



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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network</u> : \$1,750 individual/\$3,500 family; <u>Out-of-Network</u> : \$3,500 individual/ \$7,000 family. <u>Premiums</u> , charges for <u>balance billing</u> , healthcare this <u>plan</u> does not cover, <u>out-of-network</u> Walmart Health, <u>copayments</u> , pharmacy <u>coinsurance</u> (including 3rd party assistance), <u>out-of-network</u> preventive care, and <u>coinsurance</u> for COE hip/knee replacement without exception don't count toward the <u>deductible</u> .	Generally, you must pay all costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. The employer allocation to the HRA is \$250/individual or \$500/family per year. If you have HRA funds from a prior year that roll over, the rollover combined with the new year allocation cannot exceed the <u>network deductible</u> ; your rollover will be reduced by the amount exceeding the <u>network deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Deductible</u> is waived for eligible <u>preventive care</u> , Doctor On Demand, eligible <u>prescription drugs</u> , and COE programs (except weight loss surgery and family building).	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this <u>plan</u>?	<u>Network</u> : \$6,850 individual/\$13,700 family; <u>Out-of-Network</u> : Unlimited.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they must meet their own <u>out-of-pocket limit</u> until the overall family <u>out-of-pocket limit</u> has been met.

* For more detail about limitations and exceptions, see Summary Plan Description (SPD) at www.One.Walmart.com/Benefits.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	<u>Premiums</u> ; <u>balance-billing charges</u> ; health care this <u>plan</u> doesn't cover; penalties for failure to obtain <u>preauthorization</u> ; <u>out-of-network coinsurance</u> ; <u>out-of-network preventive care</u> ; hip/knee replacement <u>coinsurance</u> outside COE without exception, when an alternate <u>network provider</u> or Blue Select <u>Network provider</u> is not used; <u>out-of-network Walmart Health</u> ; and 3 rd party <u>prescription drug</u> assistance.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.IncludedHealth.com/Walmart or call 1-800-941-1384 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay the least if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You pay the least)	<u>Out-of-Network Provider</u> (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Lower <u>copayments</u> , may apply to <u>network Walmart Health</u> . \$0 <u>copayment</u> /Doctor On Demand visits. Fertility benefits covered only when under the COE; limited to a \$20,000 max lifetime benefit. If BlueAdvantage is TPA, using <u>network provider</u> in area with Blue Select <u>Network</u> may lower benefit. *See "Walmart Health", "Centers of Excellence", and " <u>Provider networks</u> " section in SPD. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if services needed are preventive. Then check what your <u>plan</u> will pay for.
	<u>Specialist</u> visit	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge, <u>deductible</u> doesn't apply	50% <u>coinsurance</u> , <u>deductible</u> doesn't apply	

* For more detail about limitations and exceptions, see Summary Plan Description (SPD) at www.One.Walmart.com/Benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	No charge for routine in-office <u>diagnostic tests</u> on same day as <u>network provider</u> visit.
	Imaging (CT/PET scans, MRIs)	CT/MRIs: 25% <u>coinsurance</u> for alternate <u>network provider</u> ; 50% <u>coinsurance</u> for other <u>network providers</u> ; PET scans: 25% <u>coinsurance</u>	50% <u>coinsurance</u>	PET scans are reimbursed as a <u>diagnostic test</u> . For CT/MRIs: If no alternate <u>network provider</u> available, <u>network services</u> paid as alternate <u>network provider</u> benefit. If services provided by a <u>provider</u> when alternate <u>network provider</u> is available, <u>coinsurance</u> will not apply to <u>out-of-pocket limit</u> . *See “Provider <u>networks</u> ” section in SPD. <u>Preauthorization</u> may be required. *See “ <u>Preauthorization</u> ” section in SPD.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.OptumRx.com/Walmart	Generic drugs	\$4 <u>copayment</u> (1-30 days); \$8 <u>copayment</u> (31-60 days); \$12 <u>copayment</u> (61-90 days)	Not covered	Must use Walmart/Sam’s Club pharmacy/Walmart Home Delivery Pharmacy for “maintenance drugs” and Walmart Specialty Pharmacy for <u>specialty drugs</u> . Eligible fertility drugs covered only through COE program for family building. High-cost generic drugs not covered when therapeutically equivalent, lower-cost generic drugs are available. Preferred brand drugs in excess of 30-day supply must be purchased through Walmart Home Delivery Pharmacy. Prices shown for preferred brand and <u>specialty drugs</u> are for up to a 30-day supply.
	Preferred brand drugs	Greater of \$50 or 25% <u>coinsurance</u> , <u>deductible</u> doesn’t apply	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	<u>Specialty drugs</u>	Greater of \$50 or 20% <u>coinsurance</u> , <u>deductible</u> doesn’t apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Fertility benefits covered only when under the COE; limited to a \$20,000 max lifetime benefit. COE services may be paid at 0% <u>coinsurance</u> , if COE facility is used. See limitations for COE, including for spine surgeries, heart surgery and valve repair/replacement, cancer treatment, ESRD services and hip/knee replacement. Some COE services available before <u>deductible</u> . <u>Preauthorization</u> may be required. *See “ <u>Preauthorization</u> ” and “Centers of Excellence” sections of SPD.
	Physician/surgeon fees	25% <u>coinsurance</u>	50% <u>coinsurance</u>	

