



2018 Associate Benefits Book

Summary Plan Description with 2019
Summary of Material Modifications

What's inside

Medical plan

Pharmacy benefit

Dental plan

Vision plan

Life insurance and disability

Walmart 401(k) Plan

Resources for Living®

2019 Summary of Material Modifications

Effective **January 1, 2018**



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Information obtained during calls to Wal-Mart Stores, Inc. or to any Plan service provider does not waive any provision or limitation of the Plan. Information given or statements made on a call or in an email do not guarantee payment of benefits. In addition, benefits quotes that are given by phone are based wholly on the information supplied at the time. If additional relevant information is discovered, it may affect payment of your claim. All benefits are subject to eligibility, payment of premiums, limitations and all exclusions outlined in the applicable Plan documents, including any insurance policies. You can request a copy of the documents governing these plans by writing to: Custodian of Records, People Services, 508 SW 8th Street, Bentonville, Arkansas 72716-3500.

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

Welcome to your 2018 Associate Benefits Book

This is where you'll find Summary Plan Descriptions (SPDs) for the Associates' Health and Welfare Plan (aka the Plan) and the Walmart 401(k) Plan. It's a great resource to help you understand your benefits, so take a little bit of time and get to know them.



This is also where you will find the **2019 Summary of Material Modifications**, which brings the 2018 *Associate Benefits Book* up to date for another year. You'll find the "SMM" on p. 284. Throughout this book you'll also see many spots where we have alerted you to details that have been updated in the SMM—look for the page icon like the one to the left. When you see that, you'll know where to go to find the most current information.



Lots of information.
So easy to find.

When you download the 2018 *Associate Benefits Book* PDF from the **WIRE** or **WalmartOne.com**, getting answers to your benefits questions is easy and fast.

To find what you need, just launch the PDF with Adobe Reader and click "edit" on the top toolbar. Then click "search." From there, just type in what you're looking for. Want to know about coverage for preventive care? Type in "preventive" and click "search." You'll get instant results!

Eligibility and enrollment

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If you have Medicare or will become eligible for Medicare in the next 12 months, you have more choices for your prescription drug coverage. See page 271 in the [Legal information](#) chapter for more details.

Eligibility and enrollment

ELIGIBILITY AND ENROLLMENT RESOURCES


Find What You Need	Online	Other Resources
Enroll in Walmart benefits	Go to the WIRE , WalmartOne.com or Workday	Call People Services at 800-421-1362
Notify People Services within 60 days of a status change event, such as a dependent losing eligibility under the Plan	Go to the WIRE , WalmartOne.com or Workday	Call People Services at 800-421-1362
Notify People Services if you have questions about the payroll deductions for your benefits		Call People Services at 800-421-1362
Reinstate coverage upon your return from a military leave		Call People Services at 800-421-1362
Pay premiums for benefits while on a leave of absence		<p>If you have an approved short-term disability claim through Sedgwick, your premiums will be deducted out of your disability benefit check through payroll. Otherwise, send a check or money order payable to the Associates' Health and Welfare Trust to:</p> <p>Walmart People Services P.O. Box 1039 Department 3001 Lowell, Arkansas 72745</p> <p>Please be sure to include your name, insurance ID number (found on your plan ID card) or your WIN (Walmart ID) number (if you have HMO coverage) and your facility number on your payment to ensure timely posting of your payment.</p> <p>You may also pay by debit or credit card with a Visa, MasterCard or Discover card by calling 800-421-1362 and saying "make a payment."</p>

What you need to know about eligibility and enrollment

- You can enroll for benefits during your initial enrollment period as a newly eligible associate, during annual enrollment and when you have a status change event.
- When your initial enrollment period begins depends on your job classification. Changes to your job classification may affect your initial enrollment period. Eligibility and benefits information specific to associates in Hawaii is explained in the [Eligibility and benefits for associates in Hawaii](#) chapter.
- If you enroll in certain benefits (such as life insurance) after your initial enrollment period, your benefits may be affected.
- Medical, dental, vision, critical illness, accident, and accidental death and dismemberment (AD&D) insurance coverage cannot be changed except during annual enrollment, unless you have a status change event.
- If you choose to enroll in short-term disability enhanced plan coverage or long-term disability coverage options, you may drop your coverage at any time, but you will only be able to add this coverage during your initial enrollment period, annual enrollment or with a status change event.
- If you have an approved short-term disability claim, your premiums for medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness and accident coverage may be deducted out of your benefit checks, which will be issued through the Walmart payroll system.

