This packet contains the following benefits-related information:

- Puerto Rico Summary of Material Modifications for the Associates' Health and Welfare Plan
- Puerto Rico Summary of Material Modifications for the Walmart Puerto Rico 401(k) Plan
- Legal Notices for the Associates' Health and Welfare Plan

PUERTO RICO SUMMARY OF MATERIAL MODIFICATIONS TO THE ASSOCIATES' HEALTH AND WELFARE PLAN
January 1, 2024

The Puerto Rico 2022 *Associate Benefits Book,* which serves as the summary plan description for the Walmart Inc. Associates' Health and Welfare Plan ("AHWP" or "Plan"), has been revised. Please read the following Summary of Material Modifications ("SMM"), which explains these revisions. You will not receive a new *Associate Benefits Book* for 2024. Instead, you should refer to your Puerto Rico 2022 *Associate Benefits Book*, along with this 2024 SMM, which incorporates the modifications stated in the 2023 SMM. The current summary plan description for the Plan is comprised of the original printing of the Puerto Rico 2022 *Associate Benefits Book*, the 2023 SMM, and this SMM dated January 1, 2024.

The revisions and page numbers listed below refer to the initial printing of the Puerto Rico 2022 *Associate Benefits Book*. Coverage will continue to be subject to the Plan's otherwise applicable eligibility terms, exclusions, limitations, and cost-sharing as described in the Puerto Rico 2022 *Associate Benefits Book*.

NOTE: New terminology has been introduced to replace certain terms used in the 2022 Puerto Rico *Associate Benefits Book* and in this SMM, as follows:

- The **Eligibility and enrollment** chapter will be the **Eligibility, enrollment, and effective dates** chapter.
- "Status change event," used 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, will be changed to "election change event." Similarly, references to "status change" will be changed to "election change."
- The Resources for Living chapter and the benefit it describes are now "My Mental Health Resources."

Please note that when this SMM refers you to sections of the 2022 Puerto Rico *Associate Benefits Book* that include these terms, the original unchanged terms are used, to assist you in finding the relevant passages.

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. Please see page 19 of this SMM for more details.

ELIGIBILITY AND ENROLLMENT (Pages 4-33 of the Puerto Rico 2022 *Associate Benefits Book*)

Page 6—Associate eligibility

Effective January 1, 2023, replace the paragraph beginning "Our expectation is..." with the following:

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

Page 6—Associate eligibility

Effective January 1, 2023, replace the paragraph beginning "**NOTE:** Your eligibility..." with the following:

NOTE: Eligibility for benefits and the terms and conditions of each benefit are described in the Plan document and the Puerto Rico 2022 *Associate Benefits Book*, as modified by this SMM. To the extent that any information provided to you through other sources, whether oral or written, conflicts with the Plan document and the Puerto Rico 2022 *Associate Benefits Book*, as modified by this SMM, the terms in the Puerto Rico 2022 *Associate Benefits Book*, as modified by this SMM, will control. In the event of any conflict between the terms of the Plan document and the Puerto Rico 2022 *Associate Benefits Book*, as modified by this SMM, the terms of the Plan document will control. If you wish to review the Plan document, please refer to the Legal information chapter of the Puerto Rico 2022 *Associate Benefits Book*, which discusses your right to review the Plan Document.

Page 7—If you leave the company and are rehired

Insert the following text after the first paragraph in this section:

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.

Page 10—If your child is incapable of self-support

Replace this subhead and the text that follows it, in its entirety, with the following:

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, 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.

Page 11—When you enroll for benefits

Effective January 1, 2023, the following paragraph was added before the paragraph beginning "**Late enrollees**": **Proof of Good Health.**

If you enroll in optional associate life or optional dependent life insurance during your initial enrollment period for more than the guaranteed amount or for the guaranteed amount and then increase coverage for you or your spouse/partner, if eligible, at a later date, you will be subject to Proof of Good Health requirements. For more information, see **Enrollment and effective dates by job classification** later in this chapter and refer to the chart that applies to your job classification.

Effective January 1, 2024, however, that newly added paragraph beginning **"Proof of Good Health"** is removed and replaced by the following:

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.

