-4660**

KENTUCKY – Medicaid
Sitio web del Programa de pago de primas del seguro de salud de Kentucky (KI-HIPP):
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Teléfono: **855-459-6328**
Correo electrónico: **KIHIPP.program@ky.gov**
Sitio web de KCHIP: **https://kynect.ky.gov**
Teléfono: **877-524-4718**
Sitio web de Medicaid: **https://chfs.ky.gov/agencies/dms**

LUISIANA – Medicaid
Sitio web: **www.medicaid.la.gov** o **www.ldh.la.gov/lahipp**
Teléfono: **888-342-6207** (línea directa de Medicaid) o **855-618-5488** (LaHIPP)

MAINE – Medicaid
Sitio web de inscripción: **https://www.mymaineconnection.gov/benefits/s/?language=en_US**
Teléfono: **800-442-6003** TTY: Relevo de Maine **711**
Página web de la prima del seguro médico privado:
https://www.maine.gov/dhhs/ofi/applications-forms
Teléfono: **800-977-6740** TTY: Relevo de Maine **711**

MASSACHUSETTS – Medicaid y CHIP
Sitio web: **http://www.mass.gov/masshealth/pa**
Teléfono: **800-862-4840** TTY: **711**
Correo electrónico: **masspremassistance@accenture.com**

MINNESOTA – Medicaid
Sitio web: **https://mn.gov/dhs/health-care-coverage**
Teléfono: **800-657-3739**

MISURI – Medicaid
Sitio web:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Teléfono: **573-751-2005**

MONTANA – Medicaid
Sitio web: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**
Teléfono: **800-694-3084**
Correo electrónico: **HHSHIPPProgram@mt.gov**

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

NEVADA – Medicaid
Sitio web: **http://dhcfp.nv.gov**
Teléfono: **800-992-0900**

NEW HAMPSHIRE – Medicaid
Sitio web: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Teléfono: **603-271-5218**
Línea gratuita para el programa HIPP: **800-852-3345**, ext **5218**
Correo electrónico: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**

NUEVA JERSEY – Medicaid y CHIP
Sitio web de Medicaid:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid
Teléfono: **800-356-1561**
Teléfono de asistencia para primas de CHIP: **609-631-2392**
Sitio web de CHIP: **http://www.njfamilycare.org/index.html**
Teléfono de CHIP: **800-701-0710** (TTY: **711**)

NUEVA YORK – Medicaid
Sitio web: **https://www.health.ny.gov/health_care/medicaid**
Teléfono: **800-541-2831**

CAROLINA DEL NORTE – Medicaid
Sitio web: **https://medicaid.ncdhhs.gov**
Teléfono: **919-855-4100**

DAKOTA DEL NORTE – Medicaid
Sitio web: **https://www.hhs.nd.gov/healthcare**
Teléfono: **844-854-4825**

OKLAHOMA — Medicaid y CHIP
Sitio web: **http://www.insureoklahoma.org**
Teléfono: **888-365-3742**

OREGÓN – Medicaid
Sitio web: **http://healthcare.oregon.gov/Pages/index.aspx**
Teléfono: **800-699-9075**

PENNSYLVANIA – Medicaid y CHIP
Sitio web: **https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html**
Teléfono: **800-692-7462**
Sitio web de CHIP: **https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx**
Teléfono de CHIP: **800-986-KIDS (5437)**

RHODE ISLAND – Medicaid y CHIP
Sitio web: **http://www.eohhs.ri.gov**
Teléfono: **855-697-4347** o **401-462-0311** (línea directa de RIte Share)

CAROLINA DEL SUR – Medicaid
Sitio web: **https://www.scdhhs.gov**
Teléfono: **888-549-0820**

DAKOTA DEL SUR – Medicaid
Sitio web: **http://dss.sd.gov**
Teléfono: **888-828-0059**

TEXAS – Medicaid
Sitio web: **https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**
Teléfono: **800-440-0493**

UTAH — Medicaid y CHIP
Asociación Premium de Utah para el Seguro de Salud (UPP)
Sitio web: **https://medicaid.utah.gov/upp**
Correo electrónico: **upp@utah.gov**
Teléfono: **877-543-7669**
Página web de expansión para adultos:
https://medicaid.utah.gov/expansion
Página web del Programa de Compra de Medicaid de Utah:
https://medicaid.utah.gov/buyout-program
Página web de CHIP: **https://chip.utah.gov**

VERMONT – Medicaid
Programa de pago de primas del seguro médico (HIPP) / página web del Departamento de Acceso a la Salud de Vermont:
https://dvha.vermont.gov/members/medicaid/hipp-program
Teléfono: **800-250-8427**

VIRGINIA – Medicaid y CHIP
Sitio web: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select**
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Teléfono de Medicaid/CHIP: **800-432-5924**

WASHINGTON – Medicaid
Sitio web: **https://www.hca.wa.gov**
Teléfono: **800-562-3022**

VIRGINIA OCCIDENTAL — Medicaid y CHIP
Sitio web: **https://dhhr.wv.gov/bms**
http://mywvhipp.com
Teléfono de Medicaid: **344-558-1700**
Teléfono gratuito de CHIP: **855-MyWVHIPP** (**855-699-8447**)

WISCONSIN — Medicaid y CHIP
Sitio web: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**
Teléfono: **800-362-3002**

WYOMING – Medicaid
Sitio web: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility**
Teléfono: **800-251-1269**

Para consultar si otros estados han incorporado un programa de asistencia para el pago de primas después del 31 de julio de 2024 o para obtener más información sobre los derechos a la inscripción especial, comuníquese con el:

Departamento de Trabajo de los EE. UU.
Administración de Seguridad de Beneficios del Empleado
dol.gov/ebsa
866-444-EBSA (**3272**)

Departamento de Salud y Servicios Humanos de los Estados Unidos
Centros de Servicios de Medicare y Medicaid
cms.hhs.gov
877-267-2323, opción de menú **4**, Ext. **61565**

Participante del Value Plan

EL PLAN DE SALUD Y BIENESTAR PARA ASOCIADOS (AHWP) RESPETA LA DIGNIDAD DE CADA PERSONA QUE PARTICIPA EN EL PLAN.

El Plan de Salud y Bienestar para Asociados (AHWP) no discrimina por motivos de raza, color, nacionalidad, sexo, edad o discapacidad, y prohíbe estrictamente las represalias contra cualquier persona que presente un reclamo por discriminación. Además, con mucho gusto brindamos a nuestros participantes asistencia con el idioma, dispositivos y servicios auxiliares sin costo alguno. Lo valoramos como participante y su satisfacción es importante para nosotros.

Si necesita dicha asistencia o tiene inquietudes, llame al número que se encuentra en el reverso de su tarjeta de identificación del plan. Si tiene preguntas o inquietudes, utilice alguno de los métodos que aparecen a continuación para que podamos ayudarlo mejor.

Para obtener asistencia, llame al número que aparece en el reverso de su tarjeta de identificación.

Para obtener más información o utilizar nuestro proceso de queja, comuníquese con Servicios al Personal al 1-**800-421-1362**

Para presentar un reclamo por discriminación comuníquese con el Departamento de Salud y Servicios Humanos de EE. UU., Oficina de Derechos Civiles:

- Teléfono: 1-**800-368-1019** o 1-**800-537-7697** (TDD)
- Sitio web: **https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf**
- Correo electrónico: **OCRComplaint@hhs.gov**

Hay servicios de interpretación disponibles sin costo alguno. **1-800-421-1362**

عربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم رقم هاتف الصم والبكم: 1-800-421-1362.

ကြမာန်မာ (Burmese)
သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-800-421-1362. သုိ႔ ေခၚဆိုပါ။

漢語廣東話 (Cantonese)
請指出您的語言。翻譯服務免費提供1-800-421-1362.

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید 1-800-421-1362.

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. 1-800-421-1362.

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-421-1362.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-421-1362. まで、お電話にてご連絡ください。

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-421-1362. 번으로 전화해 주십시오.

汉语普通话 (Mandarin)
请指出您的语言 翻译服务免费提供 1-800-421-1362.

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-421-1362.

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-421-1362.

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-421-1362. 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian)
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la -1-800-421-1362.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-421-1362.

Soomaali (Somali)
Tilmaan luuqadaada. Adeegyada turjubaanka, lacag la'aan ayaa laguugu siinayaa. 1-800-421-1362.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-421-1362.

Kiswahili (Swahili)
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-421-1362.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-421-1362.

El Plan 401(k) de Walmart

El nombre legal del Plan es Plan 401(k) de Walmart. Su empleador es el único que proporciona este documento. Ninguna filial de Bank of America Corporation revisó ni participó en la creación de la información que se incluye en este documento.

El Plan 401(k) de Walmart

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Inscríbase o modifique sus aportes antes de impuestos o sus aportes para ponerse al corriente	Vaya a **One.Walmart.com** o el sitio web del Plan en **benefits.ml.com**	Llame al Centro de Atención al Cliente al **888-968-4015**
• Inscribirse o modificar sus aportes antes de impuestos, aportes Roth o aportes para ponerse al corriente • Solicitar una conversión Roth dentro del Plan • Solicitar un paquete de transferencia para realizar un aporte de transferencia • Obtener un folleto de información sobre gastos • Obtener información acerca de sus cuentas del Plan • Obtener una copia de su resumen trimestral • Solicitar una distribución o un préstamo del Plan	Visite **benefits.ml.com**	Llame al Centro de Atención al Cliente al **888-968-4015**
Designar a un beneficiario	Visite **One.Walmart.com**	

Lo que debe saber sobre el Plan 401(k) de Walmart

- Usted es elegible para hacer sus propios aportes al Plan tan pronto como sea administrativamente posible después de su fecha de contratación. Puede contribuir del 1 % al 50 % de su pago elegible cada periodo de pago.
- Puede elegir hacer aportes diferidos del sueldo antes de impuestos o aportes diferidos del sueldo Roth. Los aportes diferidos del sueldo antes de impuestos (y las ganancias de estas) no están sujetos a los impuestos federales sobre las ganancias actuales y, en la mayoría de los casos, impuestos estatales y locales, hasta que se distribuyan del Plan. Los aportes diferidos del sueldo Roth se hacen antes de impuestos, pero los aportes y, en la mayoría de los casos, las ganancias de estas, no están sujetos a los impuestos federales sobre las ganancias cuando se le distribuyan (siempre y cuando la distribución cumpla con ciertos requisitos).
- También podrá convertir los aportes antes de impuestos en aportes Roth después de impuestos solicitando una Conversión Roth dentro del Plan.
- Si se le acreditan al menos 1,000 horas de trabajo en su primer año y aporta a su cuenta, comienza a recibir aportes paralelos el primer día del mes calendario posterior a su primer aniversario de empleo.
- Una vez que adquiere elegibilidad para los aportes paralelos, Walmart realizará aportes paralelos por cada dólar que usted aporta, hasta el 6 % de su pago anual elegible. (No se hacen aportes paralelos por los aportes que realice antes de ser elegible para los aportes paralelos).
- Siempre tiene el derecho de posesión del 100 % sobre el dinero que contribuya y sobre el dinero que Walmart contribuya a su cuenta de contribuciones paralelas de la compañía.
- Usted decide cómo invertir todas los aportes realizados a su cuenta del Plan. Si no especifica cómo se invertirán sus aportes, se invierten automáticamente en la opción de inversión predeterminada del Plan, los fondos *myRetirement Funds*.
- El Plan acepta aportes de transferencia desde otros planes de jubilación elegibles. Puede retirar sus aportes de transferencia en cualquier momento.
- Puede solicitar un préstamo de su cuenta del Plan, sujeto a las reglas del Plan.
- Ahora, puede solicitar un retiro de hasta $5,000 con motivo del nacimiento o la adopción de un hijo.
- A partir del 1 de febrero de 2025, podrá solicitar retiros de hasta $1,000 para ayudarle a afrontar gastos personales o familiares de emergencia (lo que se denomina un retiro de emergencia limitado), o de hasta $22,000 si se ve afectado por una catástrofe grave declarada por el gobierno federal (lo que se denomina un retiro cualificado para la recuperación tras una catástrofe).

Este es un resumen de los beneficios ofrecidos por el Plan desde el 1 de octubre de 2024 (a menos que se indique lo contrario). Si surgieran cuestiones relativas a la naturaleza y al alcance de sus beneficios, prevalecerá el lenguaje formal del documento del Plan, no la redacción informal de este resumen.

Elegibilidad para el Plan 401(k) de Walmart

ASOCIADOS ELEGIBLES PARA PARTICIPAR EN EL PLAN

Todos los asociados de Walmart Inc. o de subsidiarias participantes son elegibles para participar en el Plan, excepto los siguientes:

- Empleados subcontratados; extranjeros no residentes sin ingresos provenientes de fuentes estadounidenses; contratistas o asesores independientes
- Personas que no sean tratadas como empleados de Walmart o de sus subsidiarias participantes
- Asociados cubiertos por un convenio colectivo de trabajo, en la medida en que el convenio no prevea la participación en este Plan y
- Asociados representados por un representante de un convenio colectivo de trabajo después de que Walmart haya negociado de buena fe un acuerdo con el representante respecto del tema de los beneficios.

A los fines de esta Descripción resumida del Plan, se hará referencia a todas las subsidiarias participantes como "Walmart".

CUÁNDO COMIENZA LA PARTICIPACIÓN

A los fines de sus aportes. Si es un asociado elegible, puede comenzar a hacer sus propias contribuciones al Plan tan pronto como sea administrativamente posible después de que su fecha de contratación se ingrese en el sistema de nómina. Consulte **Inscripción en el Plan** más adelante en este resumen para obtener detalles sobre el proceso de inscripción.

A los fines de los aportes paralelos. Si es un asociado elegible, comenzará a recibir aportes paralelos a partir del primer día del mes calendario siguiente a su primer aniversario de empleo en Walmart si tiene, como mínimo, 1,000 horas de trabajo acreditadas durante el primer año y está haciendo sus propios aportes (aportes antes de impuestos como aportes / Roth) al Plan. (Si está clasificado como empleado altamente remunerado, también debe haber cumplido 21 años). (No se realizan aportes paralelos a las suyas antes de que usted sea elegible para tales aportes). Por ejemplo, si su fecha de contratación fue el 15 de diciembre de 2023 y se le acreditan 1095 horas antes del 15 de diciembre de 2024 (su primer aniversario), entonces comenzará a recibir aportes paralelos el 1.º de enero de 2025, con respecto a cualquier aporte que haya realizado al Plan en o después de esa fecha.

Si no tiene 1,000 horas de trabajo acreditadas durante el primer año, su elegibilidad para recibir aportes paralelos se determinará según las horas acreditadas durante el año del Plan, que va desde el 1.º de febrero hasta el 31 de enero. Será elegible para recibir aportes paralelos sobre cualquier aporte que usted realice al Plan el 1.º de febrero, o luego de esa fecha, luego del año del Plan en que tenga, como mínimo, 1,000 horas de trabajo acreditadas. Por ejemplo, si su fecha de contratación es el 15 de diciembre de 2023 y se le han acreditado solamente 895 horas antes del 15 de diciembre de 2024 (su primer aniversario), pero usted trabajó 1,095 horas durante el año del Plan que va desde el 1.º de febrero de 2024 hasta el 31 de enero de 2025, comenzará a recibir aportes paralelos el 1.º de febrero de 2025 sobre todas los aportes que usted hace al Plan en esa fecha o después.

Si deja de trabajar para Walmart durante su primer año y se le acreditan más de 500 horas de servicio, conservará sus horas y la fecha del primer aniversario para determinar la elegibilidad para los aportes paralelos. Si vuelve a ser contratado más adelante, su elegibilidad para los aportes paralelos se determinará según las horas trabajadas durante el año del Plan, que se extiende desde el 1.º de febrero hasta el 31 de enero, a menos que se le acrediten 1,000 horas de servicio antes de la fecha de su primer aniversario.

Por ejemplo, si su fecha de contratación es el 15 de diciembre de 2023 y deja Walmart el 25 de febrero de 2024 con 600 horas de servicio, conservará sus horas de servicio y la fecha del primer aniversario para fines de elegibilidad coincidente. Si regresa a Walmart el 1.º de noviembre de 2024 (antes de la fecha de su primer aniversario) y no se le acreditan 1,000 horas de servicio antes de la fecha de su primer aniversario del 15 de diciembre de 2024, comenzará a recibir aportes paralelos sobre cualquier aporte que realice al Plan a partir del 1.º de febrero siguiente al año del Plan en el que se le acrediten al menos 1,000 horas de servicio.

CÓMO SE ACREDITAN LAS HORAS DE TRABAJO CONFORME AL PLAN

Si es un asociado pagado por hora, las horas que se contaron para el requisito de las 1,000 horas se acreditan de la siguiente manera:

- Se cuentan las horas, incluidas las horas extra, que trabaje en Walmart o en sus subsidiarias.
- También se cuentan las horas por las cuales recibe una licencia de ausencia o tiempo personal libre con derecho de sueldo.
- Cuando un periodo de sueldo se superpone con dos años del Plan, las horas se acreditan para el año del Plan en el cual verdaderamente se trabajaron.

Si es un asociado asalariado o conductor de camión, las horas que se contaron para el requisito de las 1,000 horas se acreditan de la siguiente manera:

- Se le acreditan 190 horas por mes por cada mes que trabaje al menos una hora en Walmart o en una de sus subsidiarias.
- En general, debe trabajar al menos seis meses del año del Plan para contar con 1,000 horas acreditadas para el año. (Las vacaciones pagadas en efectivo después de que deja de trabajar en Walmart no representan horas de trabajo adicional para este fin).

Si se convierte en un asociado de Walmart o de cualquier subsidiaria como resultado de la adquisición de su empleador anterior, es posible que se le apliquen reglas de acreditación de servicio especiales.

Conforme a la Ley de Derechos de Empleo y Reempleo de los Servicios Militares Uniformados de 1994 (USERRA), los veteranos que regresan a Walmart o a una subsidiaria luego de un servicio que califica pueden ser elegibles para que se considere el tiempo del servicio militar calificado para las horas de trabajo, conforme a este Plan. Comuníquese con Servicios al Personal al **800-421-1362** para obtener información.

Inscripción en el Plan

Poco después de ser elegible para contribuir al Plan (es decir, poco tiempo después de su fecha de contratación), recibirá un paquete de inscripción en la dirección particular que figura en su expediente. En este paquete, se explica cómo puede hacer aportes de su pago a su cuenta antes de impuestos o su cuenta Roth y cómo puede dirigir la inversión de los fondos de su Plan entre un menú de opciones de inversión con diversos objetivos de inversiones y sus riesgos relacionados. Dado que el Plan tiene el fin de ser una fuente importante de seguridad financiera durante su jubilación, debe leer detenidamente toda la información relacionada con el Plan.

Una vez que usted cumpla con los requisitos de elegibilidad para recibir aportes paralelos, Walmart igualará todas sus aportes posteriores dólar por dólar hasta un 6 % del pago anual elegible, tal como se explica en la sección **Aportes de Walmart a su cuenta de aportes paralelos de la compañía** sección

Para comenzar a hacer contribuciones al Plan, inscríbase en línea en **One.Walmart.com** o **benefits.ml.com**. También puede llamar al Centro de Atención al Cliente al **888-968-4015**. No obstante, recuerde que, si desea hacer aportes Roth al Plan, debe inscribirse en **benefits.ml.com**. Una vez que es elegible, puede inscribirse en cualquier momento.

Cuando se inscribe, puede elegir:

- El porcentaje del pago que desea aportar por cada periodo de pago, ya sean sus aportes antes de impuestos o aportes Roth, o una combinación de ambas (consulte **Cómo realizar aportes a su cuenta** más adelante en este resumen).
- Cómo invertir sus cuentas entre las opciones de inversión del Plan. Los procedimientos y las opciones de inversión del Plan se describen en el paquete de inscripción.

Luego de inscribirse, se le enviará por correo un aviso de confirmación a su dirección particular o, si eligió la opción de envío electrónico de los materiales del Plan, recibirá una notificación por correo electrónico cuando la confirmación esté disponible. La confirmación mostrará el porcentaje del pago de cada cheque que haya escogido para aportar, ya sea que haya elegido hacer aportes antes de impuestos, aportes Roth, o ambas, y las opciones de inversión que haya seleccionado. Consulte la confirmación para asegurarse de que la información de inscripción sea correcta.

Sus aportes al Plan comenzarán tan pronto como sea administrativamente posible, por lo general, dentro de dos periodos de pago después de inscribirse. Walmart solo realizará aportes paralelos para los participantes que contribuyan con sus propios fondos al Plan, conforme a los requisitos de elegibilidad descritos en la sección **Aportes de Walmart a su cuenta de aportes paralelos de la compañía**.

Es su responsabilidad revisar sus cheques de pago para confirmar que se haya implementado correctamente su elección. Si considera que su elección no se ha implementado correctamente, notifíquelo al Centro de Atención al Cliente al **888-968-4015** oportunamente, para que se tomen las medidas correctivas pertinentes. Su notificación no se considerará oportuna si se realiza pasados los tres meses posteriores a su elección.

Sus cuentas del Plan 401(k) de Walmart

El Plan 401(k) de Walmart consiste en varias cuentas. Usted tendrá algunas o la totalidad de las siguientes cuentas:

- **Cuenta antes de impuestos:** en esta cuenta, se mantienen sus aportes antes de impuestos al Plan (incluidos los aportes para ponerse al corriente, si las hubiera) ajustadas según las pérdidas o ganancias derivadas de tales aportes.
- **Cuenta Roth:** en esta cuenta, se mantienen sus aportes Roth al Plan (incluidos los aportes Roth para ponerse al corriente, si las hubiera) ajustadas según las pérdidas o ganancias derivadas de tales aportes. La cuenta Roth también contendrá cualquier importe que haya elegido convertir en una conversión Roth dentro del Plan, en la medida en que dichos importes no fueran distribuibles de otro modo en virtud del Plan en el momento de la conversión, ajustados por las ganancias o pérdidas.
- **Cuenta de aportes paralelos de la compañía:** en esta cuenta, se mantienen los aportes paralelos de Walmart ajustadas según las pérdidas o ganancias derivadas de tales aportes.
- **Cuenta de transferencia al siguiente año antes de impuestos:** en esta cuenta, se mantienen los aportes (excepto los aportes de una cuenta de aplazamiento de salario Roth designada) que usted transfirió a este Plan desde otro plan de jubilación elegible, ajustadas según las pérdidas y ganancias derivadas de tales aportes.
- **Cuenta Roth de transferencia al siguiente año:** en esta cuenta, se mantiene cualquier monto transferido a este Plan de su cuenta de diferimientos del sueldo Roth designada de otro plan de jubilación elegible, así como los importes que haya elegido convertir en una conversión Roth dentro del Plan, en la medida en que dichos importes fueran distribuibles de otro modo en virtud del Plan en el momento de la conversión, ajustados según las ganancias o pérdidas.
- **Cuenta 401(k) financiada por la compañía:** en esta cuenta, se mantienen los aportes discrecionales de Walmart realizadas al Plan para los años del Plan que finalizaron el 31 de enero de 2011 o antes, ajustadas según las pérdidas y ganancias derivadas de tales aportes.
- **Cuenta de reparto de utilidades financiada por la compañía:** en esta cuenta, se mantienen los aportes discrecionales de Walmart realizadas al Plan para los años del Plan que finalizaron el 31 de enero de 2011 o antes, ajustadas según las pérdidas y ganancias derivadas de tales aportes.

Las diferencias entre estas cuentas se analizan en más detalle a lo largo de este resumen.

Recuerde que, si pasa a ser un asociado de Walmart o de cualquier subsidiaria como resultado de la adquisición de su empleador anterior, y usted participó en el plan 401(k) de su empleador anterior, es posible que tenga otras cuentas en este Plan en el que se mantengan los montos contribuidos al plan de su empleador anterior. Si cree que este es su caso, llame al Centro de Atención al Cliente al **888-968-4015** para obtener más información sobre sus otras cuentas.

Transferencia de fondos de un plan de un empleador previo o de una IRA

Cuando comienza a trabajar para Walmart, es posible que tenga fondos a su favor provenientes del plan de jubilación de su empleador anterior, por ejemplo, un plan 401(k), un plan de reparto de utilidades, un plan 403(b) de un empleador exento de impuestos o un plan 457(b) de un empleador del gobierno. Si es así, puede transferir su dinero a este Plan. También puede transferir los fondos antes de impuestos que tenga en una cuenta de jubilación individual (IRA). Usted puede, en general, transferir los fondos antes de impuestos, pero puede transferir directamente los montos del Plan de una cuenta de diferimientos del sueldo Roth designada a otro plan de jubilación calificado. Si transfiere fondos a este Plan, recuerde estos puntos:

- Una vez que sus fondos se transfieren al Plan 401(k) de Walmart, deben ajustarse a las normas de este Plan, incluidas las normas de pagos de liquidación, y no a las normas de su empleador anterior o de su IRA
- Su aporte transferido será depositado en su cuenta de transferencia o a su cuenta Roth de transferencia y usted tendrá 100 % de derecho de posesión, y
- Podrá retirar en cualquier momento una parte o la totalidad de sus aportes de transferencia.

Si le interesa transferir sus aportes al Plan, comuníquese con el Centro de Atención al Cliente al **888-968-4015** o visite **benefits.ml.com** para obtener un paquete de transferencia.

Reembolso de determinadas distribuciones al Plan

Si anteriormente recibió uno de los siguientes tipos de distribuciones del Plan, puede amortizar la totalidad o parte de esas distribuciones al Plan siempre y cuando lo haga en un plazo de tres años a partir de la fecha en que recibió la distribución (o antes del 31 de diciembre de 2025 en el caso de una distribución cualificada por nacimiento o adopción recibida el 29 de diciembre de 2022 o antes), y se considerarán parte de su cuenta de reinversión, de acuerdo con las reglas descritas arriba:

- Una distribución cualificada por nacimiento o adopción.
- Un retiro de emergencia limitado.
- Un retiro cualificado en caso de catástrofe.

Asimismo, si recibe un retiro por dificultades económicas con el fin de comprar o construir su residencia principal, pero no puede utilizarlo para ese fin debido a una catástrofe grave declarada por el gobierno federal, por lo general puede reembolsar el retiro al Plan en un plazo de 180 días a partir del primer día del periodo del incidente (es decir, el periodo especificado por la Administración Federal de Gestión de Emergencias (FEMA) como el periodo en el que se produjo la catástrofe).

Consulte la sección **Recepción de un pago de liquidación mientras trabaja para Walmart** a continuación para obtener más información sobre estas distribuciones. Si le interesa volver a hacer una contribución por la totalidad o parte de esas distribuciones anteriores al Plan, comuníquese con el Centro de Atención al Cliente al **888-968-4015** o visite **benefits.ml.com**.

Cómo realizar aportes a su cuenta

Luego de convertirse en un participante del Plan, por lo general, puede elegir contribuir del 1 % al 50 % de cada cheque de pago a su cuenta antes de impuestos o su cuenta Roth. Sin embargo, sus aportes (incluidos tanto los aportes antes de impuestos como los aportes Roth) en cualquier año calendario no pueden exceder el límite determinado por el IRS. Para 2025, el límite es de $23,500. El IRS aumentará este monto de tanto en tanto.

El IRS limita el monto de remuneración que puede tenerse en cuenta conforme al Plan para todo participante para un año del Plan. Para el año del Plan con cierre al 31 de enero de 2026, este límite es de $350,000.

Además, puede elegir si sus aportes serán “aportes antes de impuestos” o “aportes Roth”. Conjuntamente, estas aportes se denominan “aportes 401(k)” en este resumen.