The Associates' Health and Welfare Plan

The Associates' Health and Welfare Plan (the Plan) is a single, comprehensive employee benefit plan that offers medical, dental, vision, critical illness insurance, accident insurance, AD&D, business travel accident insurance, life insurance, disability and Resources for Living (employee assistance and wellness) coverage to eligible associates and their eligible dependents. The eligibility for these benefits is described in this chapter, and the terms and conditions for these benefits are described in the applicable chapters of this 2018 *Associate Benefits Book*. The Plan is sponsored by Walmart Inc.

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You are automatically enrolled for certain benefits under the Plan on your date of hire or a later date. For other benefits, however, you must enroll for coverage to take effect. Refer to the [Enrollment and effective dates by job classification](#) section in this chapter for details about initial enrollment periods and when coverage is effective, for all benefits available under the Plan.

Associate eligibility

The benefits you are eligible for depend on a number of factors, which may include your hire date, average weekly hours and your job classification in the company's (Wal-Mart Stores, Inc.) payroll system. In addition, for most benefits, you may be required to meet the applicable waiting period. See the [Enrollment and effective dates by job classification](#) section in this chapter for a list of the benefits you are eligible for and for your benefits eligibility waiting period based on your job classification.

Our expectation is that you will apply for or enroll in benefits using correct and accurate information. If not, you may be subject to the loss of benefits and/or loss of employment. To review Walmart's policy about intentional dishonesty, please refer to the Statement of Ethics, which can be found on the [WIRE](#).

MANAGEMENT ASSOCIATE ELIGIBILITY

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

FULL-TIME HOURLY ASSOCIATE ELIGIBILITY

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

MANAGEMENT AND FULL-TIME HOURLY ASSOCIATES: IF YOU HAVE A BREAK IN SERVICE

If your employment ends and you return to employment within less than 31 days, you will be automatically re-enrolled in your previous coverage (or the most similar coverage offered under the Plan).

If your employment ends and you return to employment after 30 days and before 13 weeks, you will be automatically re-enrolled in the same coverage you had before you left, but your annual deductibles and out-of-pocket maximum will reset and you will be responsible for meeting the new deductibles and out-of-pocket maximum in their entirety. You will have 60 days to drop or otherwise change the medical, dental, vision, AD&D, critical illness and accident coverage in which you were automatically re-enrolled.


If your employment ends and you return to employment after 13 or more weeks, you will be treated as if you were a new associate.

PART-TIME HOURLY ASSOCIATE ELIGIBILITY

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

To be eligible to receive medical benefits, you must work an average of at least 30 hours per week, with the following exceptions:

- Part-time hourly pharmacists hired on or after February 1, 2012, must work an average of at least 24 hours per week.
- Part-time hourly pharmacists hired prior to February 1, 2012, do not need to work a minimum number of hours per week.
- Part-time field Logistics must work an average of at least 24 hours per week.
- As of Aug. 1, 2018, part-time nurse practitioners must work an average of at least 24 hours per week.
- Part-time truck drivers do not need to work a minimum number of hours per week.

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Part-time associates are subject to the annual eligibility check process described later in this chapter, with the exception of part-time hourly pharmacists hired prior to February 1, 2012, and part-time truck drivers. The annual eligibility check determines your eligibility for medical benefits based on the number of hours you worked on average in the 52-week period preceding the date of the annual eligibility check. For more information, see the section titled [Part-time hourly and temporary associates: eligibility checks for medical coverage](#).

TEMPORARY ASSOCIATE ELIGIBILITY

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

To be eligible to receive medical benefits, you must work an average of at least 30 hours per week. Temporary pharmacists hired on or after February 1, 2012, and temporary field Logistics must work an average of at least 24 hours per week.