Page 12—When coverage is effective

Effective January 1, 2024, the following text replaces the text beginning under the **When coverage is effective** subhead, through the end of the ACTIVE WORK OR ACTIVELY AT WORK section:

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 My Mental Health 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 My Mental Health 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 coverage.

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*Note that the above changes on page 12 **replace** the following changes made effective January 1, 2023:*

- Effective January 1, 2023, replace the paragraph beginning "If you are not at work for any reason..." with the following:

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

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

- Effective January 1, 2023, replace the third paragraph under the "'Active Work' or 'Actively at Work'" subhead with the following:

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

Page 13—In the "Enrollment and effective dates by job classification" section, the "Full-time hourly associates" chart

Effective January 1, 2023, in the row including "Optional associate life insurance" and "Optional dependent life insurance," the following text was added in the "When coverage is effective" subsection.

- If you are on a leave of absence when your coverage would have otherwise been effective, coverage will be effective when you return to active status.

Effective January 1, 2024, this text is deleted again.

Effective January 1, 2023, in the row including "Long-term disability (LTD) plan (including enhanced benefits)," the two bullet points under "If you enroll in coverage after your initial enrollment period" were replaced with the following:

– If you enroll in coverage following an election change event and are approved, your coverage is effective on the later of 1) the first day of the pay period following the date Lincoln approves your coverage, or 2) the 12-month anniversary of your date of hire.

– If you enroll in coverage during Annual Enrollment and are approved, your coverage will be effective the later of 1) January 1 of the following year, 2) if approved on or after January 1, the first day of the pay period following the date Lincoln approves your coverage, or 3) the 12-month anniversary of your date of hire.

Effective January 1, 2023, in the row including "Long-term disability (LTD) plan (including enhanced benefits)," add the following at the end of the "If you enroll in coverage after your initial enrollment period" subsection:

If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until Annual Enrollment for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment section** of this chapter.

Effective January 1, 2024, the bullet points under "If you enroll in coverage after your initial enrollment period," including the two bullet points added effective January 1, 2023, are replaced with the following:

- If you enroll in 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 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.

Page 15—In the "Enrollment and effective dates by job classification" section, the "Management associates" chart

Effective January 1, 2023, in the row including "Long-term disability (LTD) plan (including enhanced benefits)," the second bullet point under "If you enroll in coverage after your initial enrollment period" was replaced with the following:

- If you enroll in coverage during Annual Enrollment and are approved, your coverage will be effective the later of 1) January 1 of the following year, or 2) if approved on or after January 1 of the current year, the first day of the pay period following the date Lincoln approves your coverage.

Effective January 1, 2023, in the row including "Long-term disability (LTD) plan (including enhanced benefits)," add the following at the end of the "If you enroll in coverage after your initial enrollment period" subsection:

If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until Annual Enrollment for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.

Effective January 1, 2024, the bullet points under "If you enroll in coverage after your initial enrollment period," including the bullet point added effective January 1, 2023, are replaced with the following:

- 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.

Page 30—In the "Full-time hourly associates transferring to part-time hourly or temporary" chart

Effective January 1, 2023, replace the last bullet in reference to long-term disability with the following:

- If you elected **long-term disability plan** coverage, your enrollment is canceled effective the day prior to the first day of the pay period following the pay period in which your transition occurs.

THE MEDICAL PLAN (Pages 34-39 of the Puerto Rico 2022 *Associate Benefits Book*)

Page 36—What is covered by the AMP

Effective January 1, 2024, add the following text before "Filing a medical claim":

Centers of Excellence for fertility and 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, this benefit is available only to Puerto Rico associates and dependent spouse/partners, aged 21 or older, who are enrolled in the Premium or Elite medical plan option under the Associates' Health and Welfare Plan ("Plan").

If you are eligible to participate in the fertility and family-building Centers of Excellence program and choose to do so, Walmart will pay 100% of eligible medical expenses, including fertility medications, for covered services received from a Kindbody Signature Clinic through the Centers of Excellence program for fertility and family building, up to a $20,000 maximum lifetime benefit.