- los aportes antes de impuestos se deducen de su pago antes de que se retenga el impuesto federal sobre las ganancias. Esto significa que no paga los impuestos federales sobre las ganancias para los montos que contribuye al Plan. Las ganancias derivadas de estos aportes se acumulan libres de impuestos y no se le cobrarán impuestos hasta que el Plan le distribuya su cuenta antes de impuestos (o hasta que elija una conversión Roth dentro del Plan). También puede ahorrar en impuestos locales y estatales, según su localidad. Recuerde que sus aportes quedan sujetos a los impuestos de Seguridad Social en el año en que se deduce el monto de su paga. Sin embargo, las distribuciones del Plan no están sujetas a los impuestos de Seguridad Social.
- los aportes Roth se deducen de su pago después de que se retenga el impuesto federal sobre las ganancias. Esto significa que usted paga impuestos federales y estatales sobre las ganancias, y de seguridad social, para los montos que contribuye al Plan en el año en que se deduce el monto de su pago. Los aportes Roth y las ganancias derivadas de tales aportes no suelen estar sujetos a impuestos estatales y federales cuando el Plan distribuye su cuenta Roth. A fin de que las ganancias estén libres de impuestos, la distribución debe ser una distribución “calificada”, como se explica más adelante. (Recuerde que las limitaciones a las ganancias aplicables a las cuentas IRA Roth no se aplican a los aportes Roth del Plan. Puede elegir hacer aportes Roth independientemente de sus ingresos).

Asimismo, si hace aportes al Plan, puede llegar a ser elegible para el “crédito de ahorristas”. Si es un contribuyente casado que presenta una declaración de impuestos conjunta y tiene un ingreso bruto ajustado (AGI) de $79,000 o menos (para 2025), o si es un contribuyente soltero con $39,500 o menos (para 2025) de AGI en su declaración de impuestos, es elegible para obtener este crédito impositivo que puede reducir sus impuestos. Para obtener más información, su asesor fiscal puede consultar el Boletín 2001-106 del IRS.

CÓMO SE DETERMINA SU APORTE A LA CUENTA 401(K)

El porcentaje de su pago que elige contribuir al Plan se aplica a los siguientes tipos de pago:

- Salario o sueldo regular, incluidas las bonificaciones (excepto como se indica abajo) y los dólares antes de impuestos que utilice para sus aportes antes de impuestos o para comprar beneficios disponibles conforme al Plan de Salud y Bienestar para Asociados de Walmart Inc.
- Horas extras, tiempo libre pagado (utilizado y pagado), paga por luto, deber como jurado y pago de primas
- Bonificaciones por días festivos
- Premios especiales de reconocimiento, por ejemplo, el Premio al Desempeño Sobresaliente
- Pagos de sueldos diferenciales que reciba de Walmart mientras se encuentra con licencia militar calificada. Esto significa que el aporte que tenga vigente cuando sale de licencia continuará aplicándose a sus pagos de salarios diferenciales mientras se encuentra de licencia, a menos que cambie su elección y
- Pago por transición designado en relación al evento de la Ley WARN.

El porcentaje del pago que elija para contribuir al Plan no se aplicará a los siguientes tipos de pago:

- Contribución paralela del 15 % que Walmart realiza en el Plan de Compra de Acciones para Asociados;
- Reembolsos de gastos, como los gastos de traslado
- Beneficios sociales
- Beneficios complementarios
- Indemnizaciones
- Pago por discapacidad aprobado
- Un bono de contratación que se le pague a usted por venir a trabajar a Walmart
- Compensación por despido
- Compensaciones diferidas e ingresos derivados de acciones, incluidos los ingresos que surgen de opciones de compra de acciones o de derechos restringidos sobre acciones, o
- Al finalizar el empleo, un último cheque de pago antes del final de un ciclo normal de pagos (a menos que sea administrativamente posible retener su aporte de ese cheque de pago).

MODIFICACIÓN DEL MONTO DE SU APORTE AL PLAN 401(K)

Puede aumentar, reducir, interrumpir o comenzar sus aportes en cualquier momento en **One.Walmart.com** o **benefits.ml.com**. También puede llamar al Centro de atención al cliente al **888-968-4015**. Su cambio entrará en vigencia tan pronto como sea administrativamente posible, por lo general, dentro de dos periodos de pago. Si modifica el monto de su aporte, se le enviará una confirmación a su dirección particular o, si eligió la opción de envío electrónico de documentos del Plan, recibirá una notificación por correo electrónico cuando la confirmación esté disponible. Es su responsabilidad revisar sus cheques de pago para confirmar que se haya implementado correctamente su elección. Si considera que su elección no se ha implementado correctamente, notifíquelo al Centro de Atención al Cliente al **888-968-4015** oportunamente, para que se tomen las medidas correctivas pertinentes. Su notificación no se considerará oportuna si se realiza pasados los tres meses posteriores a su elección. Si no informa al Centro de atención al cliente oportunamente, el monto que se retiene de su cheque de pago se considerará su elección de diferimiento.

SI TIENE 50 AÑOS O MÁS (APORTES PARA PONERSE AL CORRIENTE)

Si tiene 50 años o más (o va a cumplir 50 al finalizar el año calendario correspondiente) y está aportan hasta el límite legal o del Plan, se le permite realizar aportes adicionales, que se denominan “aportes para ponerse al corriente” y se realizan a través de deducciones del sueldo, al igual que sus otros aportes. Puede elegir si sus aportes para ponerse al corriente serán aportes antes de impuestos o aportes Roth, o ambas. Para el 2025, sus aportes para ponerse al corriente pueden ser de cualquier monto que no supere los $7,500 o el 75 % de su paga anual elegible, lo que resulte menor. Sin embargo, sus aportes para ponerse al día (incluidas tanto los aportes para ponerse al día antes de impuestos como los aportes para ponerse al día Roth) en cualquier año calendario no pueden exceder el límite determinado por el IRS. A partir de 2025, si cumple 60, 61, 62 o 63 años antes de que finalice el año calendario, podrá realizar aportes de $11,250. El IRS puede modificar estos montos en dólares de vez en cuando. Sus aportes para ponerse al corriente se acreditarán a su cuenta antes de impuestos o su cuenta Roth, según el tipo de aporte que elija hacer. Recuerde que los aportes Roth solo se pueden hacer en **benefits.ml.com**.

Por ejemplo, si tiene 55 y opta por contribuir el monto máximo en el año calendario 2025, la cual es la inferior entre $23,500 o el porcentaje máximo de su paga anual elegible permitido conforme al Plan, podría decidir contribuir hasta $7,500 más durante el año calendario 2025. Si está interesado en comenzar a hacer aportes para ponerse al corriente, puede inscribirse en **One.Walmart.com** o **benefits.ml.com**, o puede llamar al Centro de Atención al Cliente al **888-968-4015**.

CONTRIBUCIÓN A MÁS DE UN PLAN DURANTE EL AÑO

El monto máximo total que puede aportar (incluidos los aportes antes de impuestos y los aportes Roth) a este Plan y a cualquier otro plan de la compañía (incluidos los planes de anualidades 403(b), las pensiones simplificadas de los empleados u otros planes 401(k)) es de $23,500 para el año calendario 2025, o de $31,000 si reúne los requisitos para realizar aportes para ponerse al día. (A partir de 2025, el límite de aportes para ponerse al día será superior en los años en los que cumpla 60, 61, 62 o 63 años, tal y como se describe en la sección de arriba). El IRS puede aumentar estos montos en dólares de vez en cuando. Si contribuye a más de un plan durante el año, es su responsabilidad determinar si ha excedido el límite legal.

Si sus aportes totales superan el límite legal para el año calendario, debe solicitar que se le reembolse el monto excedido. El monto excedido (a excepción de lo especificado con respecto a los aportes Roth) debe estar incluido en su ingreso para el año diferido y se aplicarán impuestos. Las ganancias del monto excedido están sujetas a impuestos en el año en que se le reembolsan. Además, si el monto excedido no se le reembolsa antes del 15 de abril luego del año en que el monto fue diferido, se le cobrará un impuesto por segunda vez cuando el monto excedido se le distribuya. Para solicitar que este Plan le devuelva los aportes excedidos, llame a Servicios al cliente al **888-968-4015** antes del 1.º de abril siguiente al año calendario en el cual se efectuaron dichas aportes excedidos. El Administrador establecerá procedimientos para determinar si se le devolverán los aportes antes de impuestos o los aportes Roth, si hizo los dos tipos de aportes durante el año calendario. En la medida en que los montos en exceso se distribuyan desde sus aportes Roth, no deberá pagar impuestas por estas, pero sí por las ganancias relacionadas que se distribuyan. Se perderá todo aporte paralelo relacionado con aportes reembolsados.

SI PRESTA SERVICIO MILITAR CALIFICADO

Si se ausenta del trabajo para cumplir sus obligaciones en el servicio militar, es posible que la Ley de Derechos de Empleo y Reempleo de los Servicios Militares Uniformados de 1994 (USERRA) le otorgue el derecho de realizar los aportes que no realizó durante el periodo en el servicio militar (es decir, realizar aportes iguales al monto que habría sido elegible para hacer si hubiese estado trabajando para Walmart). Para obtener más información, comuníquese con el Servicio de Atención al Cliente al **888-968-4015**.

Cómo hacer una conversión Roth dentro del Plan

Puede optar por convertir todas o parte de los aportes otorgadas en su cuenta (que no sean aportes Roth y ganancias relacionadas, y fondos que formen parte de un saldo de préstamo pendiente) en aportes Roth a través de una "conversión Roth dentro del Plan". Los aportes que elija convertir, junto con cualquier ganancia sobre esos aportes hasta la fecha de la conversión, estarán sujetos a los impuestos federales, estatales y locales aplicables en el año de la conversión. Sin embargo, no se retendrán impuestos en el momento de la conversión, por lo que usted deberá asegurarse de que puede pagar los impuestos correspondientes a su vencimiento. Por consiguiente, es posible que desee aumentar sus deducciones del sueldo o realizar pagos de impuestos estimados. El importe convertido no está sujeto a una sanción del 10 %. Una vez convertidos, los fondos no pueden volver a convertirse en fondos antes de impuestos.

Las normas aplicables a sus fondos después de la conversión difieren en función de si los fondos eran elegibles para la distribución del Plan en el momento de la conversión.

- Si los fondos que convierte eran elegibles para su distribución (por ejemplo, si tiene 59 años y medio) y son elegibles para su transferencia, los fondos serán tratados como si fueran distribuidos desde el Plan y luego reintegrados a este. Esto significa que se acreditarán en su cuenta de transferencia Roth y podrán retirarse en cualquier momento.
- Si los fondos que convierte no eran elegibles para la distribución, se acreditarán en su cuenta Roth y seguirán sujetos a las mismas normas de distribución después de la conversión que antes de esta. Por ejemplo, si elige convertir sus aportes diferidas del sueldo antes de impuestos, esos fondos generalmente no podrán ser distribuidos hasta que tenga 59 años y medio de edad, tenga en una dificultad financiera o deje de trabajar.

Aportes de Walmart a su cuenta de aportes paralelos de la compañía

Una vez que sea elegible para recibir aportes paralelos, Walmart realizará aportes paralelos a su cuenta de aportes paralelos de la compañía iguales al 100 % de sus aportes posteriores (incluidos los aportes antes de impuestos, Roth y para ponerse al corriente) para el año del Plan, hasta el 6 % de su pago anual elegible para el año del Plan. No se realizarán aportes paralelos a las suyas antes de que usted sea elegible para tales aportes. Después de que comience a ser elegible para realizar aportes paralelos, el aporte paralelo de la compañía se realizará en su cuenta de aportes paralelos de la compañía cada periodo de pago hasta que alcance el monto total del aporte paralelo de la compañía para la cual es elegible para ese año del Plan. Su pago anual elegible para este fin es el mismo que el que se describió anteriormente para determinar sus aportes 401(k) al Plan, pero no incluye los montos que se le pagaron antes de que usted se volviera elegible para recibir aportes paralelos.

NOTA: El límite de los aportes paralelos se aplica sobre la base del *año del Plan* (del 1 de febrero al 31 de enero). Dado que el límite en dólares de sus aportes al plan 401(k) ($23,500 para 2025) se aplica sobre la base de un año calendario, es importante que tenga en cuenta el momento de sus aportes al plan 401(k) para asegurarse de recibir la totalidad del aporte paralelo. Por ejemplo, si aporta la totalidad de los $23,000 en aportes al plan 401(k) en enero de 2025, es posible que no reciba un aporte paralelo sobre esos montos si ya ha recibido el límite máximo de aporte paralelo anteriormente en el año del Plan con cierre al 31 de enero de 2025.

Como se mencionó anteriormente, si se ausenta del trabajo para cumplir obligaciones del servicio militar calificado, es posible que la Ley USERRA le otorgue el derecho de realizar los aportes a la Cuenta 401(k) que no realizó durante el periodo en el que prestó servicio militar. Si efectivamente compensa aportes a la Cuenta 401(k), Walmart deberá compensar los aportes paralelos que usted hubiera recibido para tales aportes. Si cree que esta regla se aplica a su caso, llame a Servicios al Personal al **800-421-1362**.

DERECHO DE POSESIÓN DE SU CUENTA DE CONTRIBUCIONES PARALELAS DE LA COMPAÑÍA

Siempre tiene un derecho de posesión del 100 % sobre los aportes paralelos de Walmart que realice a su cuenta de aportes paralelos de la compañía.

DERECHO DE POSESIÓN DE SU CUENTA DE REPARTO DE UTILIDADES FINANCIADA POR LA COMPAÑÍA

Si tiene una cuenta de reparto de utilidades financiada por la compañía (consulte **Sus cuentas del Plan 401(k) de Walmart** que aparece anteriormente en este resumen), el porcentaje de derecho de posesión de esta cuenta es la parte que usted tiene derecho a recibir si se va de Walmart. En sus resúmenes de cuenta, se muestran los porcentajes con derecho de posesión.

A usted se le concede derecho de posesión sobre su cuenta de reparto de utilidades financiada por la compañía (que no sean transferencias a esa cuenta, sobre las cuales tendrá siempre un derecho de posesión del 100 %) en función de los años trabajados en Walmart de la siguiente manera:

PROGRAMA DE ADQUISICIÓN DE DERECHOS DEL REPARTO DE UTILIDADES*

Años de servicio	Porcentaje de derecho de posesión
Menos de 2	0 %
2	20 %
3	40 %
4	60 %
5	80 %
6 o más	100 %

* Se aplica a los participantes que se encuentran trabajando activamente desde el 31 de enero de 2008 en adelante.

NOTA: Si su empleo finalizó antes del 1 de febrero de 2007, su pago de liquidación se basó en el cronograma previo de derechos de posesión y no en el cronograma de derechos de posesión que aparece anteriormente.

Un año de trabajo en este caso equivale a un año del Plan (del 1 de febrero al 31 de enero) en el cual se le acreditan al menos 1,000 horas de trabajo según la reglamentación de horas de trabajo (consulte la sección **Cómo se acreditan las horas de trabajo conforme al Plan** anteriormente en este resumen).

Si se le acreditan menos de 1,000 horas en un año del Plan, su derecho de posesión no aumenta por ese año. (Recuerde que en este caso los años de trabajo no se determinan por su fecha de aniversario).

Si su relación laboral con Walmart finaliza porque se jubila (a los 65 años o más) o por fallecimiento, su derecho de posesión sobre la cuenta de reparto de utilidades financiada por la compañía será del 100 %, independientemente de sus años de trabajo. Tendrá un derecho de posesión del 100 % sobre su cuenta de reparto de utilidades financiada por la compañía si el plan se terminara.

CONCESIÓN DE SU CUENTA 401(K) FINANCIADA POR LA COMPAÑÍA

Siempre dispone del 100 % de derechos de posesión sobre los aportes de Walmart a su cuenta 401(k) financiada por la compañía (consulte **Sus cuentas del Plan 401(k) de Walmart** anteriormente en este resumen).

Inversión de su cuenta

SUS OPCIONES DE INVERSIÓN

Usted decide cómo se invertirán sus cuentas. Puede elegir entre las siguientes opciones:

- **Los fondos de *myRetirement* Fund.** Los fondos de *myRetirement* Funds son una serie de opciones de inversión personalizadas creadas exclusivamente para los participantes del Plan por el Comité de Inversión de Beneficios, que se conocen comúnmente como fondos "con la jubilación como fecha tope". Los fondos de *myRetirement* Funds son opciones de inversión diversificadas que cambian automáticamente la asignación de los activos con el transcurso del tiempo, a fin de ser más conservadoras a medida que se acerca a la edad de jubilación. Para lograrlo, se mueve la cantidad de dinero que se destina a inversiones más agresivas, como las acciones, y se la asigna a inversiones más conservadoras, como los bonos, a medida que se acerca a la edad de jubilación.
- **Entre un menú de opciones de inversión que ofrece el Plan.** Tenga en cuenta que las acciones de Walmart son opciones de inversión solamente para su cuenta de reparto de utilidades financiada por la compañía. Las acciones de Walmart no se ofrecen para la inversión a través de ninguna de sus otras cuentas del Plan (aunque en la medida en que tales cuentas mantengan acciones de Walmart, siempre puede vender tales acciones, pero no se permite que se compren acciones de Walmart en el futuro).

Puede elegir una de las opciones de inversión, o bien, repartir su dinero entre varias opciones de inversión. Las ganancias o las pérdidas de las inversiones de sus cuentas dependen del rendimiento de las inversiones que elija.

Si no elige una opción de inversión para los aportes actuales de su cuenta, estas se invertirán en uno de los fondos de *myRetirement* Funds según su edad. Para obtener más información, consulte el documento Alternativa de inversión predeterminada calificada (QDIA) y la Guía de inversión. Para obtener estos documentos, visite **benefits.ml.com** o llame al Centro de Atención al Cliente al **888-968-4015**.

Como la Cuenta de reparto de utilidades financiada por la compañía es un Plan de propiedad de acciones para empleados, la totalidad o una parte significativa de los aportes al reparto de utilidades de Walmart se invirtió en acciones de Walmart en los años del Plan que finalizaron antes del 31 de enero de 2006. Si usted era un participante del Plan antes de esa fecha, es posible que tenga acciones de Walmart en su cuenta de reparto de utilidades financiada por la compañía. Para los años del Plan que finalizaron el 31 de enero de 2007 o después, los aportes de reparto de utilidades de Walmart no se invirtieron en acciones de Walmart.

En el paquete de inscripción que recibe cuando es elegible para inscribirse, se incluye una descripción de todas las opciones de inversión, incluidos los fondos de *myRetirement* Funds. También puede obtener información adicional sobre cada opción de inversión consultando la Notificación anual de información sobre los gastos del participante y la Guía de inversión. Puede obtener una copia gratuita accediendo en línea a su cuenta en **benefits.ml.com** o llamando al Centro de Atención al Cliente al **888-968-4015**.

Recuerde que este Plan se elaboró expresamente como un "plan de la Sección 404(c) de ERISA". Esto significa que usted asume todos los riesgos de inversión relacionados con las opciones de inversión que selecciona conforme al Plan, o donde se inviertan sus fondos si usted no selecciona una opción de inversión, incluido el aumento o la disminución del valor de mercado. Ni Walmart Inc. ni el Comité de Inversión de Beneficios ni el depositario son responsables de las pérdidas de las cuentas que se produzcan como resultado directo y necesario de las decisiones de inversión que usted tomó o, si usted no tomó una decisión de inversión, como resultado de que sus cuentas no fueron invertidas en un fondo predeterminado.

Si tiene una cuenta de reparto de utilidades financiada por la compañía (consulte **Sus cuentas del Plan 401(k) de Walmart** que aparece anteriormente en este resumen) y decide invertir total o parcialmente su cuenta de reparto de utilidades financiada por la compañía en acciones de Walmart, o mantener las acciones de Walmart en sus otras cuentas, recuerde que esta opción es una inversión individual en acciones y, por lo tanto, generalmente conlleva un riesgo mayor que las opciones ofrecidas por el Plan.

CÓMO OBTENER MÁS INFORMACIÓN DE INVERSIÓN

También es importante revisar periódicamente su cartera de inversiones, los objetivos de sus inversiones y las opciones de inversión disponibles conforme al Plan, para asegurarse de que sus inversiones estén alineadas con sus objetivos y su nivel de tolerancia al riesgo. Para obtener más fuentes de información sobre inversiones individuales y diversificación, visite el sitio web de la Administración de Seguridad de los Beneficios del Empleado del Departamento de Trabajo en **www.dol.gov/agencies/ebsa** y escriba "inversiones y diversificación" en el campo de búsqueda.

Puede obtener información más específica sobre sus derechos y opciones de inversión conforme al Plan en **benefits.ml.com** o llamando al Centro de Atención al Cliente al **888-968-4015**.

MODIFICACIÓN DE SUS ELECCIONES DE INVERSIÓN

Puede modificar sus elecciones de inversión en cualquier momento en línea en **benefits.ml.com** o llamando al Centro de Atención al Cliente al **888-968-4015**. Si realiza una modificación en su inversión, se le enviará una notificación de confirmación a su dirección particular, o bien recibirá una notificación por correo electrónico cuando la confirmación esté disponible si eligió la opción de envío electrónico de sus materiales del Plan. Es su responsabilidad asegurarse de que se implemente la modificación. Si no recibe una notificación de confirmación, o si no ve aplicada la modificación que solicitó, llame al Centro de Atención al Cliente al **888-968-4015**.

Si llama al Centro de Atención al Cliente antes de las 3:00 p. m., hora del este, por lo general, la modificación de su inversión se aplicará el mismo día en que llama. Según la modificación de su inversión, puede haber un periodo de liquidación de hasta tres días antes de que sus fondos se inviertan en su nueva elección.

DIVERSIFICACIÓN

Para ayudarlo a diversificar sus ahorros de jubilación, el plan le ofrece una variedad de opciones de inversión con diferentes niveles de riesgo y potencial para aumentar en valor. "Diversificar" significa que reparte sus valores entre diferentes tipos de inversiones. Para ayudarlo a alcanzar una seguridad de jubilación a largo plazo, debe considerar cuidadosamente los beneficios de una cartera de inversión diversificada y bien equilibrada. Esta estrategia puede ayudar a reducir el riesgo y puede proporcionar ganancias constantes, ya que una reducción en el valor de una inversión podría deducirse mediante un aumento en el valor de otra. Si invierte más del 20 % de sus ahorros de jubilación en acciones de cualquier tipo, como ser las acciones de Walmart, o en una industria, sus ahorros pueden no llegar a diversificarse de manera adecuada. Si bien la diversificación no puede asegurar una ganancia ni protege contra pérdidas, puede ser una estrategia efectiva para ayudarlo a manejar el riesgo de inversión.

A la hora de decidir cómo invertir sus ahorros de jubilación, debe tener en cuenta todos sus valores, incluidos los ahorros de jubilación fuera del Plan. Por ejemplo, puede poseer acciones de Walmart a través de otros medios. Nunca una sola estrategia va a ser la mejor para todos debido a que, entre otros factores, las personas tienen diferentes objetivos financieros, diferentes tiempos para alcanzar sus objetivos y diferentes niveles de tolerancia al riesgo. Recuerde sus derechos para diversificar su cuenta del Plan y considere cuidadosamente cómo elige invertir su cuenta del Plan. Para obtener información sobre su derecho para diversificar su cuenta y todas sus opciones de inversión disponibles conforme al Plan, acceda a su cuenta en línea en **benefits.ml.com** o llame al Centro de Atención al Cliente al **888-968-4015**. También es importante revisar periódicamente su cartera de inversiones, los objetivos de sus inversiones y las opciones de inversión disponibles conforme al Plan, para asegurarse de que sus inversiones sigan siendo adecuadas para sus metas de jubilación y su tolerancia al riesgo de inversión. Para obtener más información sobre inversiones individuales y diversificación, visite el sitio web de la Administración de Seguridad de los Beneficios del Empleado del Departamento de Trabajo en **www.dol.gov/agencies/ebsa** y escriba "inversiones y diversificación" en el campo de búsqueda.

Más información sobre la propiedad de acciones de Walmart

VOTACIÓN

Si invierte su cuenta en acciones de Walmart conforme al plan, cada año recibirá todo el material que generalmente se distribuye a los accionistas de Walmart, incluida una tarjeta de instrucciones que indica al depositario cómo desea usted que vote por las acciones de su cuenta del Plan. Los materiales se envían a su dirección particular o electrónicamente, según las elecciones que haya hecho en Internet.

Puede dar instrucciones al depositario, a través del agente de transferencias de la compañía, sobre cómo votar por las acciones de Walmart de sus cuentas del Plan. Esto ocurre generalmente en mayo de cada año. Las instrucciones que da al agente de transferencias y al depositario son siempre confidenciales. Envíe sus instrucciones de voto directamente al agente de transferencias, que compila los votos y notifica al Comité de Inversión de Beneficios sobre el total de votos emitidos. Luego, el Comité de Inversión de Beneficios notifica al depositario del Plan sobre el total de votos que se emitirán.

Si no da instrucciones al depositario sobre cómo desea usted que vote por sus acciones, el Comité de Inversión de Beneficios votará por esas acciones según su propio criterio. En caso de que ni usted ni el Comité de Inversión de Beneficios ejerzan los derechos de voto, el depositario o un fiduciario independiente designado por el depositario puede votar por las acciones no votadas.

CONFIDENCIALIDAD

Se han diseñado procedimientos para proteger la confidencialidad de sus derechos con respecto a las acciones de capital de Walmart que posee conforme al Plan, incluso el derecho a comprar, vender, mantener o votar en asuntos de representación. Por ejemplo, se han implementado procedimientos con el agente de transferencia de la compañía para las acciones de Walmart que previenen que Walmart Inc. y el Comité de Inversión de Beneficios averigüen cómo votó un participante individual o un beneficiario (excepto según sea necesario para cumplir con las leyes de valores) y que tengan acceso a sus tarjetas de representación individual o comentarios del titular de la tarjeta de representación.

Además, el acceso a información sobre sus decisiones de comprar, vender o mantener acciones de Walmart generalmente está limitado a aquellos que ayudan en la administración del Plan. El Comité de inversión de beneficios es responsable de garantizar que estos procedimientos sean suficientes para proteger la confidencialidad de esta información y de que se sigan los procedimientos. Si el Comité de inversión de beneficios determina que Walmart podría tener influencia indebida con respecto a sus derechos como accionista (a través de su Cuenta del Plan), el Comité de Inversión de Beneficios designará a una parte independiente para realizar las actividades que sean necesarias para prevenir tal situación.

DIVIDENDOS SOBRE SUS ACCIONES DE WALMART

Si tiene acciones de Walmart en sus cuentas, todos los dividendos que Walmart Inc. pague con respecto a las acciones se acreditarán en sus cuentas. Los dividendos adjudicados a su cuenta antes de impuestos, su cuenta 401(k) financiada por la compañía o su cuenta de transferencias 401(k) serán reinvertidos automáticamente en acciones de Walmart. Los dividendos adjudicados a su cuenta de reparto de utilidades financiada por la compañía (y su cuenta de transferencia de reparto de utilidades) también se volverán a invertir en acciones de Walmart, excepto en el caso que se indica a continuación.