Temporary associates are subject to the annual eligibility check process described later in this chapter. The annual eligibility check determines your eligibility for medical benefits based on the number of hours you worked on average in the 52-week period preceding the date of the annual benefits eligibility check. For more information, see the section titled **Part-time hourly and temporary associates: eligibility checks for medical coverage**.

HAWAII ASSOCIATES

Special rules govern eligibility and enrollment in the state of Hawaii. If you are a full-time hourly, part-time hourly or temporary associate in Hawaii, please refer to the **Eligibility and benefits for associates in Hawaii** chapter of this Summary Plan Description for information regarding eligibility for benefits. For management associates in Hawaii, the eligibility and enrollment terms described in this **Eligibility and enrollment** chapter apply.

HOURLY ASSOCIATES WITH SALARIED STATUS

Regardless of hire date, hourly associates or associates in some positions may qualify for the same benefits-eligibility waiting period as management associates if:

- The job description of the hourly associate is substantially the same as a management associate of Walmart or a participating subsidiary, and
- State law mandates that the position be classified as hourly.

INELIGIBLE ASSOCIATES

Ineligible associates (those associates who are not otherwise eligible for other Plan benefits) may still receive Resources for Living and business travel accident insurance benefits.

ELIGIBILITY RULES FOR CERTAIN INSURED BENEFITS

HMO and eComm PPO Plans are available for some facilities. The policies for the HMO and eComm PPO Plans may have different eligibility requirements and waiting periods than those described in this chapter. If you enroll for coverage under an HMO or a PPO, the enrollment materials and certificate of plan coverage you receive may describe the eligibility terms of the HMO or PPO. Please note that if there is any difference between the HMO's or PPO's eligibility terms and the eligibility terms of the Associates' Medical Plan, as described in this chapter, the Plan will apply its own eligibility requirements.

In addition, some HMOs require participants to accept an arbitration agreement, where permitted by law, before

benefits under the HMO can become effective. Your agreement must be received by the HMO within 60 days of your initial enrollment or your HMO benefits will not take effect.

LOCALIZED ASSOCIATES

Associates who have been approved by the company as having localized status, and their dependents residing in the United States, will be eligible for the same benefits under the Plan as associates who are United States citizens residing and working in the United States, including medical, dental, vision, life, disability and any other benefit available to United States associates under the Plan. These localized associates and applicable dependents will not be eligible for expatriate coverage under the Plan. For medical benefits where an eligible dependent of a localized associate resides outside the United States, the eligible dependent may choose to use any local provider or a network provider affiliated with the Third Party Administrator through whom the localized associate has coverage, if one is available. Medical benefits will be processed as network claims and paid at the applicable coinsurance rate for network charges, subject to applicable limitations and exclusions under the Plan. The localized associate or their enrolled dependent(s) must file a claim for reimbursement under the Plan's claims procedures. Any applicable waiting period will be waived for localized associates and their covered dependents.

ASSOCIATES WHO ARE NOT ELIGIBLE

You are not eligible for the Plan even if you are, or may be, reclassified by the courts, the IRS or the Department of Labor as a common-law employee of Wal-Mart Stores, Inc. or any participating subsidiary, if you are:

- A leased employee
- A nonresident alien (except for optional associate life insurance, optional dependent life insurance, accidental death and disability insurance and business travel accident insurance, and unless covered under a specific insurance policy for expatriates or third-country nationals who are employed by the company)
- An independent contractor
- A consultant
- Residing outside the United States
- Not classified as an associate of Wal-Mart Stores, Inc. or its participating subsidiaries, or
- Enrolled in Medicare Part D (applicable only to eligibility for medical plan options, including HMOs and the eComm PPO Plan).

You are also excluded if you are covered by a collective bargaining agreement, to the extent that the agreement does not provide for participation in the Associates' Health and Welfare Plan.

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

INITIAL ENROLLMENT ELIGIBILITY CHECK FOR MEDICAL COVERAGE

If you are a part-time hourly or temporary associate, your initial eligibility for medical benefits is determined by a review of your average hours worked per week over the 52 consecutive weeks beginning on your hire date. This review applies to all part-time hourly and temporary associates, with the exception of part-time hourly pharmacists hired before February 1, 2012, and part-time truck drivers.