Walmart will not provide any benefits after you have reached the $20,000 maximum lifetime benefit. The $20,000 maximum is the amount of paid benefits per individual medical plan 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. Also, the benefit will not reset if you are currently an eligible spouse/partner enrolled in the Plan 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 spouse/partner under another associate's medical coverage). The $20,000 maximum lifetime benefit does not apply to services outside the Centers of Excellence fertility and family-building program that

may be covered under other Plan (including Premium or Elite medical plan option) terms and conditions of coverage, independent of the Centers of Excellence fertility and family-building program.

The Plan will not cover fertility treatment services received from a provider other than Kindbody unless those services are otherwise covered services under the medical plan option you are enrolled in.

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. 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, including the $20,000 maximum lifetime benefit.

If you are interested in participating in the Centers of Excellence program for fertility and family building, you should contact Kindbody at 833-202-8548 or by going to **Kindbody.com/WalmartPR** to schedule an initial virtual consultation with a Kindbody Signature Clinic clinician, to begin the development of a personalized care plan.

Page 39—If you drop coverage and reenroll

Effective January 1, 2023, delete this section.

THE DENTAL PLAN (Pages 40-44 of the Puerto Rico 2022 *Associate Benefits Book*)

Page 44—If you drop coverage and reenroll

Effective January 1, 2023, delete this section.

RESOURCES FOR LIVING (Pages 54-57 of the Puerto Rico 2022 *Associate Benefits Book*)

Effective January 1, 2024, replace this chapter in its entirety with the "My Mental Health Resources" text that follows. All references to Resources for Living in the Puerto Rico 2022 *Associates Benefits Book* are replaced with references to My Mental Health Resources.

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. Services are available at no cost to you and your eligible family members from your date of hire. Associates and family members can call My Mental Health Resources or visit Lyra Health'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 like financial and legal counseling or caregiver resources.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Quickly match with a mental health therapist or coach	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**	
Visit Lyra Learn to explore on-demand knowledge courses, live monthly workshops, and small-group facilitated Gatherings.	Go to **Learn.LyraHealth.com** Enter customer code: **Walmart5&10**	

What you need to know about 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 family members can utilize My

Mental Health Resources benefits even if you are enrolled in a Walmart medical plan and your family members are not.

Using My Mental Health Resources

If you are a U.S.- or Puerto Rico-based associate, you and your eligible family members are automatically enrolled in My Mental Health Resources as of your first day of employment. Eligible dependents include your spouse/domestic partner, and your children, stepchildren, or foster children under the age of 26. Associates and eligible dependents may be required to provide the associate's WIN and date of birth to confirm eligibility for services, however all services provided are entirely confidential.

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
- Financial and legal counseling
- Caregiver resources

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 family members 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. As you work together, you'll continue to develop your toolkit of skills and strategies to support your mental health and build strength for lasting change. You can also select a more hands-off experience through Lyra's Guided Self-Care program.

Lyra therapy offers access to top mental health providers that only use evidence-based treatments with appointments available right away. Lyra's therapists are experts at diagnosing mental health conditions and identifying thoughts, behaviors, and strong emotions that may be symptoms of severe 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 that can help you achieve lasting change. 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
- 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 and its third-party partners make available access to legal and financial counseling, identity-theft support, and caregiver resources. Through Lyra's work-life services, they can help you:

- Meet your financial goals and save for the future
- Plan for your income taxes
- Explore your options related to legal issues
- Access a library of financial and legal forms and documents for a variety of needs
- Recover from identity theft
- Explore resources related to child, elder, and pet care

You can receive a half-hour consultation for each legal or financial issue or a one-hour consultation for each identity-theft issue, at no cost to you. Note that this service does not provide assistance in situations involving employment law. If you need more legal, financial, or identify-theft support beyond the initial consultation, you can continue to work with that professional for an additional discounted fee. Resources, documents, and self-help tools are all available 24/7 online at **Walmart.LyraHealth.com/Worklife**.

Learning resources

Through Lyra Learn you can build strategies to help improve your well-being at work and home all on an eLearning platform created by Lyra's team of mental health experts.