Si es un participante activo (excepto los beneficiarios y los beneficiarios alternativos, tal como se define en la sección **Si se divorcia**) con seis años de trabajo o más tiene la opción de recibir un pago de liquidación en efectivo por los dividendos pagados sobre las acciones de Walmart que mantiene en su cuenta de reparto de utilidades financiada por la compañía o cuenta de transferencia de reparto de utilidades (incluso si estos montos no se convierten a una Cuenta Roth o a una Cuenta de transferencia Roth). Además, si es un participante que fue despedido, que tenía más de seis años de trabajo al momento de finalizar su relación laboral con la compañía y que continúa manteniendo cuentas en el Plan después de irse, tiene la opción de elegir la liquidación en efectivo por los dividendos pagados sobre las acciones de Walmart que mantiene en su cuenta de reparto de utilidades financiada por la compañía o cuenta de transferencia de reparto de utilidades (incluso si estos montos no se convierten a una cuenta Roth o a una cuenta de transferencia Roth). Si no opta por el pago en efectivo, sus dividendos se volverán a invertir en acciones de Walmart.

Puede realizar su elección en cualquier momento llamando al Centro de Atención al Cliente al **888-968-4015**. Su elección registrada más recientemente se aplicará a todos los dividendos posteriores hasta que cambie su elección. (Puede cambiarla sólo una vez por cada día hábil). Recuerde que su elección debe hacerse antes del cierre de actividades de negocios el día anterior a la fecha de registro del dividendo para que pueda entrar en vigencia para ese dividendo. No podrá hacer elecciones o modificaciones de elecciones desde la fecha de registro del dividendo hasta la fecha de pago del dividendo (periodo que habitualmente es de tres a cuatro semanas después de la fecha de registro).

Cada año, Walmart Inc. publica las fechas de registro trimestrales para los pagos de liquidación de dividendos. Esta información está disponible en **walmart.com**. Si necesita información acerca de las próximas fechas de registro para dividendos, también puede llamar al Centro de atención al cliente al **888-968-4015**. Recuerde que se aplica un impuesto al pago de liquidación de dividendos.

Tenga presente que, si solicita un pago de liquidación por dificultad financiera dentro de los cinco días hábiles de la fecha de registro para un dividendo y tiene derecho a elegir un pago en efectivo del dividendo, la legislación impositiva exige que el dividendo se le pague automáticamente en efectivo.

Saldos y resúmenes de cuenta

Al menos una vez por año, recibirá un resumen de sus cuentas que muestra los aportes realizados por usted y por Walmart, si las hubiera, el rendimiento de sus opciones de inversión, los valores de sus cuentas y tarifas evaluados para su cuenta. Puede obtener información sobre sus cuentas, incluido un resumen trimestral, en cualquier momento en línea en **benefits.ml.com** o llamando al Centro de Atención al Cliente al **888-968-4015**. También puede pedir una copia impresa de los resúmenes trimestrales, sin cargo alguno, en cualquier momento llamando al Centro de Atención al Cliente.

GASTOS APLICADOS A SU CUENTA

Podrán procesarse gastos administrativos y de inversión para sus cuentas. Puede encontrar información sobre los gastos en la Notificación anual de información sobre los gastos del participante y en línea en **benefits.ml.com.**

Recepción de un pago de liquidación mientras trabaja para Walmart

Generalmente, usted no tiene derecho a recibir un pago de liquidación del Plan 401(k) de Walmart hasta que finaliza su empleo en Walmart. Sin embargo, en las siguientes situaciones específicas puede tener derecho a recibir un pago de liquidación o préstamo de alguna o todas sus cuentas con derecho de posesión mientras aún se encuentra trabajando:

- Ante una dificultad financiera.
- Para ayudar con gastos de emergencia limitados.
- Si se ve afectado por una catástrofe grave declarada a nivel federal.
- Después de alcanzar la edad de 59 años y medio.
- Con motivo del nacimiento o la adopción de un hijo.
- Las transferencias pueden retirarse en cualquier momento.
- Puede solicitar un préstamo de su cuenta del Plan.

Puede solicitar cualquiera de estos retiros por Internet en **benefits.ml.com** o llamando al Centro de atención al cliente al **888-968-4015**.

Es importante entender cómo cualquier tipo de pago de liquidación o préstamo por parte del Plan 401(k) de Walmart afecta su situación fiscal. Para obtener más información, consulte **Consecuencias del impuesto a las ganancias luego de un pago de liquidación** en este resumen.

Recuerde que, si pasa a ser un asociado de Walmart o de cualquier subsidiaria como resultado de la adquisición de su empleador anterior, y usted participó en el plan 401(k) de su empleador anterior y ese plan se incorporó al Plan, es posible que tenga otras opciones de retiro con respecto a montos contribuidos al plan de su empleador anterior. Para obtener más información sobre las opciones de retiro disponibles para sus otras cuentas, llame al Centro de Atención al Cliente al **888-968-4015**.

RETIROS POR DIFICULTAD FINANCIERA

Puede retirar el monto total o parcial de sus cuentas del Plan con derecho irrevocable, según sea necesario para resolver una “dificultad financiera”. Se le solicitará que certifique que no tiene el dinero en efectivo suficiente u otros activos líquidos para satisfacer la necesidad.

Según los lineamientos del IRS, se considera que puede existir una dificultad financiera si se solicita para lo siguiente:

- Pago de gastos de atención médica que el seguro no cubre para usted, su cónyuge, sus dependientes o su beneficiario principal afirmativamente designado
- Costos relacionados directamente con la compra de su residencia principal
- Pagos de matrícula, aranceles y alojamiento con comida durante los próximos 12 meses de educación superior para usted, su cónyuge, sus dependientes o su beneficiario principal afirmativamente designado
- Pagos necesarios para evitar el desalojo o el remate judicial de su residencia principal
- Pago de gastos de sepelio o funeral por fallecimiento de sus padres, cónyuge, hijos, dependientes o su beneficiario principal afirmativamente designado, o
- Gastos de reparación por daños ocasionados a su residencia principal, lo que calificaría para una deducción por contingencia conforme a las normas del impuesto federal a las ganancias (determinados independientemente de si la contingencia se trató de un desastre declarado a nivel nacional y si la pérdida supera el 10 % de su ingreso bruto ajustado).
- Los gastos y las pérdidas (incluida la pérdida de ingresos) en que usted haya incurrido a causa de un desastre declarado federalmente en virtud de la Ley Robert T. Stafford de Ayuda por Desastre y Asistencia por Emergencia, siempre que su residencia o su lugar principales de empleo al momento del desastre se encuentre dentro de una zona designada para la asistencia individual con respecto al desastre.

La legislación impositiva federal exige que usted ya haya obtenido todos los pagos de liquidación en el trabajo disponibles (incluidos los retiros en servicio de aportes de transferencia y los retiros después de alcanzar la edad de 59 años y medio), antes de solicitar un pago de liquidación por dificultad financiera. De conformidad con las condiciones del Plan, también deberá haber obtenido cualquier retiro de emergencia limitado disponible antes de poder solicitar un pago por dificultades económicas. Recuerde también que, si solicita un pago por dificultad financiera dentro de los cinco días hábiles de la fecha de registro de un dividendo y tiene derecho a emitir un voto por un pago en efectivo de ese dividendo, el dividendo se le distribuirá automáticamente en efectivo.

Tenga en cuenta que si solicita un retiro por dificultades económicas para comprar o construir su vivienda principal en una zona que se haya declarado catastrófica por el gobierno federal, pero no puede hacerlo debido a la catástrofe, es posible que pueda amortizar el retiro al Plan y evitar que se le cobren impuestos. Para que esto se aplique, debe haber realizado el retiro entre 180 días antes del “periodo del incidente” y los 30 días posteriores a la finalización del periodo del incidente, y, por lo general, debe amortizar el retiro al Plan en un plazo de 180 días a partir del primer día del periodo del incidente. El periodo del incidente es el periodo especificado por la Administración Federal de Gestión de Emergencias (FEMA) como el periodo en el que ocurrió la catástrofe. Si cree que esto puede aplicarse a su caso, debe ponerse en contacto con el Centro de atención al cliente llamando al **888-968-4015** para obtener más información.

RETIROS DE EMERGENCIA LIMITADOS

A partir del 1 de febrero de 2025, podrá solicitar un retiro de su cuenta de derechos adquiridos de hasta $1,000 (o, si es inferior, el monto de derechos adquiridos de su cuenta que exceda de $1,000) para cualquier emergencia imprevisible o necesidad financiera inmediata relacionada con gastos de emergencia personales o familiares necesarios. Debe declarar al Plan que presenta su solicitud para este fin. Puede solicitar un retiro por año calendario y no puede solicitar otro en los tres años calendarios siguientes, a menos que reembolse puntualmente al Plan el monto total del retiro o que, desde su retiro, haya realizado aportes al plan 401(k) al menos iguales al monto del retiro. Si desea reembolsar el monto retirado, debe hacerlo en un plazo de tres años a partir de la fecha en que lo recibió.

RETIROS EN CASO DE CATÁSTROFE QUE REÚNA LOS REQUISITOS

A partir del 1 de febrero de 2025, podrá solicitar un retiro de fondos de su cuenta de derechos adquiridos de hasta $22,000 si su residencia principal se encuentra en una zona declarada catastrófica por el gobierno federal y sufre una pérdida económica debido a la catástrofe, como daños en su vivienda o gastos en los que incurra por no poder vivir en ella. (Tenga en cuenta que este límite de $22,000 se aplica, en conjunto, a todos los retiros que reciba de todos los planes y cuentas IRA que tenga). Por lo general, su distribución debe realizarse dentro de un plazo de 180 días a partir del primer día del "periodo del incidente" (el periodo especificado por la FEMA como el periodo en el que se produjo la catástrofe). Se le pedirá que declare ante el Plan que reúne los requisitos para tal retiro. Si desea reembolsar el monto retirado, debe hacerlo en un plazo de tres años a partir de la fecha en que lo recibió.

RETIROS DESPUÉS DE ALCANZAR LA EDAD DE 59 AÑOS Y MEDIO

En cualquier momento después de alcanzar la edad de 59 años y medio, puede optar por retirar todo o parte de sus cuentas del Plan, hasta donde lo permita el derecho de posesión, aunque todavía trabaje para Walmart.

RETIROS CON MOTIVO DE NACIMIENTO O ADOPCIÓN DE UN HIJO

Puede solicitar un retiro de hasta $5,000 de la porción con derecho a posesión de su cuenta del Plan, dentro del plazo de un año a partir de la fecha de nacimiento o adopción de su hijo. En el caso de la adopción, el adoptado debe ser menor de 18 años o estar incapacitado física o mentalmente para valerse por sus propios medios, y no debe ser hijo de su cónyuge. Tiene que declarar al Plan que el retiro está relacionado con el nacimiento o la adopción de su hijo. Si desea reembolsar el retiro, debe hacerlo en un plazo de tres años a partir de la fecha en que lo recibió, o antes del 31 de diciembre de 2025 en el caso de una distribución cualificada por nacimiento o adopción recibida el 29 de diciembre de 2022 o antes.

NOTA: Su distribución no se considerará una distribución calificada por nacimiento o adopción a menos que incluya el nombre, la edad y el número de identificación de contribuyente del hijo biológico o adoptado en su declaración federal de impuesto a los ingresos del año en que se realiza la distribución.

RETIRO DE APORTES DE TRANSFERENCIA

Podrá retirar una parte o la totalidad de los fondos de su cuenta de transferencia antes de impuestos, cuenta de transferencia Roth, y su cuenta de transferencia de reparto de utilidades en cualquier momento, incluso si aún trabaja para Walmart o alguna de sus subsidiarias.

PRÉSTAMOS PARA PLANES

Puede solicitar un préstamo de las partes otorgadas de la cuenta del Plan siempre y cuando siga trabajando en Walmart. El Administrador ha establecido un programa escrito de préstamos en el que se explican detalladamente los requisitos de préstamo del Plan. Para solicitar una copia del programa de préstamos o solicitar un préstamo en línea, visite **benefits.ml.com** o llame al Centro de Atención al Cliente al **888-968-4015**.

Por lo general, las normas para préstamos son las siguientes:

- El monto máximo para un préstamo está establecido por las normas del IRS que suelen limitar los saldos totales de préstamos al monto inferior de una de las siguientes opciones: (1) 50 % del total de su cuenta del Plan con derecho de posesión o (2) $50,000 (o menos según el excedente, si lo hubiera, del mayor de los saldos pendientes de los préstamos durante el plazo de un año previo a la fecha del préstamo en relación con el saldo pendiente actual de préstamos). El monto mínimo para un préstamo es de $1,000.
- Todos los préstamos tienen que estar garantizados con hasta 50 % del saldo total de su cuenta del Plan.
- Se cobrará un cargo por el procesamiento de la solicitud del préstamo. Podrían sumarse cargos adicionales a los préstamos residenciales. (Los importes de las tasas pueden aumentar periódicamente).
- Todos los préstamos tienen una tasa de interés razonable en términos comerciales establecida periódicamente por el Administrador.
- Es obligatorio pagar los préstamos en cuotas regulares a lo largo de un periodo de entre uno y cinco años, a menos que lo use para comprar una casa para usted. En ese caso, es posible extender el periodo de pago, como indica el programa escrito de préstamos de tanto en tanto.
- Solo puede tener un préstamo de uso general y uno residencial pendientes de pago en cualquier momento.
- Se considera que todos los préstamos son inversiones provenientes de su cuenta del Plan. Los pagos de capital e interés del préstamo se acreditan a sus cuentas del Plan.
- Si no realiza los pagos correspondientes en las fechas indicadas, se considerará que está en mora. En determinadas circunstancias, un préstamo impago podría considerarse una distribución del Plan. La importancia de que el saldo del préstamo se considere como una distribución consiste en que el monto de esta distribución (que no sean aportes Roth) está sujeto a impuestos como un ingreso regular y podría estar sujeto a un régimen impositivo. Se emitirá un Formulario 1099-R a su nombre y el total del monto de distribución se presentará al IRS.

Tenga en cuenta que a partir del 1 de febrero de 2025, si su residencia principal se encuentra en una zona declarada catastrófica por el gobierno federal y sufre una pérdida económica debido a la catástrofe, es posible que reúna los requisitos para los siguientes alivios a las cargas de préstamos:

- Si solicita un préstamo dentro de los 180 días siguientes a la primera fecha del "periodo del incidente" (el periodo especificado por FEMA como el periodo en el que se produjo la catástrofe), el monto máximo del préstamo aumenta hasta el menor de los siguientes montos: 1) el 100 % del total de su cuenta del Plan con derechos adquiridos, o 2) $100,000 (reducidos por el exceso, si lo hubiera, del saldo pendiente de préstamo más alto durante el periodo de un año anterior a la fecha del préstamo sobre su saldo pendiente de préstamos actual).
- Podrá retrasar hasta un año el reembolso de los pagos de cualquier préstamo que venzan durante el periodo entre el primer día del periodo del incidente y los 180 días siguientes a la finalización del periodo del incidente. Sus pagos después del retraso se ajustarán para reflejar los pagos aplazados y cualquier interés acumulado durante el retraso.

NOTA: Dado que el Plan solo permite un préstamo para fines generales y un préstamo para vivienda en cualquier momento, si ya tiene un préstamo pendiente, no podrá pedir otro de ese tipo, incluso si se ve afectado por una catástrofe declarada a nivel federal.

Cuando se le autoriza una licencia de ausencia sin goce de sueldo, puede estar exento de los pagos programados durante un periodo de hasta un año. Si es convocado para el servicio militar calificado y tiene un préstamo pendiente, es posible que se apliquen las normas especiales en virtud de la ley USERRA. Llame al Centro de atención al cliente al **888-968-4015** para obtener más información.

Si usted muere: su beneficiario designado

En el caso de su fallecimiento, el saldo total del Plan le será pagado a su beneficiario. Es muy importante que mantenga la información de su beneficiario actualizada para asegurarse de que su beneficiario amparado por el Plan refleje su intención actual. Los asociados activos pueden elegir beneficiarios en **One.Walmart.com**. (Recuerde que sigue siendo necesario completar el consentimiento de su cónyuge en el Formulario B, como se explica más adelante). Si ya no es empleado de Walmart, o está de licencia, puede obtener un formulario de designación de beneficiario en papel poniéndose en contacto con Servicios al Personal.

Debido a que su cónyuge o pareja posee ciertos derechos sobre el beneficio por fallecimiento, debe actualizar la elección de su beneficiario inmediatamente si se produce un cambio en su estado de relación.

Si tiene un cónyuge y desea nombrar a alguien que no sea su cónyuge como beneficiario designado, su cónyuge debe dar el consentimiento para esta designación. Debe completar el Formulario B de Beneficiario Alternativo para Participantes Casados y su cónyuge debe completar la sección Consentimiento del Cónyuge de ese formulario. (Tenga en cuenta que el Plan no reconoce los consentimientos o renuncias del cónyuge en cualquier otro documento entre usted y su cónyuge para este propósito). El formulario de consentimiento del cónyuge debe ser firmado por un escribano público y debe acompañar al Formulario B para que sea válido. Puede obtener el Formulario B y el formulario de Consentimiento del Cónyuge llamando a Servicios al Personal. Las designaciones de beneficiarios que realice entrarán en vigencia para todas sus cuentas del Plan.

Si no designa un beneficiario, el beneficio por su fallecimiento se otorgará de acuerdo con las disposiciones predeterminadas del Plan en el siguiente orden, como se indica a continuación:

- Su cónyuge o pareja (según se define a continuación); si no tiene, a sus
- Hijos vivos (no se incluyen los hijastros); si no tiene, a sus
- Padres vivos; si no tiene, a sus
- Hermanos vivos; si no tiene, para
- Sus herederos, en cuyo caso será distribuido según los términos de su testamento o como lo determine un tribunal.

Recuerde que, si designa a su cónyuge como beneficiario y luego se divorcia, su designación de beneficiario dejará de tener vigencia después del divorcio, a menos que usted complete un nuevo formulario de designación. De manera similar, si no tiene un cónyuge y luego contrae matrimonio, su designación de beneficiario previa dejará de tener vigencia luego del casamiento, a menos que complete un nuevo formulario de designación con el consentimiento de su cónyuge.

Si designa a un beneficiario y este muere antes de que se emita el cheque del beneficio, el beneficio se le pagará a su beneficiario secundario o, si no tiene, se pagará en virtud de las normas predeterminadas antes indicadas. Si su beneficiario muere luego de que se emita el cheque del beneficio, el beneficio se les pagará a los herederos de su beneficiario. No obstante, recuerde que, si su cónyuge o pareja es su beneficiario, el beneficio siempre se les pagará a los herederos de su cónyuge o pareja en caso de que este muera después de usted, pero antes de que se pague el beneficio. Como ya se mencionó, es muy importante que mantenga actualizada la información de sus beneficiarios.

NOTA: A partir del 26 de junio de 2013, su cónyuge del mismo sexo se trata de la misma manera que un cónyuge del sexo opuesto a los fines del Plan. Recuerde que, si tenía un cónyuge del mismo sexo en esa fecha, cualquier designación de beneficiarios que tenía vigente por la que designaba a otra persona que no sea su cónyuge como su beneficiario dejó de ser válida inmediatamente en esa fecha. Su cónyuge será automáticamente su beneficiario, a menos que usted haga una nueva designación de beneficiario con el consentimiento de su cónyuge.

Si tiene una "pareja" y no ha hecho una designación de beneficiario afirmativa, su pareja será su beneficiario a menos que usted designe afirmativamente un beneficiario diferente (independientemente de si la designación ocurrió antes o después de comenzada la relación). Su "pareja" a los fines del Plan significa:

- su pareja de hecho, siempre y cuando usted y su pareja de hecho:
  - vivan y mantengan una relación constante, exclusiva y comprometida, similar al matrimonio, durante 12 meses como mínimo, con intenciones de continuar de manera indefinida;
  - no estén casados entre sí ni con otra persona;
  - cumplan con la edad para poder casarse en el estado de residencia y sean mentalmente competentes para dar su consentimiento para el contrato en ese estado;
  - No estén relacionados de manera tal que esto impida un matrimonio legal en el estado en el que viven, y
  - no estén en la relación solo a fin de obtener la cobertura de beneficios; o

- cualquier otra persona a la que esté unida en una relación legal reconocida como creadora de algunos o de la totalidad de los derechos del matrimonio en el estado o en el país en el que se inició la relación.

DESIGNACIONES DE BENEFICIARIOS REALIZADAS ANTES DEL 31 DE OCTUBRE DE 2003

Si realizó una designación de beneficiario para el Plan 401(k) el 31 de octubre de 2003 o antes, dicha designación continuará aplicándose a su cuenta antes de impuestos, su cuenta Roth, su cuenta 401(k) financiada por la compañía, su cuenta de contribuciones paralelas de la compañía y su cuenta de transferencia. De manera similar, si designa a un beneficiario conforme al Plan de reparto de utilidades al 31 de octubre de 2003, dicha designación continuará aplicándose a su cuenta de reparto de utilidades financiada por la compañía y su cuenta de transferencia de reparto de utilidades. Si cambia su designación de beneficiario luego del 31 de octubre de 2003, se aplicará a todas sus cuentas del Plan y las designaciones previas quedarán sin validez.

Tenga presente que los cambios en su estado de relación pueden afectar su designación de beneficiarios, según se explicó anteriormente.

Como ya se mencionó, es muy importante que mantenga actualizada la información de sus beneficiarios. Las designaciones de beneficiarios se deben realizar en **One.Walmart.com**.

Si se divorcia

Si se divorcia, la totalidad o una parte del saldo de su Plan puede otorgarse a un "beneficiario alternativo" por orden judicial, denominada "orden de relaciones domésticas calificadas" (QDRO). Un beneficiario alternativo puede ser su cónyuge o excónyuge, un hijo o un dependiente. (La ley federal en este momento no permite el reconocimiento de una QDRO para una pareja a menos que la pareja también sea un dependiente del participante). Debido a que existen requisitos muy estrictos para estos casos, debe comunicarse con el administrador de QDRO al **877-MER-QDRO** (**877-637-7376**) para obtener una copia gratuita de los procedimientos que su abogado debe usar para redactar el mandato judicial. Una vez que se envía la orden judicial al administrador de la QDRO, se debe revisar para determinar si cumple con los requisitos legales para este tipo de orden, y su procesamiento llevará un plazo determinado. El gasto administrativo para procesar su QDRO se cobrará a su cuenta o según se indique en la orden.

Si se va de Walmart

Cuando deja de trabajar para Walmart, tiene derecho a recibir un pago de liquidación de todas sus cuentas con derecho de posesión del Plan.

Es importante entender cómo cualquier tipo de pago de liquidación por parte del Plan 401(k) de Walmart afecta su situación fiscal. Para obtener más información, consulte **Consecuencias del impuesto a las ganancias luego de un pago de liquidación** en este resumen.

Puede optar por recibir su pago de liquidación 30 días calendario después de la fecha en que el sistema de nómina refleja la finalización de su relación laboral. Por ejemplo, si la finalización de su empleo se registra y se procesa en el sistema de pagos el 19 de julio de 2024, usted puede optar por recibir su pago de liquidación el 18 de agosto de 2024 o después.

Después de que se va de Walmart y sus subsidiarias, por lo general, se le enviará una notificación por correo a su dirección particular o electrónicamente, según lo que haya elegido, para informarle que tiene derecho a recibir su pago. Asegúrese de que su dirección esté correcta en su cheque de pago cuando se vaya de Walmart y de sus subsidiarias, o de proporcionar una dirección de envío durante su entrevista de egreso. Si no ha recibido información sobre su pago dentro de los 60 días a partir de la fecha de finalización de su empleo, llame al Centro de atención al cliente al **888-968-4015**. Para solicitar su pago de liquidación, deberá acceder a su cuenta desde **benefits.ml.com** o llamar al Centro de Atención al Cliente al **888-968-4015**.

No se requiere de su consentimiento para el pago, y la liquidación de la cuenta con derecho de posesión se le otorgará automáticamente:

- **Si el saldo total de su cuenta del Plan con derecho de posesión es de $1,000 o menos en cualquier momento.** Este pago de liquidación automático se realizará apenas sea posible después del último día hábil del tercer mes calendario posterior al mes calendario en cual se registró la finalización de su relación laboral en el sistema de nómina, a menos que usted dé su consentimiento para un pago de liquidación previo como se describió anteriormente. En el ejemplo anterior, si su cuenta es elegible para un pago de liquidación automático y usted no da el consentimiento el pago de liquidación a partir del 19 de agosto de 2024, el pago de liquidación se realizará automáticamente apenas sea posible después del 31 de octubre de 2024, o
- **Si tiene más de 72½ años y medio, independientemente del saldo total de su cuenta del Plan con derecho de posesión.** El pago de liquidación automático se realizará apenas sea posible, después del último día hábil del segundo mes calendario que le sigue al mes calendario en el cual usted cumple 72½ años, a menos que usted dé su consentimiento para un pago de liquidación previo como se describió anteriormente. Por ejemplo, si cumple 72½ años en julio de 2024, su cuenta es elegible para un pago de liquidación automático y usted no da el consentimiento para el pago de liquidación, este se realizaría automáticamente en la primera fecha programada obligatoria, después del 30 de septiembre de 2024 según las disposiciones del Plan.

Si el saldo total de su cuenta del Plan con derecho a posesión es de más de $1,000 y usted tiene menos de 72½ años, debe dar su consentimiento para que se liquide la totalidad o una parte de su cuenta. El pago de liquidación se realizará lo antes posible después de que el Centro de atención al cliente reciba su consentimiento, pero no antes de los 30 días calendario posteriores a la fecha en que la finalización de su relación laboral se registre en el sistema de nómina.

Si el saldo total de su cuenta del Plan con derecho de posesión es de más de $1,000, puede optar por retrasar todo o parte de su pago de liquidación hasta cualquier fecha previa a que cumpla los 72½ años, pero el saldo de su cuenta del Plan quedará sujeto a un gasto de mantenimiento anual y, posiblemente, a otros gastos. Para obtener más información acerca de estos gastos, consulte la Notificación anual de información sobre los gastos del participante. Si elige retrasar su pago, podrá continuar haciendo modificaciones en las elecciones de su inversión, así como lo hizo mientras era un participante activo del plan.

Si vuelve a trabajar en Walmart antes de que se complete su pago de liquidación, este se cancelará y no se hará ningún pago de liquidación de su cuenta.

EL MONTO DE SU PAGO DE LIQUIDACIÓN

Se le pagará el valor total de su cuenta antes de impuestos, su cuenta Roth, su cuenta 401(k) financiada por la compañía, sus cuentas de transferencia y de la cuenta de contribuciones paralelas de la compañía. Además, si tiene una cuenta de reparto de utilidades financiada por la compañía (consulte **Sus cuentas del Plan 401(k) de Walmart** que aparece anteriormente en este resumen), la porción de derecho de posesión de esta cuenta es la parte que estará disponible para su pago. Perderá (cederá) la porción sin derecho de posesión de su cuenta de reparto de utilidades financiada por la compañía, como se indica en la sección **Derecho de posesión de su cuenta de reparto de utilidades financiada por la compañía** anteriormente en este resumen.

El monto que recibirá se basará en el valor de sus cuentas a la fecha en que se procesa el pago de liquidación. Si se le hace un pago de liquidación en efectivo directamente, en lugar de una transferencia a una IRA o al plan de otro empleador, los impuestos correspondientes se retendrán de su cheque.

Cuando se le pague el saldo de su Plan, se aplicará un gasto por procesamiento del cheque.

CÓMO RECIBE SU PAGO DE LIQUIDACIÓN

Dispone de varias opciones para recibir su pago de liquidación.