* For more detail about limitations and exceptions, see Summary Plan Description (SPD) at www.One.Walmart.com/Benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$300 <u>copayment</u> , in addition to any remaining <u>deductible</u> . <u>Copayment</u> still applies after <u>deductible</u> is met	<u>Emergency services</u> : \$300 <u>copayment</u> and remaining <u>deductible</u> ; <u>Non-emergency services</u> : \$300 <u>copayment</u> , and remaining <u>deductible</u> , 50% <u>coinsurance</u>	If you are admitted to the hospital directly from the emergency room or pass away prior to admission, the <u>copayment</u> is waived.
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	<u>Emergency services</u> : 25% <u>coinsurance</u> ; <u>Non-emergency services</u> : Not covered	Coverage limited to nearest hospital/treatment facility capable of providing care, only if transportation is <u>medically necessary</u> . Non-emergency transport is not covered, except if pre-authorized.
	<u>Urgent care</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	COE services may be paid at 0% <u>coinsurance</u> , if COE facility is used. See limitations for COE, including for spine surgeries, transplants, heart surgery and valve repair/replacement, cancer treatment, ESRD services and hip/knee replacement. Some COE services available before <u>deductible</u> . <u>Preauthorization</u> may be required. *See " <u>Preauthorization</u> " and "Centers of Excellence" sections of SPD.
	Physician/surgeon fees	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	\$0 <u>copayment</u> /Doctor On Demand visits. <u>Deductible</u> doesn't apply. <u>Preauthorization</u> may be required. *See " <u>Preauthorization</u> " section in SPD
	Inpatient services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	

* For more detail about limitations and exceptions, see Summary Plan Description (SPD) at www.One.Walmart.com/Benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	
If you are pregnant	Office visits	Preventive Care: No charge, deductible doesn't apply. All other services: 25% coinsurance	50% coinsurance, deductible does not apply to preventive care	Cost sharing does not apply for preventive services. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.) *See "Preventive services" and "Preauthorization" sections in SPD. Depending on the services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Home health care limited to 100 visits per calendar year. Rehabilitation services: Physical/occupational therapy - 20 visits/year, Speech therapy - 60 visits/year (except mental health conditions) Certain other inpatient rehabilitation services - 120 days/condition. Preauthorization may be required. Skilled nursing facilities limited to 60 days per /disability period. Orthopedic shoes when prescribed by physician - limited to two shoes per calendar year. Hospice services - limited to 365 days/illness.
	Rehabilitation services	25% coinsurance	50% coinsurance	
	Habilitation services	25% coinsurance	50% coinsurance	
	Skilled nursing care	25% coinsurance	50% coinsurance	
	Durable medical equipment	25% coinsurance	50% coinsurance	
	Hospice services	25% coinsurance	50% coinsurance	
If your child needs dental or eye care	Children's eye exam	No charge, deductible doesn't apply	50% coinsurance, deductible doesn't apply	Children's eye exams limited to screening that qualifies as preventive services. Children's dental check-ups not covered under medical benefits. May be additional other coverage under a separate dental plan. *See "Preauthorization" section and "When limited benefits apply to the AMP" sections in SPD.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

* For more detail about limitations and exceptions, see Summary Plan Description (SPD) at www.One.Walmart.com/Benefits.

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|---|--|--|
| <ul style="list-style-type: none"> • Acupuncture • Chiropractic care • Dental care (Adult) | <ul style="list-style-type: none"> • Glasses • Non-preferred brand drugs | <ul style="list-style-type: none"> • Routine eye care (Adult) • Weight loss programs |
|---|--|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|---|---|---|
| <ul style="list-style-type: none"> • Bariatric surgery (gastric bypass, gastric sleeve and duodenal switch surgery only) • Cosmetic Surgery (limited to conditions that are considered reconstructive) • Hearing aids (limited to external hearing aids) • Infertility treatment (limited to the diagnosis & treatment of underlying medical condition) | <ul style="list-style-type: none"> • Long-term care - 60 days/disability period • Non-Emergency Care when traveling Outside the U.S. (as provided by international business medical insurance policy) • Private-duty nursing (limited to 100 visits per calendar, billed through a home health agency, and must be provided by a licensed or registered nurse) | <ul style="list-style-type: none"> • Routine eye care (limited to services and limitations that are identified under the "<u>Preventive Care</u>" section of the SPD) • Routine foot care (nonsurgical foot care limited to 3 visits per calendar year) |
|---|---|---|

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

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

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

* For more detail about limitations and exceptions, see Summary Plan Description (SPD) at www.One.Walmart.com/Benefits.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-421-1362.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-421-1362.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-421-1362.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-421-1362.

About these Coverage Examples:

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more detail about limitations and exceptions, see Summary Plan Description (SPD) at www.One.Walmart.com/Benefits.



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

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

- The plan's overall deductible \$1,750
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,750
Copayments	\$10
Coinsurance	\$2,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,520

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

- The plan's overall deductible \$1,750
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,750
Copayments	\$100
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,670

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

- The plan's overall deductible \$1,750
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,750
Copayments	\$300
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,250

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

* For more detail about limitations and exceptions, see Summary Plan Description (SPD) at www.One.Walmart.com/Benefits.

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.

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 ayisyen
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.

Availability of Summary of Health Information

As an associate, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare options. The SBC is available on One.Walmart.com/Health. A paper copy is also available, free of charge, by calling [800-421-1362](tel:1-800-421-1362).

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](tel: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](tel:1-800-368-1019) or [1-800-537-7697](tel: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](tel:1-800-421-1362).

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

ਪੰਜਾਬੀ
ਦੇਤਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਮੁਫਤ 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.

Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, Walmart-provided medical plans provide coverage for:

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

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.