ON-DEMAND COURSES AND LIVE WORKSHOPS

Explore unlimited on-demand courses and live monthly workshops taught by mental health professionals at your own pace. While some courses feature five to eight chapters of in-depth content, Lyra's Mental Health Mini courses take less than 30 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

GATHERINGS

Engage in Lyra Gatherings—virtual listening and discussion sessions on thought-provoking topics related to mental health, current events, diversity, equity, inclusion, and belonging. Each Lyra Gathering is a supportive space led by a clinical topic expert. Attendance is limited to ensure an intimate, small-group experience.

To explore on-demand courses and to register for Lyra Gatherings, visit Learn.LyraHealth.com and enter customer code: **Walmart5&10**.

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. Registering as a new user may require you to use your WIN number and date of birth to confirm eligibility. You may also download the Lyra Health app from the App Store or Google Play to access many of Lyra's services.

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 family for 18 months after your last day with Walmart (or the maximum duration for which you would be eligible for COBRA coverage) at no cost to you. If you enroll for COBRA coverage, the benefit will be available throughout the COBRA period.

You do not have to enroll in COBRA coverage 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.

COMPANY-PAID LIFE INSURANCE (Pages 58-63 of the Puerto Rico 2022 *Associate Benefits Book*)

Page 60—Naming a beneficiary

Effective January 1, 2023, add the following sentence to the end of the first paragraph:

No paper forms are accepted.

Page 61—When benefits are not paid

Effective January 1, 2023, add an additional paragraph to the existing text as follows:

No benefits are paid if you die before your coverage effective date.

Page 62—If you leave the company and are rehired

Effective January 1, 2023, replace the text in this section with the following:

If you are a full-time hourly or management associate, see the **If you leave the company and are rehired** section in the **Eligibility and enrollment** chapter for details regarding the impact to your benefits of terminating employment with the company and then returning to work.

OPTIONAL ASSOCIATE LIFE INSURANCE (Pages 64-69 of the Puerto Rico 2022 *Associate Benefits Book*)

Page 66—Naming a beneficiary

Effective January 1, 2023, add the following sentence to the end of the first paragraph:

No paper forms are accepted.

Page 68—When benefits are not paid

Effective January 1, 2023, add an additional paragraph to the existing text as follows:

No benefits are paid if you die before your coverage effective date.

Page 68—When coverage ends

Effective January 1, 2023, delete the last bullet point and add the following:

If you voluntarily drop coverage after an election change event (status 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 **Status change events** in the **Eligibility and enrollment** chapter for information.
- **At Annual Enrollment**: coverage ends on December 31 of the current year.

Page 69—If you drop coverage and reenroll

Effective January 1, 2023, delete this section.

OPTIONAL DEPENDENT LIFE INSURANCE (Pages 70-75 of the Puerto Rico 2022 *Associate Benefits Book*)

Page 72—Optional dependent life insurance

Effective January 1, 2023, replace the paragraph prior to the “Proof of Good Health” subhead with the following:

Your dependent is not eligible for coverage while on active duty in the armed forces of any country.

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

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

Page 73—When benefits are not paid

Effective January 1, 2023, add an additional paragraph to the existing text as follows:

No benefits are paid if you die before your coverage effective date.

Page 74—When coverage ends

Effective January 1, 2023, delete the last bullet point and add the following:

If you voluntarily drop coverage after an election change event (status 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 **Status change events** in the **Eligibility and enrollment** chapter for information.
- **At Annual Enrollment**: coverage ends on December 31 of the current year.

Effective January 1, 2024, delete the fourth bullet point and replace it with the following:

- On the date that you or a dependent spouse/partner or child loses eligibility (see the **Eligibility and enrollment** chapter). However, if your spouse/partner becomes ineligible because your job status changes to part-time hourly associate, or temporary associate, coverage for your spouse/partner will end on the first day of the pay period in which your job status changes

Page 75—If you drop or decrease your coverage and reenroll

Effective January 1, 2023, delete this section.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE (Pages 76-83 of the Puerto Rico 2022 *Associate Benefits Book*)

Page 78—Naming a beneficiary

Effective January 1, 2023, replace the first paragraph with the following:

To ensure that your AD&D benefit is paid according to your wishes, you must name a beneficiary(ies). You may do this by going to **One.Walmart.com**. Note that only beneficiary designations made online are accepted. Paper forms are not accepted.

You (the associate) will receive any benefits payable for your covered dependents.