Normalmente, las cuentas se le pagarán en efectivo. Sin embargo, puede elegir que su cuenta de reparto de utilidades financiada por la compañía y su cuenta de transferencia de reparto de utilidades (incluso si esto montos han sido convertidos a una cuenta Roth o a una cuenta de transferencia Roth) se salde con acciones de Walmart (incluso si no está invertida en acciones de Walmart al momento de procesar su pago de liquidación), o bien una parte en efectivo y una parte en acciones de Walmart. (Solo se distribuirán acciones enteras del paquete accionario de Walmart; las acciones parciales se distribuirán en efectivo). También puede optar por que se le pague en acciones de Walmart el valor de su cuenta antes de impuestos, su cuenta 401(k) financiada por la compañía y su cuenta de cuenta Roth (incluso si estos montos han sido convertidos a una cuenta Roth o a una cuenta de transferencia Roth), en la medida en que dichas cuentas tengan inversiones en acciones de Walmart al momento en que se procesa el pago de liquidación. Cualquier parte de esas cuentas que no esté invertida en acciones de Walmart al momento de su pago de liquidación, se le pagará en efectivo.

Si el total de su cuenta con derecho de posesión es de $1,000 o menos, o si tiene más de 72½ años (independientemente del monto de sus cuentas con derecho de posesión), se saldará directamente a través de un pago único general en efectivo. Si desea recibir parte de su pago de liquidación en acciones de Walmart, o si desea transferir su pago de liquidación a una IRA o al plan de otro empleador, debe llamar al Centro de atención al cliente al **888-968-4015** para dar las instrucciones relativas al pago de liquidación dentro del plazo que se indica en la notificación del pago de liquidación. Si no contacta al Centro de atención al cliente en tiempo y forma, se le otorgará un pago único en efectivo.

Si el total de sus cuentas del plan con derecho de posesión es de más de $1,000, su pago no se hará hasta que usted elija la forma del pago y dé su consentimiento para la distribución o hasta que alcance los 72½ años. Puede optar por tomar la totalidad o una parte del valor de su cuenta con derecho de posesión. (No obstante, recuerde que, si toma un pago parcial de su cuenta y el monto restante en la cuenta se reduce a $1,000 o menos, se deberá retirar como se explicó anteriormente). Para obtener su pago de liquidación, debe llamar al Centro de atención al cliente al **888-968-4015**.

Por lo general, sus cuentas se le pagarán directamente a usted, a menos que elija que se transfieran a una IRA o al plan de jubilación de otro empleador.

NOTA: Si no se le puede pagar su cuenta con derecho de posesión porque no lo encuentran, el administrador hará un intento diligente de dar con su paradero. Si todavía no ha sido encontrado, su cuenta con derecho de posesión se perderá. Si más tarde lo ubican, su cuenta se restablecerá pero no recibirá ninguna ganancia por el periodo posterior a la pérdida. (Esto también se aplica si usted fallece y su beneficiario no puede ser localizado). Por lo tanto, es importante que se asegure de actualizar sus datos de contacto si hay algún cambio.

Si se va de Walmart y Walmart vuelve a contratarlo

Si deja de trabajar en Walmart y en sus subsidiarias, pero la compañía vuelve a contratarlo como un asociado elegible, usted podrá realizar aportes propios al Plan a partir de la fecha en que vuelven a contratarlo.

Si deja de trabajar en Walmart y en sus subsidiarias después de volverse elegible para recibir aportes paralelos y luego Walmart vuelve a contratarlo, será automáticamente elegible para recibir aportes paralelos en la fecha en que vuelven a contratarlo. De manera similar, si deja de trabajar en Walmart y en sus subsidiarias luego de haber alcanzado el requisito de 1,000 horas necesario para ser elegible para recibir aportes paralelos, pero antes de su fecha de participación real, pasará a ser elegible para recibir aportes paralelos a partir de la fecha en la que debería haberse convertido en un participante o la fecha en que vuelven a contratarlo (en relación con los aportes que realice luego de esa fecha). Si no era participante cuando se fue o no había alcanzado el requisito de 1,000 horas, se le exigirá completar los requisitos de elegibilidad (consulte **Cuándo comienza la participación** que aparece antes en este resumen) para poder ser elegible para los aportes paralelos bajo el Plan.

LA PORCIÓN SIN DERECHO DE POSESIÓN DE SU CUENTA DE REPARTO DE UTILIDADES FINANCIADA POR LA COMPAÑÍA

Cuando finaliza su empleo, no se le pagará la porción sin derecho de posesión de su cuenta de reparto de utilidades financiada por la compañía (si tiene una). Este monto sin derecho de posesión se denomina "pérdida".

- Si recibe un pago total del saldo de su Plan con derecho de posesión luego de la finalización de su empleo y mientras aún tiene un derecho parcial sobre su cuenta de reparto de utilidades financiada por la compañía, se perderá la porción sin derecho de posesión de su cuenta de reparto de utilidades financiada por la compañía en la fecha en que reciba el pago de liquidación.
- Si no recibe un pago total del saldo de su Plan con derecho de posesión después de la finalización del empleo, la porción sin derecho de posesión de su cuenta de reparto de utilidades financiada por la compañía no se perderá hasta que tenga cinco "interrupciones en el trabajo" consecutivas. Una interrupción en el trabajo es un año del Plan (del 1.º de febrero al 31 de enero) en el cual se le acreditan 500 horas de trabajo o menos. Si se ausenta del trabajo debido a una licencia conforme a la Ley de Licencia Familiar y Médica (FMLA) y ha trabajado 500 horas o menos en el año del Plan, se le acreditarán las horas necesarias para que alcance las 500.01 horas y no incurra en una interrupción en el trabajo.

La porción sin derecho de posesión de su cuenta de reparto de utilidades financiada por la compañía que se consideró como pérdida se restablecerá (a su valor anterior) si Walmart o una subsidiaria vuelve a contratarlo antes de que usted tenga cinco interrupciones consecutivas en el trabajo y usted le pague al Plan el monto total de su pago de liquidación dentro de los cinco años posteriores a la fecha en que se volvió a contratar. Si vuelve a trabajar con Walmart o una subsidiaria luego de cinco o más interrupciones consecutivas en el trabajo, o si elige no pagar su pago de liquidación como se mencionó anteriormente, no se restablecerá la porción sin derecho de posesión de su cuenta de reparto de utilidades financiada por la compañía que se consideró como pérdida.

Si usted tenía el 0 % de derecho de posesión en su cuenta de reparto de utilidades financiada por la compañía en el momento de la finalización del empleo, su cuenta de reparto de utilidades financiada por la compañía sin derecho a posesión se restablecerá automáticamente si lo vuelven a contratar antes de tener cinco interrupciones en el trabajo consecutivas.

Las pérdidas de la porción sin derecho de posesión de las cuentas de reparto de utilidades financiadas por la compañía de participantes que fueron despedidos generalmente se utilizan para pagar los gastos del Plan y para otros propósitos, tales como restaurar los saldos de cuentas, como se indica anteriormente.

Cuando se vuelve a contratar, sus años de trabajo en Walmart antes de que se vaya se considerarán a los fines de determinar su derecho de posesión en su cuenta de reparto de utilidades financiada por la compañía.

Consecuencias del impuesto a las ganancias luego de un pago de liquidación

Las consecuencias impositivas de su participación en el Plan son su responsabilidad. Esta explicación es sólo una descripción breve de las consecuencias de los impuestos Federales de los Estados Unidos relacionadas con su participación en el Plan. La descripción se basa en las leyes actuales y en las interpretaciones actuales de las leyes del Servicio de Impuestos Internos. Debido a que la ley está sujeta a modificaciones y a que la aplicación de la ley puede variar según las circunstancias particulares, esta descripción es de naturaleza general y no debe basarse en ella para determinar sus consecuencias impositivas. Se recomienda especialmente que consulte a un asesor fiscal.

Walmart tiene derecho a una deducción del monto de sus aportes, como también de los aportes que usted realiza, al Plan. Sus aportes antes de impuestos y los aportes de Walmart al Plan, como también las ganancias derivadas de esos aportes, no suelen estar sujetos al impuesto federal a las ganancias hasta que se le pagan (o usted opta por realizar una conversión Roth dentro del plan de dichos montos). Se le aplican impuestos sobre sus aportes Roth cuando haga estos aportes al Plan. No se aplican impuestos sobre las ganancias derivadas de los aportes Roth, a menos que tome un aporte que no sea una distribución calificada. (Consulte **Impuestos sobre los pagos de liquidación de aportes Roth** a continuación.)

POSTERGACIÓN DEL PAGO DE IMPUESTOS SOBRE PAGOS DE LIQUIDACIONES A TRAVÉS DE UNA TRANSFERENCIA (EXCEPTO UNA TRANSFERENCIA A UNA CUENTA IRA ROTH)

A pesar de que los pagos del Plan (que no sean los de su cuenta Roth o de transferencia Roth) están sujetos al impuesto federal a las ganancias, el Código Fiscal brinda un tratamiento impositivo favorable a los pagos de liquidaciones en ciertas circunstancias. Por ejemplo, generalmente, puede postergar el pago de impuestos sobre su pago de liquidación si le indica al Plan que emita su pago directamente a favor de una IRA o de un plan de jubilación calificado de otro empleador, un plan 403(b) o un plan 457 del gobierno. Esto se denomina transferencia directa. (El cheque será pagadero a la IRA o a otro depositario del plan y se le entregará a usted, a su IRA o a la institución de transferencia. Si el cheque se le envía por correo, será responsable de entregarlo al IRA o a otro depositario del plan dentro de los 60 días).

Si elige este método para su pago de liquidación, no se retendrán impuestos del monto que transfiere. No se le aplicarán impuestos a dicho monto hasta que usted reciba un pago de liquidación de la IRA o de otro plan.

Si su pago reúne los requisitos para las transferencias de un año a otro y no elige que su pago de liquidación se transfiera directamente, la ley federal exige que Walmart retenga el 20 % del pago de liquidación en concepto de impuestos federales, además de las retenciones estatales que se puedan exigir. En algunos casos, la retención del 20 % puede no ser suficiente, lo que puede significar que usted adeudará más impuestos cuando presente la declaración del impuesto a las ganancias.

Si su pago reúne los requisitos para las transferencias de un año a otro y no elige una transferencia directa (y, en cambio, recibe un pago de liquidación real del Plan), también puede transferir esos fondos a una IRA o a un plan de jubilación calificado de otro empleador, un plan 403(b) o un plan 457 del gobierno, mientras lo haga dentro de los 60 días calendario posteriores a la fecha en que recibió la distribución. El monto de la transferencia no estará sujeto al impuesto federal a las ganancias hasta tanto usted lo quite de la IRA u otro plan. Sin embargo, si desea transferir el 100 % de su pago de liquidación a una IRA u otro plan, deberá utilizar otro dinero para reponer el 20 % que se retuvo del pago de liquidación. Si solo transfiere el 80 % de lo que recibió, se le aplicará un impuesto sobre el 20 % que se retuvo.

Tenga en cuenta que no todos los pagos del Plan pueden transferirse a una cuenta IRA o a otro plan de jubilación. Por ejemplo, no se pueden reinvertir los beneficios por dificultades económicas ni los pagos por nacimiento o adopción de un hijo, retiros de emergencia limitados y retiros calificados de recuperación ante desastres. A continuación se ofrece más información sobre los impuestos aplicables a estos pagos.

NOTA: Puede transferir la totalidad o una parte de su cuenta que sea elegible para una transferencia a una IRA Roth. Todo monto transferido que estuviera sujeto a impuestos de no haberse transferido estará sujeto a impuestos al momento de la transferencia a la IRA Roth. (Tenga presente que usted puede elegir voluntariamente que se retengan los impuestos de los montos al momento de transferir a una IRA Roth).

Para obtener más información acerca de estas normas de transferencia, consulte el **Anexo especial de la notificación impositiva** que se encuentra a continuación. Guarde este anexo para revisarlo cuando sea elegible para aceptar una distribución.

IMPUESTOS SOBRE LOS PAGOS DE LIQUIDACIÓN DE APORTES ROTH

No se aplican impuestos sobre los aportes Roth y las ganancias derivadas de dichas aportes cuando se distribuyen desde el Plan, siempre que se trate de una distribución "calificada". Una distribución "calificada" es aquella que se hace: (1) a causa de su fallecimiento, discapacidad o luego de alcanzar la edad de 59 años y medio; y (2) una vez transcurrido un periodo de participación de cinco años. El periodo de participación de cinco años es el periodo de cinco años que comienza con el primer año calendario en el cual hizo su primer aporte Roth al Plan (u otro plan 401(k) o 403(b), si dicho monto se transfirió a este Plan) y finaliza el último día del cuarto año calendario a partir de entonces. Por ejemplo, si hace su primer aporte Roth en julio de 2021, su periodo de participación de cinco años finaliza el 31 de diciembre de 2025. No es necesario que haga un aporte Roth en cada uno de los cinco años.

Si recibe una distribución de sus aportes Roth y las ganancias de dichos aportes, que no sea una distribución "calificada", las ganancias de sus aportes Roth estarán sujetos a impuestos al momento de distribución (a menos que transfiera la distribución a una IRA Roth o una cuenta Roth designada en un plan de otro empleador). Si transfiere los aportes Roth y las ganancias, no deberá pagar impuestos actualmente sobre las ganancias y posteriormente sobre los pagos de liquidaciones que sean distribuciones calificadas.

Sus aportes Roth se pueden transferir solo a una IRA Roth o a una cuenta Roth designada en un plan de otro empleador. Si la transferencia se hace a una cuenta Roth designada en el plan de otro empleador, por lo general, la transferencia debe ser directa (a menos que el monto transferido incluya solo montos que estarían sujetos a impuestos si se los distribuyera a usted).

NOTA: Si elige una conversión Roth dentro del Plan, el importe convertido se considera un aporte Roth realizado en el momento de la conversión. Cuando esos importes se distribuyan posteriormente, se aplicarán en general las normas descritas anteriormente. A estos efectos, un aporte Roth dentro del Plan se considerará un aporte a efectos de iniciar el periodo de participación de cinco años descrito anteriormente.

Para obtener más información acerca de estas normas de transferencia, consulte el **Anexo especial de la notificación impositiva: aportes Roth** que se encuentra a continuación. Guarde este anexo para revisarlo cuando sea elegible para aceptar una distribución.

SANCIÓN POR RETIRO TEMPRANO

Si hace un retiro antes de la edad de 59 años y medio, en vez de transferirlo, en la mayoría de los casos deberá asumir una sanción del 10 % por retiro temprano, establecida por el IRS sobre la parte que estará sujeto a impuestos del pago de liquidación. Por lo tanto, los aportes Roth y, si se las distribuye en una distribución "calificada", las ganancias de dichos aportes, no están sujetos a la sanción del 10 % por retiro temprano. Existen algunas excepciones para esta sanción, tales como pagos por fallecimiento, discapacidad, jubilación luego de los 55 años y pago de ciertos gastos médicos, los pagos de liquidaciones relacionados con el nacimiento o la adopción de su hijo, retiros de emergencia limitados y retiros de recuperación ante desastres calificados. También se aplican reglas especiales en el caso de los pagos realizados a reservistas que son llamados a prestar servicio militar activo.

IMPUESTOS SOBRE LOS PAGOS DE LIQUIDACIÓN DE ACCIONES DE WALMART

También existen normas especiales para las distribuciones de acciones ordinarias de Walmart. Si recibe dinero en efectivo (más de $200) y acciones de Walmart, y el dinero en efectivo no se transfiere de manera directa, es posible que se aplique una retención, pero el monto retenido no será mayor que el monto de dinero en efectivo que recibe.

Generalmente, si recibe acciones ordinarias de Walmart como parte del pago de liquidación que no se transfiere, solo se aplica el impuesto sobre el valor de las acciones en el momento en que el Plan las adquirió.

Recuerde que, si opta por pagos de liquidación en efectivo de dividendos pagados sobre las acciones de Walmart de su cuenta de reparto de utilidades financiada por la compañía, el dividendo estará sujeto a impuestos y no es elegible para su transferencia. El dividendo también estará sujeto a impuestos si solicita un pago por dificultad financiera de su cuenta dentro de los cinco días hábiles posteriores a la fecha de registro para el dividendo y el dividendo se le paga automáticamente en efectivo. El pago de liquidación de dividendos no está sujeto a la sanción del 10 % por retiro temprano mencionada anteriormente. En algunos casos, Walmart Inc. tendrá derecho a la deducción de dividendos pagados sobre las acciones sujetas a esta elección.

IMPUESTOS SOBRE LOS PAGOS A BENEFICIARIOS Y BENEFICIARIOS ALTERNATIVOS

El tratamiento impositivo mencionado anteriormente se aplica sólo a los pagos de liquidación realizados a participantes. Se pueden aplicar diferentes reglas a los pagos a beneficiarios de participantes fallecidos. En general, si su cónyuge es el beneficiario, tendrá el mismo trato con respecto al impuesto federal a las ganancias y las opciones de transferencia que usted hubiese tenido. Otros beneficiarios, incluso las parejas, solo tendrán derecho a una transferencia directa a una IRA heredada o IRA Roth. La sanción del 10 % por retiro temprano no se aplica a los pagos a su beneficiario.

El cónyuge o excónyuge de un participante que recibe un pago de liquidación del Plan conforme a una orden de relaciones domésticas calificada (QDRO) generalmente tiene el mismo trato y las mismas opciones con respecto al impuesto federal a las ganancias que hubiese tenido el participante. Sin embargo, en ciertos casos, un pago de liquidación a nombre de un dependiente no cónyuge, conforme a una QDRO (por ejemplo, manutención de menores ordenada por el estado) puede estar sujeto a impuestos en el impuesto federal a las ganancias para el participante, aunque el pago de liquidación se realice para un beneficiario alternativo dependiente, o en su nombre.

IMPUESTOS APLICABLES AL RETIRO POR DIFICULTADES FINANCIERAS

Un pago por dificultades económicas (distinto de los aportes Roth y, si se trata de una distribución cualificada, de los rendimientos de sus aportes Roth) está sujeto inmediatamente a impuestos, que incluye la penalización por retiro anticipado del 10 %, a menos que reúna los requisitos para obtener una exención. No puede transferir la distribución y Walmart no está obligado a retener el 20 %, pero la distribución estará sujeta a una retención del 10 %, a menos que elija una tasa de retención diferente.

IMPUESTOS APLICABLES A EMERGENCIAS LIMITADAS

Si recibe un retiro de emergencia limitado del Plan, la distribución está sujeta inmediatamente a impuestos (salvo los aportes Roth y, si el pago es una distribución cualificada, las ganancias de sus aportes Roth), pero no está sujeto a la penalización por retiro anticipado del 10 %. No puede transferir la distribución y Walmart no está obligado a retener el 20 %, pero la distribución estará sujeta a una retención del 10 %, a menos que elija una tasa de retención diferente.

APLICACIÓN DE IMPUESTOS DE LOS RETIROS CUALIFICADOS PARA LA RECUPERACIÓN TRAS UNA CATÁSTROFE

Si recibe una distribución relacionada con una catástrofe grave declarada a nivel federal, el monto de la distribución estará sujeto a impuestos a lo largo de un periodo de tres años, a partir del año en que reciba la distribución, a menos que opte para que la totalidad de la distribución esté sujeta a impuestos el año en que la reciba. No puede transferir la distribución y Walmart no está obligado a retener el 20 %, pero la distribución estará sujeta a una retención del 10 %, a menos que elija una tasa de retención diferente. La distribución de dividendos no está sujeto a la sanción del 10 % por retiro temprano.

IMPUESTOS SOBRE PRÉSTAMOS

Según lo establece la legislación impositiva actual, todos los préstamos hechos desde el Plan, sin importar el propósito, no se consideran ingresos sujetos a impuestos para el participante a menos que falle en el cumplimiento del pago. En ese caso (como ya se detalló más arriba), la declaración de impuestos mostrará el monto de los ingresos correspondiente al año en que usted se convirtió en moroso. Es posible también que usted deba asumir una sanción del 10 % por retiro temprano.

IMPUESTOS SOBRE LAS DISTRIBUCIONES CALIFICADAS POR NACIMIENTO O ADOPCIÓN

Si recibe una distribución relacionada con el nacimiento o la adopción de su hijo, la distribución estará sujeta a impuestos para usted a efectos del impuesto federal a las ganancias, pero no está sujeta a la sanción por retiro temprano del 10 %. No puede transferir la distribución y Walmart no está obligado a retener el 20 %, pero la distribución estará sujeta a una retención del 10 %, a menos que elija una tasa diferente.

Presentación de reclamaciones al Plan 401(k) de Walmart

Si considera que tiene derecho a un beneficio, además de los que procesa el depositario de registros del Plan (Bank of America), puede presentar una reclamación ante el Administrador o su delegado:

Walmart Inc.
Attn: 401(k) Plan Administrator
508 SW 8th Street
Bentonville, Arkansas 72716-0295

Si tiene preguntas acerca de la presentación de reclamaciones, llame a Servicios al Personal al **800-421-1362**.

Si su reclamación es rechazada en su totalidad o en parte, recibirá una notificación por escrito sobre la decisión dentro de un plazo razonable, pero no mayor de 90 días, a partir de la fecha en que el Administrador recibe su reclamación. El Administrador o su delegado puede extender este periodo hasta 90 días adicionales si determina que se necesita una prórroga debido a circunstancias especiales. Recibirá una notificación sobre toda prórroga antes del vencimiento del periodo original de 90 días. En la notificación por escrito que recibirá, se indicarán las razones específicas del rechazo de su reclamación, una referencia específica a las disposiciones del Plan sobre las cuales se basa el rechazo, y una descripción de los procedimientos de revisión y los plazos aplicables a dichos procedimientos, incluido su derecho a iniciar acciones legales ante el rechazo de una apelación.

Si no está de acuerdo con la decisión del Administrador, o de su delegado, puede solicitar que el Administrador revise la decisión. El Administrador tiene autoridad discrecional para resolver todas las cuestiones relacionadas con la administración, la interpretación o la aplicación del Plan. Su solicitud debe hacerse por escrito y enviarse al Administrador a:

Walmart Inc.
Attn: Benefits Compliance
508 SW 8th Street
Bentonville, Arkansas 72716-0295

Su solicitud debe realizarse dentro de los 60 días calendario a partir del rechazo. Su solicitud por escrito debe contener toda la información adicional que usted desee que el Administrador considere. Si no solicita una revisión dentro de este plazo, se considerará que renunció a su derecho a una revisión.

El Administrador procederá inmediatamente con la revisión. Se le enviará notificación escrita sobre la decisión del Administrador con respecto a la revisión dentro de los 60 días calendario posteriores a la recepción de su solicitud, a menos que se requiera una prórroga de hasta 60 días adicionales debido a circunstancias especiales. En aquellas circunstancias en las cuales la revisión se retrasa para permitirle proporcionar la información adicional necesaria para una revisión adecuada, la duración del retraso no se incluirá en el cálculo de la fecha límite de 60 días y de los periodos de prórroga establecidos anteriormente. La notificación por escrito sobre la decisión del Administrador incluirá las razones específicas de la decisión y hará referencia a las disposiciones específicas del Plan sobre las cuales se basa la decisión.

Debe agotar estos procedimientos antes de que pueda presentar una demanda con respecto a los beneficios de su Plan. Si usted presenta una demanda, debe presentarla en el plazo de un año desde la fecha de su pago o, si no se realiza el pago, la fecha en la que el Administrador rechaza la reclamación de beneficios, en su totalidad o parcialmente, en la apelación (o, si es antes, la fecha en la que el Administrador no responde a su reclamación o apelación dentro de los periodos indicados anteriormente).

Información administrativa

NOMBRE DEL PLAN

El nombre legal del Plan es Plan 401(k) de Walmart.

PATROCINADOR DEL PLAN Y ADMINISTRADOR DEL PLAN EN VIRTUD DE LA LEY ERISA

Walmart Inc. es el Patrocinador del Plan. La información de contacto para asuntos relacionados con el Plan es la siguiente:

Walmart Inc.
Attn: 401(k) Plan Administrator
508 SW 8th Street
Bentonville, Arkansas 72716-0295
800-421-1362

Como Administrador del Plan en virtud de la ley ERISA, Walmart Inc. es responsable de informar y divulgar las obligaciones que tiene bajo la Ley de Garantía de los Ingresos de Jubilación para los Empleados de 1974 (ERISA) y todas las demás obligaciones que se exija desempeñar a los administradores de planes de acuerdo con el Código Fiscal y la ley ERISA, excepto para aquellas obligaciones delegadas al Administrador, el Comité de inversión de beneficios o el depositario del Fideicomiso. ERISA es la ley federal que impone ciertas responsabilidades a Walmart Inc., al Administrador, al Comité de inversión de beneficios y al depositario con respecto a los beneficios de jubilación.

Las subsidiarias de Walmart Inc. pueden participar en el Plan. Para obtener una lista de las subsidiarias que participan actualmente en el Plan, llame a Servicios al Personal.

NÚMERO DE IDENTIFICACIÓN DE EMPLEADOR DEL PATROCINADOR DEL PLAN

71-0415188

FIDUCIARIO ADMINISTRATIVO DESIGNADO

El Administrador es la persona que periódicamente ocupa el cargo de vicepresidente ejecutivo de recompensas totales globales de Walmart. El Administrador es el fiduciario administrativo designado del Plan. Como fiduciario administrativo designado del Plan, el Administrador generalmente es responsable del manejo, la interpretación y la administración del Plan, lo cual incluye, entre otros, las determinaciones sobre elegibilidad, los pagos de beneficios y otras funciones requeridas, necesarias o aconsejables para llevar a cabo los propósitos del Plan.

Puede comunicarse con el Administrador a la siguiente dirección:

Senior Vice President, Global Total Rewards/Administrator
Walmart Inc.
508 SW 8th Street
Bentonville, Arkansas 72716-0295

FIDUCIARIO DE INVERSIONES DESIGNADO

El Comité de inversión de beneficios es el fiduciario de inversiones designado del Plan. El Comité es responsable de las políticas de inversión del Plan, incluida la selección de opciones de inversión puestas a disposición conforme al Plan y la selección de la opción de inversión predeterminada.

Puede comunicarse con el Comité de Inversión de Beneficios a la siguiente dirección:

Benefits Investment Committee
Walmart Inc.
508 SW 8th Street
Bentonville, Arkansas 72716-0295

DEPOSITARIO DEL PLAN

Northern Trust Company
50 S. LaSalle Street
Chicago, Illinois 60603

Uno o más fideicomisos mantienen todos los activos del Plan, como los aportes realizados por los participantes y los aportes de Walmart. Como administrador de bienes, Northern Trust Company recibe y guarda los aportes hechas al plan en fideicomiso e invierte dichas aportes de acuerdo a las políticas establecidas conforme al Plan.

AGENTE DEL SERVICIO DEL PROCESO LEGAL

Corporation Trust Company
1209 Orange Street
Corporation Trust Center
Wilmington, Delaware 19801

También se puede notificar al Administrador del Plan en virtud de la ley ERISA o al depositario.

NÚMERO DEL PLAN

003

AÑO DEL PLAN

Del 1.º de febrero al 31 de enero

TIPO DE PLAN

El Plan 401(k) de Walmart es un plan de aportes definidos (plan 401(k), de reparto de utilidades y de propiedad de acciones para empleados).

CESIÓN

Debido a que este es un plan de jubilación controlado por la ley ERISA y otras leyes federales, sus cuentas no pueden asignarse o utilizarse como garantía para un préstamo, ni pueden embargarse o quedar sujetas a procesos de bancarrota. No obstante, pueden formar parte de un acuerdo de divorcio, como se explicó anteriormente en este resumen, en la sección **Si se divorcia**. Además, en algunos casos, el IRS puede ejecutar un embargo de impuestos federales contra sus cuentas para saldar los impuestos federales que adeuda.

SIN COBERTURA DE LA PBGC

La ley ERISA creó un organismo gubernamental denominado Corporación de Garantías de Beneficios Jubilatorios (PBGC). Uno de los fines de la PBGC es asegurar los beneficios que se pagarán conforme a los planes de beneficios definidos. Sin embargo, la PBGC no brinda cobertura para los planes de aporte definidos. Debido a que el Plan es un plan de aportes definidos, no es elegible para la cobertura de la PBGC.