Page 80—Additional AD&D benefits

Effective January 1, 2023, replace the third and fourth bullet points, addressing spouse/partner education benefit and child education and care benefit, with the following:

- 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.

Page 82-83—When coverage ends

Effective January 1, 2024, replace the paragraph at the top of page 83 that begins “In addition...” with the following:

In addition, if you have chosen associate + dependent(s) coverage and your job status changes to part-time hourly associate or temporary associate, your coverage for your spouse/partner will end on the first day of the pay period in which your job status changes.

Page 83—If you drop or decrease your coverage and reenroll

Effective January 1, 2023, delete this section.

BUSINESS TRAVEL ACCIDENT INSURANCE (Pages 84-89 of the Puerto Rico 2022 *Associate Benefits Book*)

Page 86—Changing your beneficiary

Effective January 1, 2023, replace the paragraph with the following:

You can change your beneficiary(ies) at any time on **One.Walmart.com**. No paper forms are accepted.

SHORT-TERM DISABILITY (Pages 91-94 of the Puerto Rico 2022 *Associate Benefits Book*)

Effective February 1, 2024, “paid time off (PTO)” is added to all references to “vacation,” “sick time,” and similar.

LONG-TERM DISABILITY (Pages 96-103 of the Puerto Rico 2022 *Associate Benefits Book*)

Effective February 1, 2024, “paid time off (PTO)” is added to all references to “vacation,” “sick time,” and similar.

Page 98—The LTD plans

Effective January 1, 2024, the following text replaces the text on page 98 in its entirety:

The LTD plans

If you become disabled, as defined in the **When you qualify for LTD benefits** section, the LTD plan provides a benefit of 50% of your average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive, after your benefit waiting period.

If you become disabled, as defined in the **When you qualify for LTD benefits** section, the LTD enhanced plan provides a benefit of 60% of your average monthly wage up to a maximum monthly benefit of $18,000, minus the amount of certain other benefits or income you are eligible to receive, after your benefit waiting period.

Both plans are insured by Lincoln. For information about your benefit waiting period, see **When LTD benefits begin** later in this chapter. For information about your average monthly wage or other income or benefits that may reduce your benefit, see **Calculating your benefit** and **Other benefits or income that reduce LTD benefits** later in this chapter.

THE COST OF LTD COVERAGE

Your cost for LTD coverage is based on your biweekly eligible earnings 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.

When you qualify for LTD 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.

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)
- Vacation, sick time, or 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 before October 14, 2023, and coverage was 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.

Note that the above changes on page 98 ***replace*** *the following changes made effective January 1, 2023:*

Page 98—The LTD plans

Effective January 1, 2023, delete the paragraph at the top of the second column, beginning “To receive benefits under the LTD plan...”.

Page 98—When you qualify for LTD benefits

Effective January 1, 2023, add the following text after the last bullet point under “To qualify for LTD benefits”:

- You must be actively at work at the time of your disability. You will be considered actively at work if you are performing services at the company’s usual place of business or a location designated by the company or if you were actually at work on the day immediately preceding:
  - A weekend or holiday (except where one or both of these days are scheduled work days)
  - Vacation or sick time
  - Any non-scheduled work day, or
  - An approved leave of absence.

  If your LTD coverage was subject to Proof of Good Health and approved by Lincoln, Lincoln has the right to reexamine your Proof of Good Health questionnaire within the first two years from the date LTD coverage became effective. If material facts about you are found to have been stated inaccurately, the true circumstances will be used to determine if your coverage should be in effect and for what amount, and your premium may be adjusted.

Page 99-100—Calculating your benefit

Effective January 1, 2023, replace the opening text on p. 100 from “Average monthly wage...” through the sentence beginning “Commissions or any other extra compensation...” with the following:

Earnings used to determine average monthly wage include:

- Regular earnings for the 26 pay periods prior to your last day worked
- Overtime
- Regularly scheduled target incentive bonuses that you and associates in similarly situated job types or job levels are eligible to earn
- Vacation or sick pay and similar that replaces regular earnings (e.g., bereavement, jury duty, and sick time) Any pay periods in

which you have no earnings are excluded, decreasing the number of pay periods used for the calculation.

Earnings used to determine average monthly wage exclude commissions or any other extra compensation or fringe benefits not listed above.

Page 100—Calculating your benefit

Effective January 1, 2023, add the following text above the “Taxes and your LTD benefit” subhead:

VACATION OR SICK TIME AND YOUR LTD BENEFIT

Vacation or sick time may not be used while receiving LTD benefits. You do not accrue additional vacation or sick hours while receiving LTD benefits.

Page 100—Calculating your benefit

Effective January 1, 2024, delete the “Taxes and your LTD benefit” subhead and the paragraph that follows it.

Page 101—Calculating your benefit

Effective January 1, 2023, add the following text after the first paragraph of “Applying for Social Security Disability Benefits”:

If you are required to pursue Social Security disability benefits and you do not apply, or you do not provide proof of application or appeal, your LTD benefits will be reduced by the amount you are estimated to receive from Social Security disability.

Page 101—If you are disabled and working

Effective January 1, 2023, replace all references to “pre-disability earnings” and “pre-disability monthly earnings” with “average monthly wage.”

Effective January 1, 2023, replace the two paragraphs following the list of bullet points with the following:

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.

Page 102—Coverage during a leave of absence or temporary layoff

Effective January 1, 2024, replace this subhead and the paragraph that follows it with the following:

If you go on a leave of absence or experience a temporary layoff

Once your LTD coverage is effective, if you are not actively at work due to a leave of absence or temporary layoff, your LTD coverage continues for 90 days from the beginning of your leave or temporary layoff. Your LTD 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 **Continuing benefit coverage if you go on a leave of absence** in the **Eligibility and enrollment** chapter for more information, including details on paying for benefits while on leave.

Page 103—When coverage ends

Effective January 1, 2024, delete this entire section and replace it with the following:

When your long-term disability coverage ends

Your long-term disability coverage ends:

- The day following 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 when your job status changes from an eligible job status
- The last day of coverage for which premiums were paid, if you fail to pay your premiums within 30 days of the date your premium is due
- On the date you lose eligibility
- If you do not return to work after the last day of a leave of absence
- When the benefit is no longer offered by Walmart, or
- On the date of your death.

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

- **After an election change event:** coverage ends the day you voluntarily drop your coverage. 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.

Page 103—If you lose and then regain eligibility or drop coverage and reenroll

Delete this section.

CLAIMS AND APPEALS (Pages 104-119 of the Puerto Rico 2022 *Associate Benefits Book*)

Page 113—Right to reduction, reimbursement, and subrogation

Insert the following text before the first paragraph in this section.

> **NOTE:** This section applies to self-funded benefits under the Plan. It does not apply to insured benefits. 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.

Page 117—Claims and appeals process for disability coverage claims

Effective January 1, 2024, the title of this section is changed to “Claims and appeals process for short-term disability coverage claims.” All references to “disability” in this section are replaced with references to “short-term disability.”

Page 118—Appealing a disability claim that has been fully or partially denied

Effective January 1, 2024, this subhead is changed to read “Appealing a short-term disability claim that has been fully or partially denied,” as stated above. References in this section stating that appeals must be sent to “Multinational (or Lincoln, as applicable)” are changed to refer only to Multinational. The text at the end of this section, beginning “Long-term disability appeals should be sent to...” is deleted.

Effective January 1, 2023, the following text was added to the end of this section:

If you elected 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. Submit your appeal via email to **EOIQuestions@lfg.com** or by U.S. mail to:

Lincoln Financial Group
ATTN: Medical Underwriting
P.O. Box 2870
Omaha, NE 68103-2870

Effective January 1, 2024, however, that newly added text beginning “If you elected long-term disability” is deleted and the following new block of text is added:

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, 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.

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 or oral 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.

Page 118—Resources for Living benefits

Effective January 1, 2024, this section is replaced in its entirety with the following:

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.

LEGAL INFORMATION (Pages 121-132 of the Puerto Rico 2022 *Associate Benefits Book*)

Pages 121, 122: Mailing address for Plan Administrator

Replace the mailing address for the Plan Administrator in its appearances on these pages with the following:

Mail Stop 3610–Plan Administrator
Senior Vice President, U.S. Benefits
Associates' Health and Welfare Plan
508 SW 8th Street
Mail Stop #3610
Bentonville, Arkansas 71716-3610

Pages 124, 127: References to Resources for Living (RFL)

Replace the references to Resources for Living (RFL) on these pages with My Mental Health Resources.