MODIFICACIÓN O CANCELACIÓN DEL PLAN

Walmart se reserva el derecho de modificar o finalizar el Plan en cualquier momento. Las modificaciones son realizadas por la Junta directiva de Walmart o por su vicepresidente ejecutivo y funcionario ejecutivo del personal. Ni el Plan ni los beneficios descritos en este resumen se pueden modificar de manera oral. Las declaraciones y manifestaciones orales no tienen vigencia ni efecto aunque las realice un asociado administrativo de Walmart o una subsidiaria participante, el Administrador, un miembro del Comité de inversión de beneficios o Merrill Lynch.

Para obtener una copia del documento formal del Plan, escriba a la siguiente dirección:

Walmart Inc.
Attn: Benefits Compliance
508 SW 8th Street
Bentonville, Arkansas 72716-0295

También puede llamar al Centro de atención al cliente al **888-968-4015**.

PAGOS ERRÓNEOS

Si se realiza un pago conforme al Plan a la parte equivocada, o si se realiza un pago a la parte correcta, pero por la cantidad incorrecta, el Administrador puede tener derecho a recuperar el pago erróneo del destinatario, ya sea mediante la reducción de su cuenta del Plan o de pagos futuros que se deben al destinatario, o puede exigir que el destinatario devuelva el pago a la brevedad al Plan.

DECLARACIÓN DE LOS DERECHOS DE LA LEY ERISA

Como participante de este Plan, se le confieren ciertos derechos y protecciones conforme a la ley ERISA. La ley ERISA establece que todos los participantes del Plan tienen derecho a lo siguiente:

- Examinar, de forma gratuita, en la oficina del Administrador del Plan en virtud de la ley ERISA y en otras instalaciones especificadas, todos los documentos que rigen el Plan, incluidos los contratos de seguros y los convenios colectivos de trabajo, y una copia del último informe anual (serie del Formulario 5500) presentado por el Plan ante el Departamento de Trabajo de los Estados Unidos y disponible en la Sala de Información Pública de la Administración de Seguridad de Beneficios de Empleados.
- Obtener, previa solicitud por escrito al Administrador del Plan en virtud de la ERISA, copias de los documentos que rigen el funcionamiento del Plan, incluidos los contratos de seguros y los convenios colectivos de trabajo, copias del último informe anual (serie del Formulario 5500) y una Descripción Resumida del Plan actualizada. El Administrador del Plan en virtud de la ley ERISA puede cobrar un precio razonable por las copias. Su solicitud debe enviarse por correo a la siguiente dirección:

  Walmart Inc. — ERISA Section 104(b) Request
  Attn: Benefits Compliance
  508 SW 8th Street
  Bentonville, Arkansas 72716-0295
- Recibir un resumen del informe financiero anual del Plan. La ley exige que el Administrador del Plan en virtud de la ley ERISA otorgue a cada participante una copia del resumen del informe financiero.
- Obtener un resumen que indique el saldo actual de su cuenta y la porción de su cuenta que es no confiscable (que tiene derecho de posesión). Este resumen se debe solicitar por escrito y no se exige más de una vez cada 12 meses. El Plan debe proporcionar el resumen de forma gratuita.

Además de crear derechos para los participantes del Plan, la ley ERISA impone deberes sobre las personas que son responsables del funcionamiento del Plan. Las personas que manejan el Plan, denominadas "fiduciarios" del Plan, tienen el deber de hacerlo en forma prudente y para la conveniencia de todos los participantes y beneficiarios del Plan. Nadie, incluidos su empleador u otras personas, puede despedirlo o discriminarlo de manera alguna para evitar que usted obtenga un beneficio jubilatorio o ejerza sus derechos conforme a la ley ERISA.

Si su reclamación de un beneficio se rechaza o se ignora total o parcialmente, usted tiene derecho a saber el motivo, a obtener copias de los documentos relacionados con la decisión de forma gratuita y a apelar el rechazo, todo dentro de ciertos plazos.

Conforme a la ley ERISA, existen pasos que puede seguir para hacer valer los derechos expuestos anteriormente. Por ejemplo, si solicita material sobre el plan y no lo recibe dentro de 30 días, puede iniciar un reclamo en el tribunal federal. En tal caso, el tribunal puede exigir que el Administrador del Plan en virtud de la ley ERISA o el Administrador brinde los materiales y pague hasta $110 por día hasta que reciba los materiales, a menos que los materiales no hayan sido enviados por razones más allá del control del Administrador del Plan en virtud de la ley ERISA o del Administrador. Si su reclamación de un beneficio se rechaza o se ignora total o parcialmente, puede iniciar acciones legales en un tribunal estatal o federal. Sumado a esto, si no está de acuerdo con la decisión del Plan o la falta de decisión concerniente al estado calificado de una orden de relación doméstica, puede iniciar un juicio en un tribunal federal.

Si los fiduciarios del Plan hacen mal uso del dinero del Plan, o si usted es discriminado por hacer valer sus derechos, puede solicitar la ayuda del Departamento de Trabajo de los Estados Unidos, o puede iniciar acciones legales en un tribunal federal. El tribunal decidirá quién debe pagar los gastos judiciales y honorarios de abogados. Si usted gana, el tribunal puede ordenar a la persona que usted demandó que pague tales gastos y honorarios. Si pierde, el tribunal puede ordenarle que pague tales costos y honorarios, por ejemplo, si determina que su reclamación es frívola.

Si tiene preguntas respecto del Plan, comuníquese con el Administrador del Plan en virtud de la ley ERISA o con el Administrador. Si tiene preguntas sobre este resumen o sobre sus derechos de acuerdo con la ley ERISA, debe comunicarse con la oficina regional más cercana de la Administración de Seguridad de Beneficios de los Empleados (Employee Benefits Security Administration), del Departamento de Trabajo de los Estados Unidos, que figura en su directorio telefónico, o la División de Asistencia Técnica y Consultas de la Administración de Seguridad de Beneficios de los Empleados, Departamento de Trabajo de los Estados Unidos a la siguiente dirección: Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. También puede obtener ciertas publicaciones sobre sus derechos y responsabilidades bajo la ley ERISA llamando a la línea de publicaciones de la Administración de Seguridad de Beneficios de los Empleados.

Anexo especial de la notificación impositiva

SUS OPCIONES DE TRANSFERENCIA

La ley establece que los participantes reciban este aviso antes de recibir una distribución del Plan que cumpla con los requisitos necesarios para el traspaso de su pago a una IRA o bien a otro plan de empleador. Usted puede o no cumplir con los requisitos para recibir una distribución del Plan en la actualidad. No obstante, si es elegible, debe leer este aviso con atención antes de elegir una distribución del Plan. El objetivo de este aviso es ayudarlo a decidir si opta por una transferencia o no. Si no es ahora elegible para una distribución, le recomendamos guardar este aviso y leerlo cuando lo sea.

Las normas para la mayoría de los pagos del Plan se describen en la sección **Información general sobre transferencias**. Las reglas especiales que corresponden a determinadas circunstancias se describen en la sección **Opciones y reglas especiales**.

En este aviso, se describen las normas de transferencia que se aplican a los pagos de liquidación del Plan, excepto aquellos de una cuenta Roth designada. Si además recibe un pago desde su cuenta Roth o su cuenta de transferencia Roth del Plan, consulte el anexo **Anexo especial de la notificación impositiva: aportes Roth** que se encuentra a continuación.

INFORMACIÓN GENERAL SOBRE TRANSFERENCIAS

¿Cómo puede una transferencia afectar mis impuestos? Se le cobrará un impuesto a un pago que se realice desde el Plan si no lo transfiere. Si usted tiene menos de 59 años y medio, y no hace una transferencia, tendrá que pagar además un 10 % adicional al impuesto a las ganancias sobre las distribuciones anticipadas (por lo general, distribuciones realizadas antes de los 59 años y medio, como se explica más adelante), a menos que se aplique una excepción. No obstante, si realiza una transferencia, no tendrá que pagar ningún impuesto hasta que reciba un pago más adelante, y no corresponderá el 10 % adicional al impuesto a las ganancias si se realiza el pago después de que alcance la edad de 59 años y medio (o si corresponde una excepción al 10 % adicional al impuesto a las ganancias).

¿Qué tipos de cuentas y planes de jubilación pueden aceptar mi transferencia? Puede transferir el pago a una IRA (cuenta de jubilación individual o renta vitalicia individual) o a un plan de un empleador (un plan con incentivos fiscales, un plan sección 403(b) o un plan del gobierno sección 457(b)) que acepte la transferencia. Las reglas de la IRA o del plan del empleador que mantiene la transferencia determinarán sus opciones de inversión, los cargos y los derechos a recibir pagos desde la IRA o el plan del empleador (por ejemplo, las IRA no están sujetas a las reglas del consentimiento del cónyuge y, a su vez, las IRA no ofrecen préstamos). Además, el monto transferido estará sujeto a las reglas impositivas que corresponden a la IRA o al plan de un empleador.

¿Cómo hago una transferencia? Tiene dos opciones: Puede hacer una "transferencia directa" o una "transferencia de 60 días".

Si elige la primera, el Plan realizará el pago directamente a su IRA o al plan del empleador. Deberá comunicarse con el patrocinador de la IRA o el administrador del plan del empleador para obtener más información acerca de cómo realizar una transferencia directa.

Si elige la segunda, puede realizar una transferencia mediante un depósito en una IRA o un plan del empleador elegible que acepte la transferencia. Tendrá 60 días después de recibido el pago para realizar el depósito. Si no realiza una transferencia directa, está establecido que el Plan retenga el 20 % del pago para impuestos federales (hasta el monto recibido en dinero efectivo o bienes, excepto acciones de la compañía). Esto significa que, para transferir todo el pago con una transferencia de 60 días, deberá usar otros fondos para cubrir el 20 % retenido. Si no transfiere todo el monto del pago, la parte no transferida estará sujeta a impuestos y al 10 % adicional del impuesto a las ganancias sobre distribuciones anticipadas, siempre que tenga menos de 59 años y medio (salvo que corresponda una excepción).

¿Qué monto puedo transferir? Si desea realizar una transferencia, puede transferir el monto elegible para una transferencia de forma total o parcial. Cualquier pago realizado desde el Plan es elegible para una transferencia, pero existen algunas excepciones:

- Distribuciones mínimas obligatorias
- Distribuciones por dificultad económica
- Pago de dividendos de un Plan de compra de acciones para empleados (ESOP)
- Distribuciones correctivas de los aportes que superan los límites establecidos por la legislación impositiva
- Retiros con motivo de nacimiento o adopción de un hijo
- Retiros de emergencia limitados
- Retiros en caso de catástrofe que reúna los requisitos
- Los préstamos considerados distribuciones (por ejemplo, los préstamos en mora debido a pagos no realizados antes de que finalice su relación laboral).

El Administrador del Plan o el pagador puede indicarle qué parte de un pago es elegible para una transferencia.

Si no realizo una transferencia, ¿tendré que pagar el 10 % adicional al impuesto a las ganancias sobre las distribuciones anticipadas? Si tiene menos de 59 años y medio, tendrá que pagarlo para todos los pagos realizados desde el Plan (incluso sobre los montos retenidos para el impuesto a las ganancias) que no transfiera, a menos que corresponda alguna de las excepciones que se detallan a continuación. Este impuesto se aplica a la parte de la distribución que debe incluir en los ingresos y se suma al impuesto a las ganancias ordinario sobre el pago no transferido.

El 10 % adicional al impuesto a las ganancias no corresponde a los siguientes pagos del Plan:

- Pagos realizados después de que finalice su relación laboral si tiene, por lo menos, 55 años en el año en que esto ocurre
- Pagos realizados por discapacidad
- Pagos después de su fallecimiento
- Pagos de dividendos en virtud del ESOP
- Distribuciones correctivas de los aportes que superan los límites establecidos por la legislación impositiva
- Pagos realizados directamente al gobierno para cumplir con un gravamen federal
- Pagos realizados a otros beneficiarios conforme a una orden de relaciones domésticas calificada (QDRO)
- Pagos durante una enfermedad terminal
- Pagos de hasta $5,000 destinados a usted desde un plan de aporte definido, si el pago es una distribución calificada por nacimiento o adopción
- Pagos hasta el importe de sus gastos médicos deducibles (sin tener en cuenta si detalla las deducciones para el año fiscal)
- Determinados pagos realizados mientras se encontraba en servicio activo si fue un miembro de la reserva militar que fue convocado después del 11 de septiembre de 2001 y permaneció en servicio durante más de 179 días.
- Pagos de hasta $1,000 para hacer frente a gastos de emergencia limitados
- Pagos de hasta $10,000 a una víctima de abuso doméstico en el plazo de un año a partir de la fecha del abuso.
- Pagos de hasta $22,000 efectuados en relación con catástrofes declaradas a nivel federal.

Si realizo una transferencia a una IRA, ¿el impuesto adicional del 10 % a las ganancias corresponderá a las distribuciones anticipadas efectuadas desde la IRA? Si recibe un pago desde una IRA cuando tiene menos de 59 años y medio de edad, tendrá que pagar el 10 % adicional al impuesto a las ganancias sobre las distribuciones anticipadas de la parte de la distribución que debe incluir en las ganancias, a menos que corresponda una excepción. Por lo general, las excepciones de este caso son las mismas que corresponden a las distribuciones anticipadas de un plan. No obstante, existen algunas diferencias para los pagos desde una IRA, entre ellas:

- No se aplica la excepción para pagos realizados después de que finalice su relación laboral si tiene, por lo menos, 55 años en el año en que esto ocurre.
- No corresponde la excepción para una QDRO (aunque sí hay una regla especial que establece que, como parte de un acuerdo de divorcio o separación, es posible realizar una transferencia libre de impuestos a una IRA de un cónyuge o excónyuge).
- Corresponde la excepción para pagos realizados por lo menos anualmente en montos iguales o aproximados durante un periodo específico (independientemente de si finalizó su empleo o no).
- Corresponden excepciones para los pagos desde una IRA, entre las cuales se incluyen las siguientes: (1) pagos de gastos calificados relacionados con la educación superior, (2) pagos de hasta $10,000 usados en compras calificadas de primera vivienda y (3) pagos para las primas del seguro de salud realizados después de que recibió compensación por desempleo durante 12 semanas consecutivas (o hubiese sido elegible para recibirla si no fuera por su situación de trabajador independiente).

¿Deberé impuestos estatales a las ganancias? Este aviso no describe ninguna regla de los impuestos estatales o locales a las ganancias (incluidas las normas de retención).

OPCIONES Y REGLAS ESPECIALES

Si su pago incluye aportes después de impuestos: Si tiene aportes después de impuestos que se fusionaron al Plan 401(k) de Walmart, están sujetos a reglas impositivas especiales cuando se distribuyan desde el Plan 401(k) de Walmart. (Consulte el siguiente Anexo si hizo aportes Roth al Plan).

Los aportes después de impuestos incluidos en un pago no están sujetos a impuestos. Si recibe un pago parcial de su beneficio total, se incluye una parte imputable de sus aportes después de impuestos en el pago, por lo que no puede tomar un pago solo de aportes después de impuestos. Sin embargo, si tiene aportes después de impuestos previas a 1987 en una cuenta separada, es posible que se aplique una norma especial para determinar si los aportes después de impuestos están incluidas en el pago. Además, se aplican reglas especiales cuando hace una transferencia, como se describe a continuación.

Puede transferir a una IRA un pago que incluya aportes después de impuestos a través de una transferencia directa o una transferencia de 60 días. Debe llevar un registro del monto unificado de los aportes después de impuestos en todas sus IRA (para determinar los ingresos que están sujetos a impuestos para pagos posteriores de IRA). Si hace una transferencia directa solo de una parte del monto pagado del Plan y al mismo tiempo se le paga a usted el resto, la parte transferida estará compuesta primero por el monto que estaría sujeto a impuestos si no se transfiriera. Por ejemplo, supongamos que recibe una distribución de $12,000, de los cuales $2,000 son por aportes después de impuestos. En este caso, si usted transfiere directamente $10,000 a una IRA que no sea una IRA Roth, ningún monto estará sujeto a impuestos debido a que el monto de $2,000 no transferido se considera aporte después de impuestos. Si hace una transferencia directa de todo el monto pagado del Plan a dos o más destinos al mismo tiempo, puede elegir qué destino recibe los aportes después de impuestos.

Del mismo modo, si hace una transferencia directa de 60 días a una cuenta IRA de solo una parte del monto pagado, la parte transferida consiste primero en el monto del pago que estaría sujeto a impuestos si no se transfiriera. Por ejemplo, supongamos que recibe una distribución de $12,000, de los cuales $2,000 son por aportes después de impuestos, y ninguna parte de la distribución se transfiere directamente. En este caso, si usted transfiere $10,000 a una IRA que no sea una IRA Roth en una transferencia de 60 días, ningún monto estará sujeto a impuestos debido a que el monto de $2,000 no transferido se considera aporte después de impuestos.

Puede hacer una transferencia a un plan del empleador que incluya aportes después de impuestos, pero solo a través de una transferencia directa (y solo si el plan de recepción justifica de manera independiente los aportes después de impuestos y no es un plan del gobierno sección 457(b)). Puede hacer una transferencia de 60 días a un plan del empleador de un pago que incluya aportes después de impuestos, pero solo hasta el monto del pago que estaría sujeto a impuestos si no se transfiriera.

Si no cumple con la fecha límite de la transferencia a 60 días: por lo general, no es posible prorrogarla. No obstante, el IRS tiene autoridad limitada para eximir del cumplimiento con la fecha límite en determinadas circunstancias extraordinarias; por ejemplo, cuando no pudo completar la transferencia por fuerza mayor antes de la fecha límite de 60 días. Para solicitar una eximición, usted deberá presentar una solicitud para resolución por carta privada al IRS. Esto requiere el pago de un cargo para usuarios no reembolsable. Para obtener más información, consulte la Publicación 590 del IRS, *Medidas de jubilación individual*.

Si su pago incluye acciones del empleador que usted no transfiere: si no realiza una transferencia, puede usar una regla especial para pagos de acciones del empleador que se pagan en una única suma después de que finaliza la relación laboral (o después de que el participante cumpla 59 años y medio, sufra una discapacidad o fallezca). Según lo establecido por esta regla, la apreciación accionaria neta no realizada no se aplicarán impuestos cuando se distribuya desde el Plan, pero sí cuando venda la acción (y se cobrará a tasa de ganancias eventuales). Por lo general, la apreciación accionaria neta no realizada se refiere al incremento del valor de las acciones del empleador después de haber sido adquiridas por el Plan. Si transfiere un pago que incluye las acciones del empleador (por ejemplo, vendiendo las acciones y transfiriendo las ganancias dentro de los 60 días del pago), la regla especial relacionada con las acciones del empleador distribuidas no se aplicará a ningún pago posterior desde la IRA o, en general, desde el Plan. El Administrador del Plan puede informarle acerca del monto de cualquier apreciación accionaria neta no realizada.

Si tiene un préstamo pendiente que se está compensando: si tiene un préstamo pendiente del Plan, su beneficio del Plan puede ser compensado con el monto del préstamo pendiente, normalmente cuando su relación laboral finaliza. El monto compensado del préstamo se considera una distribución para usted al momento de la compensación. Por lo general, puede transferir la totalidad o una parte del monto compensado. A cualquier monto compensado que no se transfiera se le aplicarán impuestos (incluido el impuesto adicional de 10 % a las ganancias sobre distribuciones anticipadas, a menos que se aplique una excepción). Puede transferir montos compensados a una IRA o a un plan del empleador (si los términos del plan del empleador permiten que el plan reciba transferencias de montos compensados del préstamo del plan).

El tiempo que tiene para completar la transferencia depende de qué tipo de compensación de préstamo del plan tiene. Si tiene una compensación de préstamo del plan calificada, tendrá hasta la fecha límite de la declaración de impuestos (incluidas las prórrogas) del año fiscal durante el cual se produce la compensación para completar su transferencia. Una compensación de préstamo del plan calificada se produce cuando se compensa un préstamo del plan vigente debido a que el plan del empleador finaliza, o debido a que usted se aparta del empleo. Si la compensación de préstamo del plan se produce por cualquier otro motivo (como el incumplimiento de los reembolsos a nivel de préstamo que dan lugar a lo que se considera una distribución), tiene 60 días a partir de la fecha en que se produce la compensación para completar la transferencia.

Si nació el 1 de enero de 1936 o antes: si nació el 1 de enero de 1936 o antes y recibe una distribución de única suma que no transfiere, es posible que correspondan reglas especiales para calcular el monto del impuesto sobre el pago. Para obtener más información, consulte la Publicación 575 del IRS, *Pensiones y rentas vitalicias*.

Si transfiere su pago a una IRA Roth: si transfiere un pago realizado desde el Plan a una IRA Roth, se aplicará una regla especial según la cual el monto del pago transferido se aplicarán impuestos (reducido por cualquier monto después de impuestos). En general, no corresponde el impuesto adicional del 10 % a las ganancias sobre las distribuciones. No obstante, si retira el importe transferido de la cuenta IRA Roth dentro del periodo de cinco años que comienza el 1 de enero del año de la transferencia, se aplicará el impuesto adicional del 10 % a las ganancias (a menos que corresponda una excepción). Si transfiere el pago a una IRA Roth, los pagos posteriores realizados desde allí que se consideren distribuciones calificadas no estarán sujetos a impuestos (incluso ganancias posteriores a la transferencia). Se considera una distribución calificada desde una IRA Roth a un pago realizado después de que usted haya cumplido los 59 años y medio (o después de fallecimiento o discapacidad, o como una distribución de compra calificada de primera vivienda de hasta $10,000) y haya tenido una IRA Roth durante por lo menos cinco años. Para aplicar la regla de los cinco años, debe contar desde el 1.º de enero del año para el que realizó su primer aporte a una IRA Roth. Aquellos pagos realizados desde una IRA Roth que no se consideren distribuciones calificadas se aplicarán impuestos hasta el monto de ganancias posteriores a la transferencia, que incluye el 10 % adicional al impuesto a las ganancias sobre distribuciones anticipadas (a menos que corresponda una excepción). No es necesario que acepte distribuciones mínimas obligatorias de una IRA Roth de por vida. Para obtener más información, consulte la Publicación 590 del IRS, *Medidas de jubilación individual*.

Si realiza una transferencia a una cuenta Roth designada del Plan: no puede transferir una distribución a una cuenta Roth designada en un plan del empleador. Sin embargo, puede transferir la distribución a una cuenta Roth designada en el Plan de distribución. Si transfiere un pago realizado desde el Plan a una cuenta Roth designada en el Plan, el monto del pago transferido estará sujeto a impuestos (reducido por cualquier monto después de impuestos que se transfiera directamente). En general, no corresponde el impuesto adicional del 10 % a las ganancias sobre las distribuciones. No obstante, si retira el importe transferido de la cuenta IRA Roth dentro del periodo de cinco años que comienza el 1 de enero del año de la transferencia, se aplicará el impuesto adicional del 10 % a las ganancias (a menos que corresponda una excepción). Si transfiere el pago a una cuenta Roth designada en el Plan, los pagos posteriores realizados desde la cuenta Roth designada que se consideren distribuciones calificadas no estarán sujetos a impuestos (incluso ganancias posteriores a la transferencia). Una distribución calificada de una cuenta Roth designada es un pago hecho después de la edad de 59 años y medio (o después del fallecimiento o la declaración de una discapacidad) y después de haber tenido una cuenta Roth designada en el Plan durante al menos cinco años. Para aplicar esta regla de los cinco años, debe contar desde el 1 de enero del año en el que realizó su primer aporte a una cuenta Roth designada. Sin embargo, si hizo una transferencia directa a una cuenta Roth designada del Plan desde una cuenta Roth designada de otro plan del empleador, el periodo de cinco años se contará desde el 1.º de enero del año en el que hizo su primer aporte a la cuenta Roth designada en el Plan o, si fuera anterior, a la cuenta Roth designada del plan de otro empleador. Aquellos pagos realizados desde una cuenta Roth designada que no se consideren distribuciones calificadas estarán sujetos a impuestos hasta el monto de ganancias posteriores a la transferencia , que incluye el 10 % adicional al impuesto a las ganancias sobre distribuciones anticipadas (a menos que corresponda una excepción).

Si usted no es un participante del plan

Pagos realizados después del fallecimiento del participante. Si recibe una distribución después de la muerte del participante y no la transfiere, estará sujeta a impuestos de la misma forma en que se describió en otras secciones de este aviso. No obstante, no corresponderá el 10 % adicional al impuesto a las ganancias sobre distribuciones tempranas, y la regla especial detallada en la sección **Si nació el 1 de enero de 1936** corresponderá únicamente si el participante nació el 1 de enero de 1936 o antes.

Si es un cónyuge sobreviviente: si recibe un pago desde un Plan como cónyuge sobreviviente de un participante fallecido, usted tendrá las mismas opciones de transferencia que hubiera tenido el participante, como se detallan en otras secciones de este aviso. Además, si elige transferir un pago a una IRA, es posible usar la IRA como si fuera una cuenta propia o heredada.

Usar la IRA como una cuenta propia es usarla como las otras IRA a su nombre. Así, los pagos que usted reciba antes de los 59 años y medio estarán sujetos al 10 % adicional al impuesto a las ganancias sobre distribuciones tempranas (a menos que correspondan excepciones) y las distribuciones mínimas obligatorias desde su IRA no deben empezar hasta después de los 73.

Si usa la IRA como una IRA heredada, los pagos realizados desde allí no estarán sujetos al 10 % adicional al impuesto a las ganancias sobre distribuciones anticipadas. No obstante, si el participante había empezado a tomar las distribuciones mínimas obligatorias, usted tendrá que recibirlas desde la IRA heredada. De lo contrario, usted no tendrá obligación de recibir las distribuciones mínimas obligatorias desde la IRA heredada hasta el año en que el participante hubiera alcanzado los 73.

Si es un beneficiario sobreviviente, pero no un cónyuge: si recibe un pago desde el Plan debido al fallecimiento del participante y porque usted aparece como beneficiario designado y no como cónyuge sobreviviente, la única opción que tiene es realizar una transferencia directa a una IRA heredada o una IRA Roth. Pagos realizados desde allí no estarán sujetos al 10 % adicional al impuesto a las ganancias sobre distribuciones tempranas. Tendrá que recibir las distribuciones mínimas obligatorias desde una IRA heredada o una IRA Roth.

Pagos conforme a una orden de relaciones domésticas calificada (QDRO): si usted es el cónyuge o excónyuge de un participante que recibe un pago desde un Plan conforme a una orden de relaciones domésticas calificada (QDRO), por lo general, contará con las mismas opciones y el mismo tratamiento impositivo que el participante (por ejemplo, podrá transferir el pago a su propia IRA o a un plan del empleador elegible que acepte la transferencia). No obstante, los pagos realizados conforme a una orden de relaciones domésticas calificada no estarán sujetos al 10 % adicional al impuesto a las ganancias sobre distribuciones anticipadas.

Si es un extranjero no residente: si es un extranjero no residente y no realiza una transferencia directa a una IRA estadounidense o a un plan de un empleador estadounidense, el Plan establece que se le retenga el 30 % del pago (y no el 20 %, como en los casos descritos anteriormente) para el impuesto federal a las ganancias. Si el monto retenido supera el monto del impuesto que usted adeuda (como podría suceder si realiza una transferencia de 60 días), usted podrá solicitar un reembolso del impuesto a las ganancias con solo completar

el Formulario 1040NR y adjuntar el Formulario 1042-S. Vea el Formulario W-8BEN para reclamar que le corresponde una tasa reducida de retención de acuerdo con lo establecido en el convenio sobre el impuesto a las ganancias. Para obtener más información, consulte la Publicación 519 del IRS, *La guía sobre impuestos para extranjeros no residentes de los Estados Unidos* y la Publicación 515 del IRS, *Retención de impuestos para extranjeros no residentes y entidades extranjeras*.