PUERTO RICO SUMMARY OF MATERIAL MODIFICATIONS TO THE WALMART PUERTO RICO 401(k) PLAN
February 1, 2024

This Summary notifies you of some recent changes to the Walmart Puerto Rico 401(k) Plan (Plan) and how those changes may affect your Plan participation. These changes are discussed in more detail below. **You should keep this Summary with the 401(k) Plan section of the 2022 Puerto Rico *Associate Benefits Book* and read the documents together**.

WALMART PUERTO RICO 401(k) PLAN (Pages 146-165)

Page 154-155—Financial hardship withdrawals

Effective February 1, 2023, the following section was added on page 155 at the end of the **Financial hardship withdrawals** section:

DISASTER DECLARED SPECIAL DISTRIBUTIONS

Effective October 6, 2022, Disaster Declared Special Distributions are available due to Hurricane Fiona. During the period starting on October 6, 2022 and ending on December 31, 2022, or such earlier date established by the Company or the Trustee, a Participant or Beneficiary may request a distribution from his or her Account under the Plan to cover Eligible Expenses as a result of the Disaster Declared

by the Governor of Puerto Rico due to the passage of hurricane Fiona, subject to compliance with the conditions and requirements of the law.

Effective February 1, 2024, this text is deleted again.

Page 156-157—If you leave Walmart Puerto Rico

Effective February 1, 2023, the second bullet point on page 157 was replaced with:

- **If you are over age 71½, regardless of the amount of your total vested Plan balance.** This automatic payout will be made as soon as possible after the last business day of the second calendar month following the calendar month in which you turn age 71½, unless you consent to an earlier payout as described on the previous page. If you turn age 71½ in July 2023 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, 2023, according to Plan provisions.

Effective February 1, 2024, however, that newly added bullet point beginning "If you are over age 71½" is replaced with the following:

- **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 on the previous page. 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.

Effective February 1, 2023, the first sentence of the paragraph on page 157 beginning "If your total vested Plan balance is more than $1,000..." was replaced with:

If your total vested Plan balance is more than $1,000, and you are under age 71½, you must consent to your payout.

Effective February 1, 2024, however, that newly added sentence beginning "If your total vested Plan balance..." is replaced with the following:

If your total vested Plan balance is more than $1,000, and you are under age 72½, you must consent to your payout.

Effective February 1, 2023, the first sentence of the paragraph on page 157 beginning "If you wish, you can choose to delay..." was replaced with:

If you wish, you can choose to delay your payout until any date up to age 70½, but your Plan balance will be subject to an annual maintenance fee and possibly other expenses.

Effective February 1, 2024, however, that newly added sentence beginning "If you wish, you can choose to delay..." is replaced with:

If you wish, you can choose to delay 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.

Page 157-158—How you receive your payout

Effective February 1, 2023, the first sentence of the paragraph on page 158 beginning "If the total of your vested accounts is $1,000 or less…" was replaced with:

If the total of your vested accounts is $1,000 or less, or if you are over age 71½ (regardless of the amount of your vested accounts), your payout will be made directly to you in a single cash payout.

Effective February 1, 2024, however, that newly added sentence beginning "If the total of your vested accounts..." is replaced with the following:

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.

Effective February 1, 2023, the first sentence of the paragraph on page 158 beginning "If the total of your vested accounts in the Plan is more than $1,000…" was replaced with:

If the total of your vested accounts in the Plan is more than $1,000, your payout will not be made until you make an election regarding the form of payout and consent to the distribution, or until you reach age 71½.

Effective February 1, 2024, however, that newly added sentence beginning "If the total of your vested accounts in the Plan..." is replaced with:

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.

Please attach this Summary of Material Modifications ("SMM") to your Puerto Rico 2022 *Associate Benefits Book* and retain it for future reference. Among other items, the Puerto Rico *2022 Associate Benefits Book* contains important information about the Plan's rules concerning eligibility and benefits. The amendments described above do not supersede any of the provisions of the Plan not expressly addressed herein, and Walmart reserves the right to amend or terminate the Plan at any time and to any extent.