OTRAS NORMAS ESPECIALES

Si sus pagos del año son inferiores a $200 (solo se incluyen los pagos desde una cuenta Roth designada del Plan), el Plan no está obligado a permitirle realizar una transferencia directa ni a retener el impuesto federal a las ganancias. No obstante, usted puede realizar una transferencia de 60 días.

Es posible que tenga derechos especiales para transferencias si recientemente ha prestado servicio en las Fuerzas Armadas de los EE. UU. Para obtener más información sobre los derechos especiales para transferencias para las Fuerzas Armadas de los EE. UU., consulte la Publicación 3 del IRS *Guía impositiva para las Fuerzas Armadas*. También es posible que tenga derechos especiales para transferencias si sufrió un desastre declarado a nivel federal (o un evento similar) o si recibió una distribución a causa de un desastre. Para obtener más información sobre los derechos especiales para transferencias relacionados con fondos para asociados en caso de desastres, consulte el sitio web del IRS en **www.irs.gov**.

PARA OBTENER MÁS INFORMACIÓN

Antes de tomar un pago desde el Plan, debe comunicarse con el Administrador del Plan o el pagador, o con un asesor impositivo profesional. Además, puede encontrar información más detallada sobre el tratamiento impositivo federal de los pagos de los planes del empleador en la Publicación 575 del IRS, *Pensiones y rentas vitalicias*; la Publicación 590 del IRS, *Acuerdos de jubilación individual (Individual Retirement Arrangements, IRA)*; y la Publicación 571 del IRS, *Planes de renta vitalicia con beneficios tributarios (planes 403(b))*. Puede encontrar estas publicaciones en la oficina local del IRS, en la página **www.irs.gov**, o puede pedirlas por teléfono al **800-TAX-FORM**.

Anexo especial de la notificación impositiva: aportes Roth

SUS OPCIONES DE TRANSFERENCIA

La ley exige que los participantes reciban este aviso antes de recibir una distribución del Plan de su cuenta Roth (o cualquier monto de Roth que se haya fusionado y agregado al Plan desde el plan de su empleador anterior). Usted puede o no cumplir con los requisitos para recibir una distribución del Plan en la actualidad. No obstante, si es elegible, debe leer este aviso con atención antes de elegir una distribución del Plan. El objetivo de este aviso es ayudarlo a decidir si opta por una transferencia o no. Si no es ahora elegible para una distribución, le recomendamos guardar este aviso y leerlo cuando lo sea.

Las reglas que se aplican a la mayoría de los pagos de su cuenta Roth o cuenta de transferencia Roth (denominadas en este anexo, en forma conjunta, "cuenta Roth") se describen en la sección **Información general sobre transferencias**. Las reglas especiales que corresponden a determinadas circunstancias se describen en la sección **Opciones y reglas especiales**.

Las reglas que se aplican a los pagos del Plan, que no sean desde su cuenta Roth, se describen por separado en el **Anexo especial de la notificación impositiva** anterior.

INFORMACIÓN GENERAL SOBRE TRANSFERENCIAS

¿Cómo puede una transferencia afectar mis impuestos? No se aplican impuestos sobre los aportes después de impuestos incluidas en un pago de su cuenta Roth, pero se pueden aplicar impuestos sobre las ganancias. El tratamiento impositivo de las ganancias incluidas en el pago depende de si el pago se trata de una distribución calificada. Si un pago es solo una parte de su cuenta Roth, este incluirá una parte imputable de las ganancias de su cuenta Roth.

Si el pago del Plan no es una distribución calificada y usted no hace una transferencia a una IRA Roth o una cuenta Roth designada de un plan del empleador, se aplicarán impuestos sobre la parte del pago que corresponda a ganancias. Si tiene menos de 59 años y medio, también se aplicará un impuesto adicional del 10 % a las ganancias sobre las distribuciones anticipadas (por lo general, distribuciones realizadas antes de los 59 años y medio de edad), a menos que corresponda una excepción. Sin embargo, si hace una transferencia, no deberá pagar impuestos actualmente sobre las ganancias y posteriormente sobre los pagos que sean distribuciones calificadas.

Si el pago del Plan es una distribución calificada, no se aplicarán impuestos sobre ninguna parte del pago, incluso si no hace una transferencia. Si hace una transferencia, no se aplicarán impuestos sobre el monto que transfiera ni sobre cualquier ganancia derivada de dicho monto transferido si se paga posteriormente en una distribución calificada.

Una distribución calificada de su cuenta Roth del Plan es un pago hecho después de la edad de 59 años y medio (o después de fallecimiento o discapacidad) y después de haber tenido una cuenta Roth en el Plan por al menos cinco años. Para aplicar la regla de los cinco años, debe contar desde el 1.º de enero del año en el que realizó su primer aporte a una cuenta Roth. Sin embargo, si hizo una transferencia directa a una cuenta Roth del Plan desde una cuenta Roth designada de otro plan del empleador, su participación se contará desde el 1.º de enero del año en el que hizo su primer aporte a la cuenta Roth del Plan o, si fuera anterior, a la cuenta Roth designada del plan de otro empleador.

¿Qué tipos de cuentas y planes de jubilación pueden aceptar mi transferencia? Puede transferir el pago a una IRA Roth (una cuenta de jubilación individual Roth o renta vitalicia individual Roth) o a una cuenta Roth designada de un plan del empleador (un plan con incentivos fiscales, un plan sección 403(b) o un plan del gobierno sección 457) que

acepte la transferencia. Las reglas de la IRA Roth o del plan del empleador que acepta la transferencia determinarán sus opciones de inversión, los cargos y los derechos a recibir pagos desde la IRA Roth o el plan del empleador (por ejemplo, las IRA Roth no están sujetas a las reglas del consentimiento del cónyuge y, a su vez, las IRA Roth no ofrecen préstamos). Además, el monto transferido estará sujeto a las reglas impositivas que corresponden a la IRA Roth o a la cuenta designada del plan del empleador. Por lo general, estas normas impositivas son similares a las descritas en otras secciones de este aviso, pero existen algunas diferencias:

- Si realiza una transferencia a una IRA Roth, todas sus IRA Roth entrarán en consideración para determinar si usted ha cumplido o no con la norma de los cinco años (empezando a partir del 1.º de enero del año que realizó su primer aporte a cualquiera de sus IRA Roth).
- Si realiza una transferencia a una IRA Roth, no será necesario que tome una distribución desde una IRA Roth de por vida, pero tendrá que hacer un seguimiento del monto unificado de los aportes después de impuestos en todas sus IRA Roth (para determinar los ingresos sujetos a impuestos para pagos posteriores de IRA Roth que no se consideran distribuciones calificadas).
- Las distribuciones de transferencia elegibles que se realizan desde una IRA Roth únicamente pueden transferirse a otra IRA Roth.

¿Cómo hago una transferencia? Tiene dos opciones: Puede hacer una transferencia directa o una transferencia de 60 días.

Si hace una transferencia directa, el Plan realizará el pago directamente a su IRA Roth o a la cuenta Roth designada de un plan del empleador. Deberá comunicarse con el patrocinador de la IRA Roth o el administrador del plan del empleador para obtener más información acerca de cómo realizar una transferencia directa.

Si no hace una transferencia directa, también puede hacer una transferencia mediante un depósito (generalmente dentro de los 60 días) a una IRA Roth, independientemente de si el pago es una distribución calificada o no calificada. Además, puede hacer una transferencia mediante un depósito dentro de los 60 días a una cuenta Roth designada de un plan del empleador si el pago es una distribución no calificada y la transferencia no supera el monto de las ganancias en el pago. No puede hacer una transferencia de 60 días a un plan del empleador de ninguna parte de una distribución calificada. Si recibe una distribución no calificada y no transfiere un monto por lo menos equivalente a las ganancias imputables a la distribución, se aplicarán impuestos sobre el monto de dichas ganancias no transferidas, incluido el impuesto adicional de 10 % a las ganancias sobre distribuciones anticipadas si usted es menor de 59 años y medio de edad (a menos que se aplique una excepción).

Si hace una transferencia directa solo de una parte del monto pagado del Plan y al mismo tiempo se le paga a usted una parte, la parte transferida directamente estará compuesta primero por ganancias. Si no realiza una transferencia directa y el pago no es una distribución calificada, está establecido que el Plan retenga el 20 % de las ganancias para impuestos federales (hasta el monto recibido en dinero efectivo o bienes, excepto acciones de la compañía). Esto significa que, para transferir todo el pago con una transferencia de 60 días a una IRA Roth, deberá usar otros fondos para cubrir el 20 % retenido.

¿Qué monto puedo transferir? Si desea realizar una transferencia, puede transferir el monto elegible para una transferencia de forma total o parcial. Cualquier pago realizado desde el Plan es elegible para una transferencia, pero existen algunas excepciones:

- Distribuciones mínimas obligatorias
- Distribuciones por dificultad económica
- Pago de dividendos de un Plan de compra de acciones para empleados (ESOP)
- Distribuciones correctivas de los aportes que superan los límites establecidos por la legislación impositiva
- Retiros con motivo de nacimiento o adopción de un hijo
- Retiros de emergencia limitados
- Retiros en caso de catástrofe que reúna los requisitos
- Los préstamos considerados distribuciones (por ejemplo, los préstamos en mora debido a pagos no realizados antes de que finalice su relación laboral).

El Administrador del Plan o el pagador puede indicarle qué parte de un pago es elegible para una transferencia.

Si no realizo una transferencia, ¿tendré que pagar el 10 % adicional al impuesto a las ganancias sobre las distribuciones anticipadas? Si un pago no es una distribución calificada y usted tiene menos de 59 años y medio de edad, deberá pagar el impuesto adicional de 10 % a las ganancias sobre las distribuciones anticipadas con respecto a las ganancias adjudicadas al pago que no transfirió (incluidos los montos retenidos para el impuesto a las ganancias), a menos que corresponda alguna de las excepciones que se detallan a continuación. Este impuesto se cobra aparte del impuesto regular a las ganancias sobre el pago no transferido.

El 10 % adicional al impuesto a las ganancias no corresponde a los siguientes pagos del Plan:

- Pagos realizados después de que finalice su relación laboral si tiene, por lo menos, 55 años en el año en que esto ocurre
- Pagos realizados por discapacidad
- Pagos después de su fallecimiento
- Pagos de dividendos en virtud del ESOP
- Distribuciones correctivas de los aportes que superan los límites establecidos por la legislación impositiva
- Pagos realizados directamente al gobierno para cumplir con un gravamen federal
- Pagos realizados a otros beneficiarios conforme a una orden de relaciones domésticas calificada (QDRO)
- Pagos durante una enfermedad terminal
- Pagos de hasta $5,000 destinados a usted desde un plan de aporte definido, si el pago es una distribución calificada por nacimiento o adopción
- Pagos hasta el importe de sus gastos médicos deducibles (sin tener en cuenta si detalla las deducciones para el año fiscal)
- Determinados pagos realizados mientras se encontraba en servicio activo si fue un miembro de la reserva militar que fue convocado después del 11 de septiembre de 2001 y permaneció en servicio durante más de 179 días.
- Pagos de hasta $1,000 para hacer frente a gastos de emergencia limitados
- Pagos de hasta $10,000 a una víctima de abuso doméstico en el plazo de un año a partir de la fecha del abuso.
- Pagos de hasta $22,000 efectuados en relación con catástrofes declaradas a nivel federal.

Si realizo una transferencia a una IRA Roth, ¿el impuesto adicional de 10 % a las ganancias corresponderá a las distribuciones anticipadas de la IRA? Si recibe un pago desde una IRA Roth cuando tiene menos de 59 años y medio de edad, tendrá que pagar el impuesto adicional del 10 % a las ganancias sobre las distribuciones tempranas desde la IRA Roth, a menos que corresponda una excepción o el pago sea una distribución calificada. Por lo general, las excepciones del impuesto adicional del 10 % a las ganancias sobre las distribuciones tempranas de una IRA Roth que se indican anteriormente son las mismas que las excepciones de las distribuciones tempranas de un plan. No obstante, existen algunas diferencias para los pagos desde una IRA Roth, entre ellas:

- No se aplica la excepción para pagos realizados después de que finalice su relación laboral si tiene, por lo menos, 55 años en el año en que esto ocurre.
- No corresponde la excepción para una QDRO (aunque sí hay una regla especial que establece que, como parte de un acuerdo de divorcio o separación, es posible realizar una transferencia libre de impuestos a una IRA Roth de un cónyuge o excónyuge).
- Corresponde una excepción para pagos realizados por lo menos anualmente en montos iguales o aproximados durante un periodo específico (independientemente de si finalizó su empleo o no).
- Existen otras excepciones para (1) pagos de gastos calificados relacionados con la educación superior, (2) pagos de hasta $10,000 usados en compras calificadas de primera vivienda y (3) pagos para las primas del seguro de salud realizados después de que recibió compensación por desempleo durante 12 semanas consecutivas (o hubiese sido elegible para recibirla si no fuera por su situación de trabajador independiente).

¿Deberé impuestos estatales a las ganancias? Este aviso no describe ninguna regla de impuestos estatales o locales a las ganancias (incluidas las normas de retención).

OPCIONES Y REGLAS ESPECIALES

Si no cumple con la fecha límite de la transferencia a 60 días: por lo general, no es posible prorrogarla. No obstante, el IRS tiene autoridad limitada para eximir del cumplimiento con la fecha límite en determinadas circunstancias extraordinarias; por ejemplo, cuando no pudo completar la transferencia por fuerza mayor antes de la fecha límite de 60 días. En determinadas circunstancias, puede presentar una reclamación de elegibilidad para una anulación de la fecha límite de 60 días de la transferencia mediante una autocertificación por escrito. De lo contrario, para solicitar una anulación del IRS, deberá presentar una solicitud para resolución por carta privada al IRS. Esto requiere el pago de un cargo para usuarios no reembolsable. Para obtener más información, consulte la Publicación 590-A del IRS *aportes a los acuerdos de jubilación individual (IRA)*.

Si su pago incluye acciones del empleador que usted no transfiere: si recibe un pago que no es una distribución calificada y no lo transfiere, puede usar una regla especial para pagos de acciones del empleador (u otros valores del empleador) que se pagan en una única suma después de que finaliza la relación laboral (o después de que el participante cumpla los 59 años y medio, sufra una discapacidad o fallezca). Según lo establecido por esta regla, la apreciación accionaria neta no realizada, incluida en las ganancias en el pago, no se aplicarán impuestos cuando se le distribuya desde el Plan, pero sí cuando venda la acción (y se cobrará a tasa de ganancias eventuales). Si transfiere a una IRA Roth una distribución no calificada que incluye las acciones del empleador (por ejemplo, vendiendo las acciones y transfiriendo las ganancias dentro de los 60 días de la distribución), no tendrá ningún ingreso sujeto a impuestos y la regla especial relacionada con las acciones del empleador distribuidas no se aplicará a ningún pago posterior desde la Roth IRA o, en general, desde el Plan. Por lo general, la apreciación accionaria neta no realizada se refiere al incremento del valor de las acciones del empleador después de haber sido adquiridas por el Plan. El Administrador del Plan puede informarle acerca del monto de cualquier apreciación accionaria neta no realizada.

Si recibe un pago que no es una distribución calificada que incluye las acciones del empleador y no lo transfiere, su base en las acciones (utilizada para determinar la ganancia o la pérdida cuando venda posteriormente las acciones) será igual al valor justo de mercado de las acciones en el momento del pago del Plan.

Si tiene un préstamo pendiente que se está compensando: si tiene un préstamo pendiente del Plan, su beneficio del Plan puede ser compensado con el monto del préstamo pendiente, normalmente cuando su relación laboral finaliza. El monto compensado se considera una distribución para usted al momento de la compensación. Por lo general, puede transferir la totalidad o una parte del monto compensado. Si la distribución atribuible a la compensación no es una distribución calificada y usted no transfiere el monto compensado, se aplicarán impuestos sobre cualquier ganancia incluida en la distribución (incluido el impuesto adicional de 10 % a las ganancias sobre las distribuciones anticipadas, a menos que se aplique una excepción). Puede transferir las ganancias incluidas en la compensación de préstamo a una IRA Roth o a una cuenta Roth designada de un plan del empleador (si los términos del plan del empleador permiten que el plan reciba transferencias de montos compensados del préstamo del plan). También puede transferir el monto total de la compensación a una IRA Roth.

El tiempo que tiene para completar la transferencia depende de qué tipo de compensación de préstamo del plan tiene. Si tiene una compensación de préstamo del plan calificada, tendrá hasta la fecha límite de la declaración de impuestos (incluidas las prórrogas) del año fiscal durante el cual se produce la compensación para completar su transferencia. Una compensación de préstamo del plan calificada se produce cuando se compensa un préstamo del plan vigente debido a que el plan del empleador finaliza, o debido a que usted se aparta del empleo. Si la compensación de préstamo del plan se produce por cualquier otro motivo, tiene 60 días a partir de la fecha en que se produce la compensación para completar la transferencia.

Si usted recibe una distribución no calificada y nació el 1 de enero de 1936 o antes: si nació el 1 de enero de 1936 o antes y recibe una distribución de única suma que no es una distribución calificada y que usted no transfiere, es posible que correspondan reglas especiales para calcular el monto del impuesto sobre el pago. Para obtener más información, consulte la Publicación 575 del IRS, *Pensiones y rentas vitalicias*.

Si usted no es un participante del plan

Pagos realizados después del fallecimiento del participante. Si recibe una distribución después de la muerte del participante y no la transfiere, estarán sujetos a impuestos de la misma forma en que se describió en otras secciones de este aviso. Sin embargo, si el pago es una distribución calificada generalmente depende de cuándo el participante hizo un aporte por primera vez a la cuenta Roth designada del Plan. Además, no corresponde el impuesto adicional de 10 % a las ganancias sobre las distribuciones tempranas ni las reglas especiales para agentes de seguridad pública, y la regla especial detallada en la sección "Si recibe una distribución no calificada y nació el 1 de enero de 1936 o antes" corresponde solo si el participante nació el 1 de enero de 1936 o antes.

Si es un cónyuge sobreviviente: si recibe un pago desde un Plan como cónyuge sobreviviente de un participante fallecido, usted tendrá las mismas opciones de transferencia que hubiera tenido el participante, como se detallan en otras secciones de este aviso. Además, si elige transferir un pago a una IRA Roth, puede usar la IRA Roth como si fuera una IRA Roth propia o heredada.

Una IRA Roth que considere como propia se considera como cualquier otra IRA Roth que tenga, por lo que no tendrá que recibir ninguna distribución mínima obligatoria durante su vida y las ganancias que se le paguen en una distribución no calificada antes de los 59 años y medio de edad, estarán sujetas al impuesto adicional de 10 % a las ganancias sobre las distribuciones anticipadas (a menos que se aplique una excepción).

Si usa la IRA Roth como una IRA Roth heredada, los pagos realizados desde la IRA Roth no estarán sujetos al impuesto adicional de 10 % a las ganancias sobre las distribuciones anticipadas. Una IRA Roth heredada está sujeta a las distribuciones mínimas obligatorias. Si el participante había empezado a tomar las distribuciones mínimas obligatorias desde el Plan, tendrá que recibirlas desde la IRA Roth heredada. De lo contrario, no tendrá obligación de recibir las distribuciones mínimas obligatorias desde la IRA Roth heredada hasta el año en que el participante hubiera alcanzado los 73 años y medio de edad.

Si es un beneficiario sobreviviente, pero no un cónyuge: si recibe un pago desde el Plan debido al fallecimiento del participante y porque usted aparece como beneficiario designado y no como cónyuge sobreviviente, la única opción que tiene es realizar una transferencia directa a una IRA Roth heredada. Los pagos realizados desde allí no estarán sujetos al impuesto adicional de 10 % a las ganancias sobre las distribuciones tempranas. Tendrá que recibir las distribuciones mínimas obligatorias desde una IRA Roth heredada.

Pagos conforme a una orden de relaciones domésticas calificada (QDRO): si usted es el cónyuge o excónyuge de un participante que recibe un pago desde un Plan conforme a una orden de relaciones domésticas calificada (QDRO), por lo general, contará con las mismas opciones y el mismo tratamiento impositivo que el participante (por ejemplo, podrá transferir el pago a su propia IRA Roth o a una cuenta Roth designada en un plan del empleador elegible que acepte la transferencia).

Si es un extranjero no residente: si es un extranjero no residente y no realiza una transferencia directa a una IRA estadounidense o a un plan de un empleador estadounidense, y el pago no es una distribución calificada, el Plan establece que se le retenga el 30 % (y no el 20 %, como en los casos descritos anteriormente) para el impuesto federal a las ganancias. Si el monto retenido supera el monto del impuesto que usted adeuda (como podría suceder si realiza una transferencia de 60 días), usted podrá solicitar un reembolso del impuesto a las ganancias con solo completar el Formulario 1040NR y adjuntar el Formulario 1042-S. Vea el Formulario W-8BEN para reclamar que le corresponde una tasa reducida de retención de acuerdo con lo establecido en el convenio sobre el impuesto a las ganancias. Para obtener más información, consulte la Publicación 519 del IRS, *La guía sobre impuestos para extranjeros no residentes de los Estados Unidos* y la Publicación 515 del IRS, *Retención de impuestos para extranjeros no residentes y entidades extranjeras*.

OTRAS NORMAS ESPECIALES

Si sus pagos del año (solo se incluyen los pagos desde la cuenta Roth designada del Plan) son inferiores a $200, el Plan no está obligado a permitirle realizar una transferencia directa ni a retener el impuesto federal a las ganancias. No obstante, usted puede realizar una transferencia de 60 días.

Es posible que tenga derechos especiales para transferencias si recientemente ha prestado servicio en las Fuerzas Armadas de los EE. UU. Para obtener más información sobre los derechos especiales para transferencias para las Fuerzas Armadas de los EE. UU., consulte la Publicación 3 del IRS *Guía impositiva para las Fuerzas Armadas*. También es posible que tenga derechos especiales para transferencias si sufrió un desastre declarado a nivel federal (o un evento similar) o si recibió una distribución a causa de un desastre. Para obtener más información sobre los derechos especiales para transferencias relacionados con fondos para asociados en caso de desastres, consulte el sitio web del IRS en **www.irs.gov**.

PARA OBTENER MÁS INFORMACIÓN

Antes de tomar un pago desde el Plan, debe comunicarse con el Administrador del Plan o el pagador, o con un asesor impositivo profesional. Además, puede encontrar información más detallada sobre el tratamiento impositivo federal de los pagos de los planes del empleador en la Publicación 575 del IRS, *Pensiones y rentas vitalicias*; la Publicación 590-A del IRS, *aportes a los acuerdos de jubilación individual (IRA)*; la Publicación 590-B del IRS, *Distribuciones de los acuerdos de jubilación individual (IRA)*; y la Publicación 571 del IRS, *Planes de renta vitalicia con beneficios tributarios (planes 403(b))*. Puede encontrar estas publicaciones en la oficina local del IRS, en la página **www.irs.gov**, o puede pedirlas por teléfono al **800-TAX-FORM**.

Plan de compra de acciones para asociados (ASPP)

Plan de compra de acciones para asociados (ASPP)

El Plan de compra de acciones para asociados (Associate Stock Purchase Plan, ASPP o Plan) le permite comprar acciones de Walmart de manera conveniente a través de deducciones del sueldo y mediante pagos directos al administrador del Plan. Puede solicitar que le retengan de su nómina quincenal cualquier cantidad entre $2 y $26,000 para comprar acciones (por un monto máximo anual de deducción de nómina de $26,000). Walmart contribuye $0.15 por cada dólar que usted contribuye a través de deducciones del sueldo a la compra de acciones, hasta los primeros $1,800 que contribuye al Plan en cada año del Plan (desde abril hasta marzo).

RECURSOS		
Encuentre lo que necesita	**En línea**	**Otros recursos**
Inscribirse en el Plan o cambiar el monto de la deducción	Complete la sesión de inscripción en línea de beneficios en **One.Walmart.com/ASPP**	Llame a Computershare al **800-438-6278** (discapacitados auditivos: **800-952-9245**)
• Acceder a la información de su cuenta • Obtener el resumen de cuenta • Obtener un Formulario 1099	Acceda desde el sitio web **computershare.com/walmart** o la aplicación Associate Stock	Obtenga la aplicación Associate Stock al descargarla de **One.Walmart.com/StockApp** o escanee el código QR a continuación (disponible para dispositivos Apple o Android)
Enviar dinero directamente a Computershare		Envíe el cheque a: **Computershare** **Attn: Walmart ASPP** **P.O. Box 43080** **Providence, Rhode Island 02940-3080** (No se realizarán aportes paralelos de la compañía para el dinero enviado directamente a Computershare)

Lo que debe saber acerca del Plan de compra de acciones para asociados

- Todos los asociados elegibles pueden comprar acciones de Walmart a través de convenientes deducciones del sueldo y pagos directos a Computershare.
- Walmart contribuye $0.15 por cada $1 que usted contribuye al Plan a través de las deducciones del sueldo, hasta los primeros $1,800 que usted contribuye por año del Plan.
- No existen cargos para la compra de acciones de Walmart a través del Plan. Solo paga una comisión cuando vende las acciones.
- Sus acciones se acreditarán en una cuenta que Computershare mantiene a su nombre. Puede acceder a su cuenta en línea, por teléfono o a través de la aplicación (consulte la tabla de **Recursos** que figura a continuación) para conocer el saldo o vender acciones que tenga en su cuenta.

Elegibilidad para el Plan de compra de acciones para asociados

Usted es elegible para inscribirse en el Plan de compra de acciones para asociados si cumple con los siguientes requisitos:

- No ser miembro de un convenio colectivo de trabajo cuyos beneficios fueron objeto de un convenio colectivo de trabajo de buena fe.
- Tener 18 años, como mínimo, o la mayoría de edad en el estado donde se le paga el sueldo (en Alabama y Nebraska, la mayoría de edad es a los 19 años). Si vive en Puerto Rico, debe tener 21 años para participar. Si tiene dudas sobre los requisitos de edad, consulte las leyes de su estado relativas a la mayoría de edad.

Inscripción en el Plan de compra de acciones para asociados

Puede inscribirse en el Plan completando una sesión de inscripción para beneficios en línea en **One.Walmart.com/ASPP**. Antes de inscribirse en este plan, debe revisar atentamente este folleto del Plan de compra de acciones para asociados y el folleto informativo del Plan (cuya copia aparece en las siguientes páginas), así como los informes y otros documentos que la compañía ha incorporado como referencia en el folleto informativo del Plan.

La decisión de participar en el Plan y de comprar acciones de la compañía es una decisión individual que solo usted tomará. La compañía no recomienda, respalda ni solicita su participación en el Plan o la compra de acciones de la compañía. Cuando tome una decisión, debe tener en cuenta que el rendimiento anterior de las acciones de la compañía no es una indicación ni una predicción sobre su rendimiento futuro. El valor de las acciones de la compañía puede verse afectado por muchos factores, incluso aquellos externos a la compañía en sí, como las condiciones económicas. La compañía lo insta a consultar a sus asesores financieros e impositivos respecto de su participación en el Plan y en la inversión en acciones de la compañía.

Aportes de Walmart a su titularidad de acciones de la compañía

El Plan para Asociados permite a todos los asociados elegibles comprar acciones de Walmart de manera conveniente a través de deducciones del sueldo. Puede retener de su nómina cualquier monto entero de $2 a $26,000 para comprar acciones (hasta una deducción máxima anual de $26,000).