If you have any questions about this SMM, or if you need another copy of the Puerto Rico 2022 *Associate Benefits Book*, please contact People Services, 508 SW 8th Street, Mail Stop 3500, Bentonville, Arkansas 72716-3500, or by phone at 800-421-1362.

ERISA Information
Plan Sponsor: Walmart Inc. Plan Sponsor EIN: 71-0415188 Plan Name: The Associates' Health and Welfare Plan Plan Number: 501

LEGAL NOTICES FOR THE ASSOCIATES' HEALTH AND WELFARE PLAN

- HIPAA Notice of Privacy Practices
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- Medicare and Your Prescription Drug Coverage
- Nondiscrimination Notice: Valued Plan Participant
- Women's Health and Cancer Rights Act

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–Plan Administrator
Senior Vice President, U.S. Benefits
Associates' Health and Welfare Plan
508 SW 8th Street
Mail Stop #3610
Bentonville, Arkansas 72716-3610

Email your questions to: **AHWPrivacy@walmart.com**
Telephone: **800-421-1362**

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from Walmart Inc., your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial **877-KIDS NOW** or visit **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for the Plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Walmart Inc. Plan, the Plan must allow you and your dependents to enroll in the Plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **866-444-EBSA** (**3272**).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. 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
Healthy Indiana Plan for low-income adults 19-64
Website: **http://www.in.gov/fssa/hip**
Phone: **877-438-4479**
All other Medicaid
Website: **https://www.in.gov/medicaid**
Phone: **800-457-4584**

IOWA MEDICAID AND CHIP (Hawki)
Medicaid website: **https://dhs.iowa.gov/ime/members**
Medicaid phone: **800-338-8366**
Hawki website: **http://dhs.iowa.gov/Hawki**
Hawki phone: **800-257-8563**
HIPP website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP phone: **888-346-9562**

KANSAS – Medicaid
Website: **http://www.kancare.ks.gov**
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://kidshealth.ky.gov/Pages/index.aspx**
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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**
Phone: **800-657-3739**

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

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

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

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

NEW HAMPSHIRE – Medicaid
Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: **603-271-5218**
Toll-free for HIPP program: **800-852-3345**, ext **5218**

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

NEW YORK – Medicaid
Website: **https://www.health.ny.gov/health_care/medicaid**
Phone: **800-541-2831**

NORTH CAROLINA – Medicaid
Website: **https://medicaid.ncdhhs.gov**
Phone: **919-855-4100**

NORTH DAKOTA – Medicaid
Website: **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
Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx**
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
Health Insurance Premium Payment (HIPP) Program / Texas Health and Human Services website:
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: **800-440-0493**

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

VERMONT – Medicaid
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, 2023, 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**

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 and enrollment** 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).

The Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires that all group medical plans that provide medical and surgical benefits with respect to mastectomy must provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage will be subject to the otherwise applicable annual deductibles and coinsurance/copayment provisions under the Plan. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. For additional information, please call **866-940-7444.**

Valued Plan Participant

The Associates' Health and Welfare Plan (AHWP) Respects the Dignity of Each Individual Who Participates in the Plan.

The AHWP does not discriminate on the basis of race, color, national origin, sex, age, or disability and strictly prohibits retaliation against any person making a complaint of discrimination. Additionally, we gladly provide our participants with language assistance, auxiliary aids and services at no cost. We value you as our participant and your satisfaction is important to us.

If you need such assistance or have concerns with your Plan services, please call the number on the back of your plan ID card. If you have any questions or concerns, please use one of the methods below so that we can better serve you.

For assistance, call the number on the back of your plan ID card.

To learn about or use our grievance process, contact People Services at 1-800-421-1362.

To file a complaint of discrimination, contact the U.S. Department of Health and Human Services, Office of Civil Rights:

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

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

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

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

汉语普通话
翻译服务免费提供。1-800-421-1362.

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

Français

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

kreyòl ayisye

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

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

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

Polski

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

Português (Brasil)

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

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

Română

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

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

Af-Soomaali

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

Español

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

Kiswahili

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

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