Walmart contribuye a su cuenta de compra de acciones $0.15 por cada $1 que usted contribuye al Plan a través de las deducciones del sueldo, hasta los primeros $1,800 que contribuye por cada año del Plan. El año del Plan comienza en abril y finaliza en marzo. La contribución de la compañía se refleja como un ingreso en su recibo de sueldo y en su formulario W-2.

Además de las deducciones en su sueldo, también puede contribuir al Plan de Compra de Acciones para Asociados enviando dinero directamente a Computershare, el administrador del plan, a la siguiente dirección:

Computershare
Attn: Walmart ASPP
P.O. Box 43080
Providence, Rhode Island 02940-3080

Walmart no realizará aportes paralelos para el dinero que se envíe directamente a Computershare. El total de las deducciones del sueldo y el dinero enviado directamente a Computershare no pueden superar los $125,000 por año del Plan. Los dividendos que se pagan sobre las acciones que tiene a partir de la fecha de registro de cada dividendo se reinvierten automáticamente para comprar acciones adicionales para usted, pero no se imputan al máximo de $125,000.

El valor de las acciones que compra puede fluctuar e incluso bajar. No hay garantía de que sus acciones tengan el mismo valor en el futuro que el que tenían cuando se realizó la compra o que el valor de las acciones se va a incrementar.

Al momento de tomar una decisión acerca de comprar acciones de Walmart, considere todas sus inversiones, incluidas otras acciones de Walmart que pueda tener. Si tiene preguntas sobre inversiones, consulte a su asesor financiero. La inversión en acciones está sujeta a ciertos riesgos según se describe en el Folleto informativo del plan y el Informe anual más reciente de Walmart en el Formulario 10-K que se incorpora como referencia en el Folleto informativo del plan.

Venta de acciones a través del Plan

No se le cobran cargos por la compra de acciones; sin embargo, deberá pagar cargos para vender las acciones. Los cargos cobrados por Computershare descritos en este folleto informativo están sujetos a cambio.

APORTES DE WALMART A SU TITULARIDAD DE ACCIONES DE LA COMPAÑÍA

Si usted contribuye	Su aporte anual al Plan mediante las deducciones del sueldo es	El aporte anual paralelo de Walmart* es	Monto total utilizado para comprar acciones de Walmart
$10 quincenales	$260	$39	$299
$20 quincenales	$520	$78	$598
$70 quincenales	$1,820	$270 (Walmart contribuye $0.15 por cada $1 hasta $1,800)	$2,090

* Todos los aportes de la compañía se harán solamente sobre las acciones compradas a través de deducciones del sueldo. No se realizarán aportes de la compañía para el dinero enviado directamente a Computershare.

Si opta por vender sus acciones, estas se venderán según una orden de mercado. Sus acciones serán vendidas inmediatamente después de que su solicitud pueda procesarse razonablemente. Generalmente, las órdenes de mercado que se tramitan cuando el mercado bursátil está abierto se ejecutan inmediatamente después de ser tramitarse. El precio en el cual se ejecutará su orden no está garantizado y el precio de las acciones de Walmart antes de la ejecución de su orden no es, necesariamente, el precio al cual se ejecutará su orden.

Por lo general, las ventas de sus acciones se ejecutarán en la Bolsa de Valores de Nueva York (NYSE). Si la NYSE está cerrada cuando su orden está lista para ser procesada, esta se procesará lo antes posible al día siguiente en el que haya actividad comercial en la NYSE. La comisión es de $25.50 por venta más $0.05 (cinco centavos) por acción vendida por cada venta que ejecute.

Puede vender acciones a través de **computershare.com/walmart**, desde la aplicación Associate Stock, **One.Walmart.com/StockApp** (disponible para dispositivos Apple y Android), o llamando a Computershare al **800-438-6278** (personas con problemas de audición: **800-952-9245**). Puede elegir que sus ingresos se depositen en una cuenta bancaria registrada o que se le envíe un cheque por correo a la dirección registrada en Computershare. Si elige depositar sus ingresos en una cuenta bancaria, los fondos se envían al banco en la fecha de liquidación de las transacciones, que es dos días hábiles a partir de la fecha de venta. Tenga en cuenta que el momento cuando los fondos se reflejarán en su cuenta corriente o de ahorros variará dependiendo de su banco. Si decide recibir su venta por cheque, debería recibir el cheque entre 7 y 10 días hábiles después de realizar una orden para vender las acciones de su cuenta del Plan.

La comisión por venta se deduce automáticamente del monto que se deposita o se informa en su cheque por los ingresos netos de la venta. Cada vez que venda acciones, recibirá un resumen de la transacción. A los fines de la declaración de impuestos, usted recibirá los correspondientes documentos de impuestos (1099-B y/o 1099-DIV) adjuntos a su declaración anual el primer trimestre del año siguiente (enero a marzo). Según las preferencias de entrega, estos documentos se enviarán por correo a su dirección registrada en Computershare o se le notificará por correo electrónico cuando los documentos estén disponibles. Deberá utilizar estos documentos al declarar sus impuestos.

Es importante entender las consecuencias del impuesto de una venta de acciones. Si tiene preguntas relacionadas con los impuestos, consulte a su asesor financiero o asesor fiscal.

Seguimiento de los movimientos de la cuenta de Computershare

Recibirá un resumen por parte de Computershare al menos una vez al año (primer trimestre), en el que se indican los movimientos de su cuenta. No obstante, si optó por recibir sus resúmenes por vía electrónica, recibirá un mensaje de correo electrónico que le informará que su resumen está listo y podrá encontrarlo en **computershare.com/walmart** o en la aplicación Associate Stock al descargarla de **One.Walmart.com/StockApp**.

El resumen anual contiene información importante sobre impuestos. Guarde el resumen para saber la diferencia entre el precio de compra y el precio de venta de las acciones que venda. Necesitará esa información para su declaración de impuesto a las ganancias.

Puede acceder a la información de su cuenta en línea a través de **computershare.com/walmart**, desde la aplicación **One.Walmart.com/StockApp** (disponible para dispositivos Apple y Android) o por teléfono al **800-438-6278** (personas con problemas de audición: **800-952-9245**).

Si solicita copias de resúmenes a Computershare, se le cobrará un cargo de $5 por cada resumen para los resúmenes de años anteriores. Puede obtener copias sin cargo a través del sitio **computershare.com/walmart**.

Finalización de la participación y cierre de la cuenta

Si desea cancelar las deducciones de su sueldo para el Plan de Compra de Acciones para Asociados, debe completar la inscripción de beneficios en línea a través de **One.Walmart.com/ASPP**.

Una vez que cancele dichas deducciones, puede cerrar su cuenta vendiendo o transfiriendo el resto de las acciones de su cuenta. Para evitar pagar una tarifa de transacción de venta dos veces, cancele sus deducciones de nómina y confirme que la última compra de acciones se haya asentado en su cuenta antes de cerrarla. También tiene la opción de dejar de pagar deducciones del sueldo y guardar sus acciones del Plan en Computershare.

Si se va de la compañía

Si se va de la compañía, tiene distintas opciones con relación al estado de su cuenta:

- Puede mantener su cuenta abierta sin las deducciones del sueldo semanales o quincenales y sin las contribuciones que hace la compañía. Puede realizar compras en efectivo voluntarias y beneficiarse al no tener que pagar la comisión del corredor de bolsa. Existe un cargo de mantenimiento de $35 por año, el cual se deducirá automáticamente de su cuenta durante el primer trimestre del año, mediante la venta de una cantidad apropiada de sus acciones o una parte de su paquete accionario para cubrir este cargo.
- Puede solicitar transferir acciones al Plan de compra directa de acciones de Walmart.
- Puede cerrar su cuenta y transferir sus acciones a otro corredor.
- Puede cerrar su cuenta y vender algunas o todas las acciones de su cuenta.

Para prevenir saldos residuales y evitar pagar dos veces el cargo por la transacción de venta, espere a recibir el último cheque de pago y confirme que su última compra de acciones se haya asentado antes de cerrar su cuenta.

Actualice esta información en Computershare si hace un cambio de domicilio luego de haberse ido de la compañía.

Folleto informativo

El documento que figura a continuación constituye un folleto informativo que cubre los valores que se registraron conforme a la Ley de Valores (Securities Act) de 1933.

115,694,815 acciones

WALMART INC.

Acciones ordinarias
(valor nominal de $0.10 por acción)

WALMART INC.
Plan de compra de acciones para asociados de 2016
(anteriormente, el Plan de compra de acciones para asociados de Wal-Mart Stores, Inc. de 2016, el Plan de compra de acciones para asociados de Wal-Mart Stores, Inc. de 2004 y el Plan de compra de acciones para asociados de Walmart Stores, Inc. de 1996)

Este folleto informativo hace referencia a la compra de la cantidad de acciones ordinarias por el valor de $0.10 por acción de Walmart, Inc. ("Walmart", la "Compañía" o "nosotros") que se muestra anteriormente en el Plan de compra de acciones para asociados de Walmart, Inc. de 2016 (el "Plan") por parte de asociados elegibles de Walmart que optan por participar en el Plan.

Estos valores no han sido aprobados ni desaprobados por la Comisión de Bolsa y Valores ("SEC") ni por otras comisiones de valores de otros estados como tampoco la Comisión de Bolsa y Valores ni otras comisiones de valores de otros estados han juzgado la precisión o la idoneidad de este folleto informativo. Cualquier declaración en contrario constituye un delito.

Ninguna persona está autorizada a dar información ni a hacer ninguna declaración que no sea la que contiene este Folleto Informativo. Si alguien lo hiciera, no debe confiar en esa persona. Este Folleto Informativo no es una oferta de venta ni una solicitud de una oferta de compra de los valores a los que se hace referencia en este Folleto Informativo en los estados u otras jurisdicciones en los que tal oferta o solicitud sería ilegal. Ni la entrega de este Folleto Informativo ni la adquisición de los valores que se describen en este Folleto Informativo implican que no ha habido modificaciones en la situación de la compañía desde la fecha en que se redactó este Folleto Informativo.

La inversión en las acciones ordinarias que se ofrecen por el presente implica ciertos riesgos. Consulte "Parte I, punto 1A. **Factores de riesgo**" en el Informe Anual de Walmart en el Formulario 10-K recientemente registrado ante la SEC para ver un análisis sobre ciertos riesgos que pueden afectar nuestro negocio, nuestras operaciones, nuestra condición financiera, los resultados de nuestras operaciones y nuestros flujos de caja. Consulte "**Propiedad de acciones, cargos y riesgos**" más adelante.

La fecha de este Folleto Informativo es el 31 de agosto de 2024

Introducción e información general

El Plan es una modificación y una reformulación del Plan de compra de acciones para asociados de Wal-Mart Stores, Inc. de 2004 el cual modificó y reformuló anteriormente el Plan de compra de acciones para asociados de Wal-Mart, Stores Inc. de 1996. El Plan fue aprobado recientemente por los accionistas de Walmart en la Reunión anual de accionistas que se llevó a cabo el 3 de junio de 2016. A partir del 31 de agosto de 2024, hasta 115,694,815 acciones ordinarias de la compañía a un valor nominal de $0.10 por acción (las "Acciones") pudieron comprarse a través de la compañía o en el mercado abierto conforme al Plan; 60,000,000 acciones pudieron obtenerse para la compra a través de la compañía conforme al Plan; y 90,000,000 acciones pudieron obtenerse para la compra en el mercado abierto conforme al Plan. El 30 de noviembre de 2018, se registraron en la SEC de los Estados Unidos 150,000,000 acciones (ajustadas para reflejar el desdoblamiento de acciones a plazo 3 por 1 de la compañía con efecto a partir del 23 de febrero de 2024) para su oferta y venta mediante declaraciones de registro en el formulario S-8. Las acciones se cotizan en la Bolsa de Valores de Nueva York ("NYSE"). En este Folleto Informativo se puede hacer referencia a los asociados participantes como "usted".

El Plan consta de dos partes: el Programa de compra de acciones y el Programa de premios al desempeño sobresaliente. El Programa de compra de acciones brinda a los asociados elegibles la oportunidad de participar en la propiedad de la compañía al permitirles comprar Acciones a través de deducciones del sueldo. Además, si hacen o hicieron compras con esas deducciones del sueldo conforme

al Plan, también pueden comprar acciones mediante aportes voluntarios de sus otros fondos al Plan. Según el Programa de Premios al Desempeño Sobresaliente, la compañía puede premiar a un asociado por un desempeño laboral excepcional entregándole acciones.

Consideramos que el Plan no está sujeto a ninguna de las disposiciones de la Ley de Garantía de los Ingresos de Jubilación para los Empleados de 1974, ni a sus enmiendas. El Plan no califica conforme a las Secciones 401(a) o 423 del Código Fiscal de 1986, o sus enmiendas.

Administración del Plan y gestión de la cuenta

En el Plan se establece que el Comité de Desarrollo de Compensación y Gestión de la Junta Directiva (el "Comité") tiene la autoridad suprema para administrar el Plan. El Comité puede delegar algunos aspectos, o todos, de la administración del Plan a las autoridades o los gerentes de la compañía, o a una subsidiaria de propiedad absoluta o mayoritaria de la compañía (subsidiarias que en el presente folleto informativo se denominan "filiales"), y revocar tal delegación, sujeto a las condiciones que se consideren apropiadas. Los miembros del Comité son seleccionados por la Junta Directiva de Walmart. La Junta Directiva puede destituir a un miembro del Comité a su exclusivo criterio, y los miembros dejarán de ser miembros del Comité si dejan de ser directores de Walmart por cualquier motivo. A la fecha de este folleto informativo, el Comité estaba formado por la Sra. Carla Harris, la Sra. Marissa Mayer y el Sr. Randall Stephenson.

El Comité seleccionó un administrador externo, actualmente Computershare Trust Company, N.A. ("Computershare"), para establecer y mantener las cuentas del Plan. Computershare también cumple el rol de agente de transferencia de acciones de la compañía y presta otros servicios relacionados con las acciones a la compañía y a sus accionistas.

El Comité, como Administrador del Plan, o su delegado, deben cumplir las condiciones del Plan, pero tienen autoridad y discreción total para administrarlo, incluida, entre otras, la autoridad para realizar lo siguiente: (i) determinar cuándo, a quién y en qué tipos y cantidades deben hacerse los aportes; (ii) autorizar a la compañía a hacer aportes para los asociados elegibles cualquiera que sea su cantidad y determinar los términos y las condiciones correspondientes a cada una de dichas aportes; (iii) establecer un mínimo y un máximo de dólares, acciones o limitaciones sobre las distintas aportes permitidos conforme al Plan; (iv) determinar si una entidad de la cual somos propietarios de más del 50 % o sobre la cual tenemos el control, de manera directa o indirecta ("una filial") debe pasar a ser (o dejar de ser) un Empleador participante (según se define a continuación); (v) determinar si alguno de los asociados de Empleadores participantes que no sean estadounidenses debería ser elegible para participar en el Plan (y cuál es este asociado); (vi) tomar todas las determinaciones que se consideren necesarias o aconsejables para la administración del Plan; (vii) establecer, enmendar, anular y rescindir normas y reglamentaciones para la administración del Plan; (viii) ejercer cualquier tipo de autoridad, llevar a cabo una acción y tomar determinaciones según se consideren necesarias o aconsejables para administrar el Plan. Todas las decisiones tomadas por el Comité conforme al plan son finales y obligatorias para todas las personas, incluidas la Compañía y sus filiales, los asociados, las personas que reclamen algún derecho contemplado en el plan de un participante o a través de él, y para los accionistas de la compañía. Los miembros del Comité no actúan como depositarios de los participantes ni mantienen las acciones acreditadas en las cuentas del Plan de los participantes, ningún fondo contribuido al Plan por ningún asociado o la ganancia de las ventas de las acciones en fideicomiso para el beneficio de los participantes.

Participación y elegibilidad para el Plan

Si reúne los requisitos para participar en el Plan, puede inscribirse en línea a través de **One.Walmart.com/ASPP** para autorizar que se realicen las deducciones de su remuneración regular y se las contribuya al Plan para la Compra de Acciones que se colocarán en su cuenta del Plan. También puede comenzar a participar en el Plan si el Comité le otorga un premio en forma de acciones, conforme al Programa de premios al desempeño sobresaliente.

Todos los asociados de la compañía y las filiales aprobadas de la compañía ("Empleadores participantes") podrán participar en el Plan, a excepción de:

- Si su participación en el Plan está restringida o prohibida por la ley del estado o país donde reside, no podrá participar en el Plan o su participación en el Plan estará limitada. Es su responsabilidad asegurarse de que no haya tales restricciones o prohibiciones en su participación en el Plan.
- Debe tener la mayoría de edad según se establece en el estado donde reside o trabaja para participar. Es su responsabilidad asegurarse de tener la edad suficiente para participar. La compañía puede dar por finalizada su participación si descubre que usted no tiene la edad legal suficiente para participar en el Plan.
- Si participa de un convenio colectivo de trabajo cuyos beneficios surgieron de un convenio colectivo de trabajo de buena fe, queda excluido de la participación en el Plan.
- Si su empleador es un Empleador participante que no es estadounidense, usted puede participar solo si es un asociado aprobado (clasificado por grupo, categoría o de forma individual).

- Si es una autoridad de Walmart sujeta al apartado 16(a) de la Ley de Intercambio de Valores de 1934 o está sujeto a nuestra Política de Transacciones con Información Privilegiada, es posible que su facultad para cambiar los montos de su deducción por quincena, adquirir o vender acciones sea restringida en determinados momentos.

Si se encuentra en una licencia de buena fe concedida por la compañía o un Empleador Participante, continuará siendo elegible para hacer aportes al Plan durante el plazo en que esté vigente, pero no será elegible para los aportes paralelos que realiza la compañía durante ese periodo. Si se encuentra en una licencia militar de la compañía o de un Empleador Participante, comuníquese con el Departamento de Beneficios a fin de saber si es elegible para recibir los aportes paralelos de la compañía durante su licencia. Recuerde que debe realizar aportes de sus propios fondos si no recibe el cheque de pago mientras está de licencia, ya que las deducciones del sueldo no serían una opción disponible. Cualquier otra circunstancia que le permitiría seguir participando en el Plan mientras está de licencia de ausencia debe ser aprobada por el Comité.

Aportes del plan: Programa de compra de acciones para asociados

Si desea realizar aportes por deducción del sueldo, debe completar una sesión de inscripción para recibir beneficios en línea en **One.Walmart.com/ASPP**. Una vez que se inscribió correctamente en el Plan, los aportes por deducciones del sueldo continuarán de acuerdo con su autorización más reciente para hacerlo (sujeta a toda restricción impuesta por el Plan) mientras usted siga siendo empleado de la compañía o de un Empleador Participante, con la excepción de que usted modifique o anule la autorización para realizar deducciones del sueldo o que el Plan finalice.

Recuerde que no se aplicarán deducciones a un cheque de pago en el cual el aporte de las deducciones del sueldo exceda su salario neto después de retener los impuestos. Puede modificar o cancelar su autorización para realizar deducciones del sueldo completando una sesión de inscripción para recibir beneficios en línea en **One.Walmart.com/ASPP**. Su solicitud se procesará apenas pueda llevarse a cabo. Es posible que su inscripción o solicitud se demoren o se rechacen si alguna de las políticas de la compañía, incluida la Política de Transacciones con Información Privilegiada, prohíbe el cambio o la inscripción que usted solicita en el momento de intentar realizar la solicitud o inscripción.

Recuerde que, por lo general, los aportes de las deducciones del sueldo se toman de su último cheque de pago como asociado. Si no desea que se apliquen deducciones del sueldo a su último cheque de pago, es importante que anule a tiempo la autorización para realizar las deducciones del sueldo. Si trabaja en un estado donde se exige que le paguen su último cheque fuera del ciclo normal de sueldo, los aportes de las deducciones del sueldo no se tomarán de su último cheque de pago.

Las deducciones de nómina pueden ser de tan solo $2 o de hasta $26,000 por periodo de nómina quincenal (para un monto máximo anual de deducción de nómina de $26,000). El monto de una deducción que se realice cada quince días que supere el mínimo debe ser en incrementos de $1. La compañía o su Empleador Participante realizarán un aporte paralelo en efectivo a su nombre a su cuenta del Plan cuando usted realice aportes al Plan a través de las deducciones del sueldo. Actualmente, el aporte paralelo es un quince por ciento (15 %) de los primeros $1,800 que usted contribuye al Plan a través de las deducciones del sueldo, o $270, como máximo, por cada año del Plan. El aporte paralelo de la compañía se utilizará para comprar Acciones para su cuenta del Plan.

Si participa o ha participado en las deducciones del sueldo conforme al Plan y su cuenta del Plan no se ha cerrado como se describe a continuación, puede contribuir voluntariamente una suma en efectivo (en dólares estadounidenses) proveniente de sus otros recursos para financiar la compra de Acciones conforme al Plan, las cuales se colocarán en su cuenta del Plan, incluso después de que cese su empleo con la compañía o cualquier Empleador Participante. los aportes voluntarios se deben enviar directamente a Computershare. Las instrucciones para realizar tales aportes voluntarios están disponibles en Computershare. Ni la compañía ni su Empleador Participante realizarán aportes paralelos sobre los montos que usted contribuye directamente a Computershare. También puede depositar las Acciones que tenga guardadas fuera del Plan (ya sea que originalmente haya adquirido dichas acciones a través del Plan o de otra manera) en la cuenta de su Plan haciendo los trámites correspondientes directamente con Computershare.

El total de deducciones del sueldo y aportes voluntarios en efectivo al Plan no puede exceder los $125,000 por cada año de Plan (del 1.º de abril al 31 de marzo). Los dividendos acreditados a su cuenta del Plan no contarán contra el máximo.

El Comité determina y puede modificar el máximo y el mínimo de los aportes, puede cambiar las condiciones de los aportes voluntarias en efectivo o en acciones, y puede cambiar la cantidad de los aportes paralelas del empleador en cualquier momento.

PROGRAMA DE PREMIOS AL DESEMPEÑO SOBRESALIENTE

Según el componente de Premios al desempeño sobresaliente, se le puede otorgar un premio en Acciones por demostrar un desempeño laboral sobresaliente durante un mes, un trimestre o un año. El Comité aprueba todos los Premios al desempeño sobresaliente y, de vez en cuando, establece límites máximos en dólares para estos premios.

Las acciones que reciba según el componente de Premios al desempeño sobresaliente se entregarán mediante una cuenta que Computershare mantiene en su nombre.

COMPRA DE ACCIONES

Su empleador enviará todas las deducciones del sueldo, junto con los aportes paralelos, a Computershare tan pronto como sea posible después de cada periodo de pago. Computershare comprará Acciones para su cuenta del Plan dentro de los cinco días hábiles (5) posteriores a la recepción de los fondos. Si realiza un aporte voluntario en efectivo aparte de las deducciones del sueldo, Computershare comprará las Acciones con esa aporte voluntario en efectivo dentro de los cinco días hábiles (5) posteriores a la recepción de los fondos.

Computershare puede comprar las Acciones para las cuentas del Plan en una bolsa de valores nacional, en la compañía o en una combinación de estos lugares. El Comité se reserva el derecho de indicar a Computershare que compre las acciones a una fuente determinada, de acuerdo con las normas de valores correspondientes y las normas vigentes de las bolsas de valores nacionales.

Por lo general, cuando Computershare compra Acciones para el Plan en una bolsa de valores nacional, las acciones se compran como parte de un grupo, y no de manera individual para cada participante. En algunas instancias, las Acciones para un grupo se deben comprar para el Plan durante más de un día. Cuando las Acciones se compran como parte de un grupo, el precio de compra de cada Acción será igual al valor promedio de todas las Acciones compradas para ese grupo, según lo determine Computershare. No está permitido que un participante ordene a Computershare que compre de manera individual para el participante Acciones que sean parte de un grupo.

Si Computershare compra Acciones a la compañía, ya sean acciones autorizadas, pero no emitidas o acciones del tesoro, el precio por acción pagado a la compañía por aquellas acciones será igual al Precio Promedio Ponderado por Volumen (VWAP) que se informa en el NYSE: Transacciones Compuestas, el día de la compra. El VWAP es el promedio ponderado de los precios a los cuales se realizan todas las transacciones comerciales de las acciones de la compañía en la NYSE en la fecha en que se compran acciones de la compañía. Si bien el Plan le permite al Comité designar otra metodología para valuar las acciones compradas de la compañía, hasta el día en que se elaboró este folleto explicativo no se han designado otras metodologías.

La cantidad de acciones adjudicadas a su cuenta del Plan en relación con cualquier compra de Acciones debe igualar el monto total de los aportes y los dividendos disponibles para su cuenta del Plan divididas por el precio de compra de cada Acción atribuible a tales compras, como se mencionó anteriormente.

Información importante para participantes no estadounidenses: Todos los montos que se contribuyan al Plan a través de deducciones del sueldo, todos los aportes paralelos y todos los aportes realizados conforme al Programa de Premios al Desempeño Sobresaliente se convertirán de la moneda local a dólares estadounidenses antes de que se compren las Acciones. Generalmente, se utiliza la tasa de cambio del día hábil inmediatamente anterior al día en que se envían los fondos a Computershare, sin embargo eso puede no ser posible en algunas circunstancias. Todos los aportes voluntarios se deben convertir a dólares estadounidenses antes de enviarlos a Computershare para la compra de acciones.

Propiedad de acciones, cargos y riesgos

PROPIEDAD DE ACCIONES

Desde el momento en que se acreditan las Acciones a su cuenta del Plan, usted tendrá la propiedad total de dichas acciones (incluidas las fracciones). Las acciones de su cuenta del Plan se registrarán a nombre de Computershare hasta que usted haga una de tres cosas: solicite que le depositen sus acciones en una cuenta “General de Accionistas”, que le envíen los certificados de acciones de su cuenta del Plan, o hasta que usted venda las acciones acreditadas en su cuenta del Plan. No puede ceder ni transferir ningún interés en el Plan antes de que las acciones se acrediten en su cuenta; no obstante, puede vender, transferir, ceder o negociar de otro modo con sus acciones acreditadas en su cuenta del Plan una vez que se hayan acreditado en su cuenta del Plan, de manera similar a cualquier otro accionista de la Compañía. No puede transferir o asignar su cuenta del Plan a otra persona que no sea un participante elegible en el Plan. La compañía no mantiene automáticamente un gravamen ni derecho de garantía sobre las acciones que se mantienen en su cuenta del Plan, y los términos del Plan no prevén que nadie tenga o tenga la capacidad de crear un gravamen sobre los fondos o partes de las Acciones acreditadas a su cuenta del Plan; no obstante, puede pignorar, hipotecar o negociar con las acciones acreditadas en sus cuentas del Plan de la misma manera que lo hace con otras acciones de las que pueda ser propietario, sujeto al cumplimiento de nuestra Política de uso de información privilegiada.

DIVIDENDOS Y VOTOS

Los dividendos sobre las Acciones de su cuenta se volverán a invertir automáticamente en Acciones adicionales. Podrá emitir un voto por cada Acción completa de su cuenta del Plan, pero no por las acciones fraccionadas. Se le enviarán en forma gratuita y tan pronto como sea posible (por correo o por otro medio) todas las notificaciones de reuniones, las declaraciones de representación, avisos de disponibilidad en línea de los materiales de representación y otros materiales que la compañía distribuye entre sus accionistas. Para emitir un voto por las Acciones de su cuenta del Plan, debe enviar oportunamente las instrucciones de voto firmadas, también denominadas “instrucciones del apoderado”, tal como se describe en los materiales de representación de la compañía. Si no entrega instrucciones de voto debidamente completadas y ejecutadas como se describe en los materiales de representación de la compañía, sus acciones no se votarán en relación con ninguna elección de directores, voto de asesoramiento sobre compensaciones pagadas a los ejecutivos ni ciertas cuestiones que podrían estar sujetas al voto de los accionistas. En esas circunstancias, podría votarse por sus Acciones de la manera recomendada por la compañía en la declaración de representación, o según lo indique el Comité en cuestiones que NYSE define como “rutina”, tales como la ratificación de la designación de los auditores independientes de la compañía, siempre que al hacerlo se cumplan las leyes vigentes y todas las normas de admisión de un valor en bolsa de una bolsa de valores nacional.

CARGOS Y RESÚMENES DE CUENTA

La compañía paga todos los gastos relacionados con la compra de acciones. Generalmente, no se cobran cargos de mantenimiento ni otros cargos por su cuenta del Plan mientras usted sea un empleado de la compañía o de una de sus filiales (incluso si esa filial no es un Empleador Participante). Usted debe pagar las comisiones o los cargos que surjan a raíz de otros servicios de Computershare que solicite, por ejemplo, comisiones de corretaje y otros cargos aplicables a la venta de Acciones. Computershare puede indicarle si una solicitud en particular incurrirá en un cargo. Los cargos cobrados por Computershare descritos en este Prospecto informativo están sujetos a cambios de vez en cuando.

Al menos una vez por año, se le enviará un resumen de su cuenta conforme al Plan, en el cual se reflejan todos los movimientos de su cuenta del Plan durante el plazo indicado en el resumen. Puede optar por recibir sus resúmenes de cuenta en línea. En ese caso, recibirá un correo electrónico donde se le informe que el resumen está listo y puede encontrarlo en **computershare.com/walmart**. El resumen anual también contiene información importante sobre impuestos. Es muy importante que guarde el resumen para saber la diferencia entre el precio de compra y el precio de venta de cualquier acción que venda. Necesitará esa información para su declaración de impuestos.

Asimismo, puede acceder a la información sobre su cuenta en cualquier momento iniciando sesión en **computershare.com/walmart** o descargando la aplicación Associate Stock. Para acceder a la información sobre su cuenta por teléfono, llame al **800-438-6278** (personas con problemas de audición: **800-952-9245**).

Si solicita copias de los resúmenes a Computershare, actualmente se cobra $5 por cada resumen de los años anteriores al último año del Plan. Puede obtener copias sin cargo a través del sitio **computershare.com/walmart**.

RIESGOS

Muchos de los riesgos que usted corre al participar en el Plan son los mismos que los de otros accionistas de la compañía, es decir, usted asume el riesgo de que el valor de las Acciones aumente o disminuya. No existen garantías en cuanto al valor de las Acciones. Esto significa que asume el riesgo de que se produzcan fluctuaciones en el valor o en el precio de mercado de las Acciones. Es posible que en nuestro Informe Anual más reciente presentado en el Formulario 10-K ante el SEC y, como se indica más adelante, incorporado por referencia en este Folleto informativo, y en otros informes presentados ante el SEC, se planteen ciertos riesgos relacionados con la compañía, sus operaciones y su rendimiento financiero que pueden afectar el valor, el precio de mercado y la liquidez de las Acciones. La compañía le recomienda especialmente que revise tales planteos antes de tomar la decisión de participar en el Plan, de modificar las condiciones de su participación en él, de finalizar su participación en él, o de realizar aportes voluntarios conforme a él.

Si es un participante no estadounidense, también asume el riesgo de que se produzcan fluctuaciones en los tipos de cambio. Asimismo, Computershare aplica sus deducciones del sueldo (así como los aportes paralelos relacionados) a la compra de las acciones, por lo que dichos fondos se consideran activos generales de la compañía o del Empleador Participante y, como tales, están sujetos a las reclamaciones de los acreedores de la compañía o de los Empleadores Participantes. No se pagarán intereses sobre los aportes al Plan.

Entrega de certificados de acciones y venta de acciones

Si lo solicita, Computershare le enviará de forma gratuita un certificado de acciones en el que se representan algunas o todas las Acciones acreditadas a su cuenta del Plan. Sus acciones representadas por un certificado de acciones ya no se acreditarán ni estarán relacionadas de ningún otro modo con ninguna cuenta del Plan que usted mantenga y los dividendos relacionados con esas acciones no serán reinvertidos en virtud del Plan.

También puede permitir que Computershare transfiera algunas o todas las Acciones acreditadas a su cuenta del Plan en su nombre al sistema de registro directo. Dicha transferencia implica que mantendría sus acciones como valores “representados por anotaciones en cuenta” y que su propiedad se mostraría en nuestros registros de transferencia de acciones, y sería representada por un resumen que muestre sus posesiones de Acciones.

Puede solicitar en cualquier momento que Computershare venda todas o algunas de las Acciones (incluidas participaciones fraccionadas) acreditadas en su cuenta del Plan, ya sea que desee o no cerrar su cuenta del Plan.

Si por alguna razón solicita a Computershare que venda Acciones de su cuenta del Plan, se le cobrarán la comisión de corretaje y otros cargos aplicables. Las comisiones de corretaje y los cargos adicionales tendrán la tarifa fijada por Computershare de tanto en tanto. Estas tarifas se encuentran disponibles si las solicita a Computershare.

En **computershare.com/walmart**, puede consultar un cronograma actual de las comisiones de Computershare aplicables al Plan. La compañía negoció el monto de dichas comisiones con Computershare.

Si opta por vender sus acciones, estas se venderán según una orden de mercado. A pesar de que el Plan permite que la venta de las Acciones que se mantienen en las cuentas del Plan se realice a través de órdenes en lote, y dichas ventas se han realizado a través de órdenes en lote en el pasado, las ventas de las Acciones conforme al Plan ahora se realizan únicamente según órdenes de mercado. Como resultado, si le indica a Computershare que venda las Acciones acreditadas en su cuenta del Plan, Computershare venderá aquellas acciones en el mercado abierto al mejor precio disponible actual. Recuerde que: no obstante el precio en el cual se ejecutará su orden no está garantizado y el último precio comercializado de nuestras acciones antes de la ejecución de su orden para vender acciones no es, necesariamente, el precio al cual se va a ejecutar su orden. De tanto en tanto, compramos Acciones en el mercado abierto conforme al programa de compra de acciones adoptado por nuestra Junta Directiva. Como resultado, si Computershare vende las acciones acreditadas en su cuenta del Plan en el mercado abierto, podríamos adquirir dichas acciones. Nosotros normalmente no sabremos si las Acciones que compramos en el mercado abierto se las compramos de usted. Sus Acciones serán vendidas inmediatamente después de que su solicitud pueda procesarse razonablemente. En general, las órdenes de mercado se ejecutan inmediatamente después de que se realizan. Tenemos previsto vender todas sus acciones en la ("NYSE"), aunque no es necesario que las órdenes para dichas ventas se ejecuten en la NYSE. Si la NYSE cierra cuando su orden está lista para ser procesada, su transacción de venta se procesará lo antes posible el día siguiente de actividad comercial de la NYSE. Las órdenes de venta de acciones según el Plan pueden ejecutarse a través de una filial de Computershare que esté registrada en el SEC como agente bursátil en virtud de la Ley de Intercambio de Valores de 1934. Las ventas de las acciones se realizarán en dólares estadounidenses. Si trabaja fuera de los Estados Unidos con un Empleador Participante y si Computershare provee este servicio en su país, las ganancias de la venta pueden convertirse por un costo adicional a otra moneda si así lo pide cuando solicita que sus acciones se vendan. Si las ganancias se convierten a otra moneda, generalmente, se utiliza la tasa de cambio del día hábil inmediatamente anterior al día de la transacción, pero eso puede no ocurrir en todas las circunstancias.

Finalización de la participación y cierre de la cuenta

Una vez que se convierte en un participante del Plan, lo será hasta que decida cerrar su cuenta del Plan, y todas las Acciones y las ganancias de las ventas acreditadas en la cuenta se retiren de la cuenta del Plan, o hasta que todas las Acciones y las ganancias de las ventas se retiren de la cuenta del Plan después de que finalice su empleo en la compañía o en una de sus filiales.

Si anula su autorización para realizar las deducciones del sueldo o finaliza su relación laboral con la compañía y todas sus filiales, puede optar por continuar con su cuenta del Plan o bien cerrarla, si así se lo especifica a Computershare. Específicamente:

- Puede mantener su cuenta del Plan abierta (sin las deducciones del sueldo semanal o quincenal ni los aportes paralelas que hace la compañía). Si mantiene su cuenta abierta, puede hacer aportes voluntarios en efectivo y no se le cobrarán comisiones de corretaje sobre la compra de Acciones. Si deja de ser empleado de la compañía o de sus filiales, se le cobrará un cargo de mantenimiento anual a su cuenta. Computershare tiene la opción de cobrar dichos cargos de mantenimiento, ya sea en forma de cuotas trimestrales o en un pago de suma única anual, el primer trimestre de cada año calendario y Computershare los pagará mediante la venta de una cantidad adecuada de acciones o de la parte de una acción. (Si lo transfieren a una filial de la Compañía que no es un empleador participante, la compañía puede continuar pagando los cargos de mantenimiento por usted.)
- Si es propietario de una Acción completa, como mínimo, puede cerrar su cuenta del Plan transfiriendo sus Acciones a una cuenta "General de Accionistas" que Computershare mantendrá en su nombre. Puede hacer esta transferencia recibiendo todas las acciones enteras en forma de certificados con un cheque por cualquier propiedad de acciones fraccionadas o volver a depositarlas en la cuenta General de Accionistas, o bien, Computershare puede transferir las acciones de manera electrónica, si usted así lo solicita. Consulte a Computershare para obtener más información sobre los cargos asociados a la cuenta General de Accionistas.
- Puede cerrar su cuenta del Plan luego de vender todas las Acciones que tenía en esta y obtener todas las ganancias, o bien, puede solicitar que le entreguen certificados por las acciones completas (y ganancias en efectivo por las acciones fraccionadas que se le pagaron). Las ganancias de toda venta de acciones completas o fraccionadas estarán libres de comisiones de corretaje, honorarios de venta y otros cargos correspondientes. Su cuenta se cerrará automáticamente si lo despiden y no hay acciones o acciones fraccionadas en su cuenta.

Si fallece antes de que se cierre su cuenta del Plan, esta se distribuirá según la documentación legal presentada ante Computershare o entre sus herederos, a menos que haya acordado previamente con Computershare mantener sus acciones en una cuenta conjunta. En caso de tener una cuenta conjunta, el titular de dicha cuenta puede hacer los trámites necesarios ante Computershare para transferir las acciones a una cuenta General de Accionistas que Computershare mantendrá, a cargo del titular de la cuenta conjunta, o distribuir las Acciones (o las ganancias obtenidas de la venta de estas), menos los gastos o las comisiones correspondientes.

Si abrió una cuenta de copropietario antes del 1 de abril de 2018, puede comunicarse con Computershare por teléfono al **800-438-6278** (si tiene problemas auditivos: **800-952-9245**) para eliminar a un copropietario de su cuenta.

Modificaciones y finalización del Plan

El Plan no tiene una fecha de vencimiento determinada. La Junta Directiva de la compañía, el Comité o cualquier otro comité debidamente designado de la Junta Directiva puede modificar o finalizar el Plan en cualquier momento. Sin embargo, si la ley o las normas aplicables de una bolsa de valores nacional exigieran la aprobación de los accionistas para una modificación, la modificación quedará sujeta a esa aprobación. Ninguna enmienda o finalización del plan hará que usted pierda: (1) los fondos que contribuyó al Plan o los fondos paralelos que haya contribuido la Compañía y que aún no se hayan utilizado para comprar Acciones, (2) las acciones (o acciones fraccionadas) de las Acciones acreditadas en su cuenta del Plan, o (3) los dividendos o las distribuciones declaradas con respecto a las Acciones después de contribuir al Plan, pero antes de la fecha efectiva de la modificación o finalización.

Información sobre impuestos

El siguiente resumen de las consecuencias del Plan del impuesto sobre los ingresos en los Estados Unidos se basa en el Código Fiscal y en todas las reglamentaciones de dicho Código que se encuentran en vigencia a la fecha de creación de este folleto informativo. Este resumen no cubre los impuestos a las ganancias estatales ni locales, ni los impuestos de jurisdicciones que no sean los Estados Unidos. Consulte a su asesor fiscal con respecto a las consecuencias del impuesto individuales antes de comprar Acciones según el Plan.

COMPRA DE ACCIONES CONFORME AL PLAN DE COMPRA DE ACCIONES

No se aplican consecuencias del impuesto federal sobre los ingresos cuando se inscribe en el Plan o cuando se compran Acciones para usted conforme al Programa de compra de acciones, ya sea a través de deducciones del sueldo o de aportes voluntarios. El monto de las deducciones del sueldo y de los aportes voluntarios conforme al Plan no es deducible a los fines de determinar su ingreso gravable federal. El monto del sueldo que usted ha deducido conforme al Plan y el valor total de los aportes paralelos de la compañía se consideran como ingresos ordinarios para usted durante el año calendario de las deducciones o los aportes y se informarán en su recibo de sueldo y en el formulario W-2. La compañía deduce todas las retenciones salariales correspondientes y demás impuestos del resto de su remuneración (aumentando las deducciones del sueldo y otras deducciones impositivas a tal fin) con respecto a la cantidad del salario que se deduce conforme al Plan y los aportes paralelos a su cuenta del Plan, si existieran. La compañía tiene derecho a una deducción de impuestos sobre el monto del aporte paralelo en el mismo año que usted produce sus ingresos.

PREMIOS AL DESEMPEÑO SOBRESALIENTE CONFORME AL PROGRAMA DE PREMIOS AL DESEMPEÑO SOBRESALIENTE

Las concesiones de Acciones conforme al Programa de Premios al desempeño sobresaliente son gravables como ingresos ordinarios en el año calendario del premio, independientemente de si los certificados de Acciones se le otorgan directamente a usted o si las Acciones se otorgan a su cuenta del Plan. Sus ingresos ordinarios serán el valor de mercado de las Acciones a la fecha en que se le otorga el premio, multiplicado por el número de Acciones otorgadas. El valor de mercado de toda Acción otorgada se informará en su formulario W-2. La compañía deducirá todas las retenciones salariales correspondientes y demás impuestos del resto de su remuneración (aumentando las deducciones del sueldo a tal fin). La compañía tiene derecho a una deducción de impuestos en la misma cantidad y en el mismo año en que usted produce sus ingresos ordinarios.

VENTA DE ACCIONES O DISTRIBUCIÓN DE CERTIFICADOS

No deberá reconocer ningún ingreso sujeto a impuestos cuando solicite que se le otorguen certificados para algunas o todas las Acciones de su cuenta del Plan. Cuando vende o dispone de sus Acciones de cualquier otra forma, ya sea a través de Computershare o después de recibir los certificados de Acciones, la diferencia entre el valor justo de mercado de las Acciones en el momento de la venta y el valor justo de mercado de las Acciones en la fecha en que las adquirió se aplicará como ganancia o pérdida de capital. El periodo de tenencia para determinar si la ganancia o la pérdida de capital es a largo o a corto plazo comenzará a partir de la fecha en que adquirió las Acciones (es decir, la fecha en que se acreditan las Acciones en su cuenta del Plan). La compañía no tendrá deducciones como resultado de su disposición de las Acciones y no será responsable del pago del impuesto a las ganancias u otros impuestos que usted pague sobre las ganancias que pueda obtener de la venta de las Acciones, o que se impongan sobre la transacción de venta, o en relación con esta.

Información disponible

Para obtener más información acerca del Plan o de sus administradores, llame a Servicios al Personal al **800-421-1362**. También puede escribir a:

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

Puede comunicarse con Computershare llamando al **800-438-6278** (**800 GET-MART**)(si tiene problemas auditivos: **800-952-9245**) en línea a través de **computershare.com/walmart**, o escribiendo a la siguiente dirección para enviar toda la correspondencia, incluidas transacciones, solicitudes de certificados de acciones, cartas poder para la venta de valores, compras voluntarias y consultas al servicio de atención al cliente:

Computershare
Attn: Walmart ASPP
P.O. Box 43080
Providence, Rhode Island 02940-3080

Envío electrónico de folletos informativos y otros documentos

Para reducir los costos de administración del Plan y para ayudar con nuestros esfuerzos de sostenibilidad, le pedimos que nos permita enviar folletos informativos y otros documentos relacionados con el Plan de manera electrónica, y que consulte los folletos informativos y los documentos que proporcionamos a los participantes del Plan en **One.Walmart.com**. Su inscripción en el Plan representará su consentimiento para recibir o acceder a nuestras comunicaciones sobre el Plan y a los folletos informativos relacionados con la compra de Acciones conforme al Plan de manera electrónica a través de **One.Walmart.com**, a menos que elija afirmativamente recibir copias impresas de dichas comunicaciones. En cualquier momento después de la inscripción puede revocar dicho consentimiento enviando por escrito una revocación del consentimiento para recibir los documentos del Plan de manera electrónica al Departamento de Beneficios a la dirección que aparece a continuación. Además, si desea solicitar una copia impresa del folleto informativo actual relacionado con las compras de Acciones conforme al Plan y de nuestro Informe anual más reciente en el Formulario 10-K, escriba al Departamento de Beneficios para que le envíen dichos documentos sin cargo.

Documentos incorporados por referencia

Los siguientes documentos presentados por la compañía ante la Comisión de Bolsa y Valores (la "Comisión"), expediente n.º 1-6991, por la presente, se incorporan por referencia en este folleto informativo y forman parte de este:

- El Informe anual de la compañía en el Formulario 10-K para el año fiscal que finaliza el 31 de enero de 2024;
- Informes trimestrales de la compañía en el Formulario 10-Q para los trimestres fiscales que finalizaron el 30 de abril de 2024, el 31 de julio de 2024 y el 31 de octubre de 2024;
- Informes actuales de la compañía en el Formulario 8-K presentados en la Comisión el 15 de agosto de 2024;
- Declaración de Representación definitiva de la compañía para la Asamblea Anual de Accionistas de 2024, presentada ante la Comisión el 25 de abril de 2024; y
- Anexo 99.1 a la Declaración de registro de la compañía en el Formulario S-8 (Expediente N.º 333-214060).

Todos los documentos presentados por la compañía conforme a las Secciones 13(a), 13(c), 14 y 15(d) de la Ley de Intercambio de Valores de 1934 (la "Ley de intercambio") a la fecha de elaboración de este Folleto informativo o posteriormente serán considerados para su incorporación por referencia a este folleto informativo y para formar parte de este a partir de la fecha de presentación de dichos documentos, excepto para la información provista a la Comisión que no es considerada para ser "presentada" en relación con motivos incluidos en la Ley de Intercambio (de aquí en más, nos referiremos a tales documentos, y los documentos enumerados anteriormente, como "Documentos incorporados"). Toda declaración contenida en un Documento incorporado será considerada para su modificación o invalidación para los propósitos de este folleto informativo, en la medida en que una declaración contenida en el presente o en cualquier otro archivo posterior del Documento incorporado modifique o invalide dicha declaración. Las declaraciones modificadas o reemplazadas no se considerarán, excepto en la medida en que sean modificadas o reemplazadas de esa manera, como parte del folleto informativo de la Sección 10(a) de la compañía en relación con la compra de las Acciones conforme al Plan, tal como se describe en la portada de este folleto informativo. Este documento y los documentos incorporados por referencia en el presente constituyen dicho folleto informativo de la Sección 10(a).

Estos documentos y el último Informe anual de la compañía para los accionistas, y cualquier otro documento que debamos enviarle conforme a la Norma 428(b) en virtud de la Ley de Valores de 1933, y sus enmiendas, están a su disposición sin cargo, ya sea que los solicite de forma escrita u oral. Envíe su solicitud para recibir los documentos a:

Walmart Inc.
Benefits Department
508 SW 8th Street
Bentonville, Arkansas 72716-0295

O bien, puede llamar a Servicios al Personal al **800-421-1362**.

Para obtener más información

SI TIENE PREGUNTAS ACERCA DE...	SITIO WEB	TELÉFONO
Cuándo es elegible para acceder a los beneficios o cómo inscribirse	**One.Walmart.com/Benefits**	Llame a Servicios al Personal al **800-421-1362.**
Beneficios médicos y reclamaciones, o administración de la atención	Consulte **Buscar un médico y obtener ayuda con el plan del seguro médico** en la próxima página	
Nombrar sus beneficiarios	**One.Walmart.com/Beneficiary**	Llame a Servicios al Personal al **800-421-1362.**
Beneficios de farmacia	**One.Walmart.com/Pharmacy**	OptumRx: **844-705-7493**
Cuenta de ahorro de salud (HSA) para asociados inscritos en el Plan Saver	**Learn.HealthEquity.com/Walmart/HSA** **One.Walmart.com/Saver**	HealthEquity: **866-296-2860**
Centros de Excelencia	**One.Walmart.com/COE** Contigo Health (prótesis de cadera y rodilla, cirugía de columna, cirugía de pérdida de peso) HealthSCOPE (revisión de historial clínico de cáncer, viajes de fertilidad, revisión electrónica de cirugía cardiaca, trasplantes)	BlueAdvantage: **866-823-3790** Aetna: **800-525-6257** UMR: **855-870-9177** Plan local Mercy Arkansas: **800-804-1272** Plan local Banner: **855-548-2387** Contigo Health: **877-230-7037** HealthSCOPE Benefits: **800-804-1289** **479-621-2830** (trasplantes)
Programa de salud digestiva: Todos los estados excepto Hawái	**One.Walmart.com/Cylinder**	Cylinder: **833-336-9488** *(O llame al número que aparece en su tarjeta de identificación del plan)*
Programa digital de fisioterapia: Todos los estados excepto Hawái	**One.Walmart.com/OmadaHealth**	*(Vea la tarjeta de identificación del plan)*
Plan de la visión	**One.Walmart.com/Vision**	VSP: **866-240-8390**
Plan dental	**One.Walmart.com/Dental**	Delta Dental: **800-462-5410**
Seguro por discapacidad a corto plazo	**One.Walmart.com/ShortTermDisability** (CA, CO, CT, DC, HI, MA, NJ, NY, OR, RI, WA: Para más información sobre los planes estatales, consulte el capítulo **Discapacidad a corto plazo para asociados a tiempo completo pagados por hora**	Sedgwick/Lincoln: **800-492-5678**
Seguro por discapacidad a largo plazo	**One.Walmart.com/LongTermDisability**	Lincoln: **877-353-6404**
Seguro por accidentes y enfermedades graves	**One.Walmart.com/Accident** **One.Walmart.com/Critical**	Allstate Benefits: **800-514-9525**
Seguro de vida, por muerte accidental y desmembramiento (AD&D), y seguro de viaje durante viajes de negocios	**One.Walmart.com/Life** **One.Walmart.com/ADD**	Prudential: **877-740-2116**
Recursos de asistencia para los asociados	Help Now: **One.Walmart.com/HelpNow** Mis recursos de salud mental: **One.Walmart.com/HelpNow**	**855-4HLPNOW** (**855-445-7669**) de lunes a viernes 7 a. m. a 7 p. m. CT **800-825-3555**, disponible 24/7
AiRCare: Apoyo personalizado para el bienestar	**One.Walmart.com/AiRCare**	**866-307-2081**
Apoyo para la formación de familias	**One.Walmart.com/FamilyBuilding** **One.Walmart.com/LifeWithBaby**	Llame a al administrador del plan de la salud al número que figura en su tarjeta de identificación del plan
Programa Quit Tobacco (Dejar de fumar)	**One.Walmart.com/QuitTobacco**	Kick Buts: **855-955-1905** Disponible de lunes a viernes 9 a. m. a 6 p. m. CT
myAgileLife	**One.Walmart.com/HealthyLiving** **One.Walmart.com/Diabetes**	MyAgileLife: **855-955-1905**, de lunes a viernes. 9 a. m. a 6 p. m. CT
Twin Health: Diabetes y gestión metabólica	**Connect.TwinHealth.com/Walmart** *Después de enero de 2025*	**888-99-TWINHEALTH** o **888-998-9464** *Después de enero de 2025*
Plan 401(k) de Walmart	**Benefits.ML.com** **One.Walmart.com/401k**	Merrill: **888-968-4015**
Plan de compra de acciones para asociados	**ComputerShare.com/Walmart** **One.Walmart.com/ASPP**	ComputerShare: **800-438-6278** Asociados con dificultades auditivas: **800-925-9245**

Buscar un médico y obtener ayuda con el plan del seguro médico

La información de contacto para obtener ayuda con el plan médico depende de dos cosas:

- De dónde trabaje o, en algunos casos, del plan en el que esté inscrito.
- Qué administrador del plan presta servicio en su área. Encontrará el suyo en el reverso de su tarjeta de identificación.

UBICACIÓN O PLAN	ADMINISTRADOR DEL PLAN	BUSCAR UN MÉDICO	RECLAMACIONES, ATENCIÓN AL CLIENTE Y ADMINISTRACIÓN DE CUIDADO
Premier, Contribution, Saver	BlueAdvantage Aetna UMR	Aetna, BlueAdvantage y UMR (a través de Included Health): **800-941-1384** **IncludedHealth.com/Walmart** Médico de atención primaria virtual: **One.Walmart.com/VirtualPrimaryCare**	BlueAdvantage: **866-823-3790** Aetna: **855-548-2387** UMR: **855-870-9177**
Plan local Mercy Arkansas	UMR	Included Health: **800-941-1384** **IncludedHealth.com/Walmart** Médico de atención primaria virtual: **One.Walmart.com/VirtualPrimaryCare**	UMR: **800-804-1272**
Plan local Banner	Aetna	Included Health: **800-941-1384** **IncludedHealth.com/Walmart** Médico de atención primaria virtual: **One.Walmart.com/VirtualPrimaryCare**	Aetna: **855-548-2387**
Hawái	Plan de salud Hawái (HMSA) Kaiser	**HMSA.com**: **808-948-6111** **KP.org**: **800-966-5955**	**HMSA.com**: **808-948-6111** **KP.org**: **800-966-5955**
Plan PPO	Aetna	Included Health: **800-941-1384** **IncludedHealth.com/Walmart** Consulta virtual con un médico: **Teladoc.com/Aetna**	Aetna: **855-548-2387** Teladoc: **800-835-2362**

Para asociados inscritos en planes HMO: busque un médico y obtenga ayuda con el plan médico

Si tiene preguntas sobre cómo encontrar un médico, beneficios, reclamaciones médicas o cómo administrar la atención para un plan HMO:

PLAN HMO	SITIO WEB	TELÉFONO
Health Net	**HealthNet.com**	Health Net: **800-722-5342**
HMSA Hawaii	**HMSA.com**	HMSA: **808-948-6111**
Kaiser de California	**kp.org**	**800-464-4000** (Ingles) **800-788-0616** (Español)
Kaiser de Colorado	**kp.org**	Área metropolitana de Denver : **303-338-3800** otras áreas: **800-632-9700**
Kaiser of Georgia	**kp.org**	Atlanta metropolitana: **404-261-2590** otras áreas: **888-865-5813**
Kaiser de Hawaii	**kp.org**	Kaiser: **800-966-5955**
Kaiser of the Mid-Atlantic	**kp.org**	Kaiser: **855-249-5018**
Kaiser de Oregon	**kp.org**	Área de Portland: **503-813-2000** Otras áreas: **800-813-2000**
Kaiser Foundation Health Plan of WA	**kp.org**	Kaiser: **888-901-4636**

Libro de beneficios para asociados de 2025 | Descripciones resumidas del plan