If you average at least 30 hours a week (24 hours a week for part-time hourly pharmacists hired on or after February 1, 2012, and part-time field Logistics) over the 52-week review period without a break in employment of 13 weeks or greater, you will become eligible for medical benefits. Specifically, your eligibility will begin on the first day of the calendar month that falls not less than one month and not more than two months after the end of the 52-week review period (i.e., on the first day of the second calendar month following the day before your one-year anniversary date). For example, if you are hired on April 16, 2018, the company will average the hours you work beginning April 16, 2018, through April 15, 2019. If you work an average of at least 30 hours a week over the review period, your coverage (if you enroll in a timely manner) would begin June 1, 2019.

Initial medical coverage for associates who work an average of at least 30 hours a week over the 52-week review period will continue through the end of the second calendar year following date of hire. In the example above, your coverage (if you enroll in a timely manner) would continue through the end of 2020.

ANNUAL ELIGIBILITY CHECK FOR MEDICAL COVERAGE

Generally, part-time hourly associates (including those initially hired as management or full-time hourly who have been employed one year or more and change to part-time hourly status) and temporary associates will be subject to an annual benefits eligibility check to establish their eligibility for medical benefits for the next calendar year. The annual eligibility check will be administered prior to each calendar year's annual enrollment period.

The measurement period for the annual eligibility check will be the 52 weeks preceding an annually designated date in early October prior to each calendar year's annual enrollment period. For example, the annual check prior to the annual enrollment occurring in fall 2017 (for the 2018 calendar year) will review the associate's hours worked

from October 5, 2016, through October 4, 2017. If you meet your appropriate average weekly hours requirement (24 or 30 hours, depending on job classification) over the 52-week period, you will be eligible to enroll in medical benefits during the annual enrollment period for coverage during 2018, in addition to the other benefits to which part-time hourly and temporary associates are eligible

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

For questions about the annual benefits eligibility check process, please talk to your personnel representative or call People Services at **800-421-1362**.

IF YOU MEET THE ANNUAL ELIGIBILITY CHECK FOR MEDICAL BENEFITS

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

You will be subject to the annual eligibility check each year to determine your eligibility for medical benefits for the following year.

IF YOU DO NOT MEET THE ANNUAL ELIGIBILITY CHECK FOR MEDICAL BENEFITS

If you are a part-time hourly or temporary associate who is currently eligible for medical benefits and subject to the annual eligibility check requirement, but you do not meet the annual eligibility check in October, you will:

- Remain eligible for medical coverage for the remainder of the current year (if you are in your initial coverage period, you will be considered eligible for medical coverage through the end of the second calendar year following your date of hire)
- Not be eligible for medical coverage under Walmart's plans for the following year unless your job classification changes and you meet the eligibility requirements based on your new classification, and
- Receive a letter that will explain your options under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue your medical coverage when the calendar year ends.

You will be subject to the annual eligibility check each year to determine your eligibility for medical benefits for the following year.

IF YOU TAKE TIME OFF OR HAVE A BREAK IN SERVICE

Unpaid time off: If you take any type of unpaid time off that is not an approved leave of absence, as described below, your number of actual service hours will still be used in your average hours calculation (even if it is zero).

Leave of absence: If your absence is an approved leave (including for jury duty), Family and Medical Leave Act of 1993 (FMLA) leave or military leave, the average-hours-worked calculation will be based on the number of weeks during the 52-week measurement period that you are working. For example, if you take a leave during two weeks of the 52-week measurement period, your average hours will be calculated over the 50 weeks for which you have actual service hours, rather than 52.

Break in service

If your employment ends and you return to employment within 13 weeks or less: If you terminate employment during a measurement period but are rehired as a part-time hourly associate within 13 weeks after leaving, for the remainder of the measurement period you will be treated as if you had not left. Your hours will continue to be tracked and used in the average hours calculation. The period you were not employed will be excluded from the 52-week measurement period.

If you terminate employment after the completion of a measurement period and are rehired as a part-time associate within 13 weeks, you retain your previous status through the end of the calendar year, except as noted below. For example, if you are eligible for medical benefits and you enroll before you leave, and you return to the company within 13 weeks, you will be automatically re-enrolled in your previous coverage (or the most similar coverage offered under the Plan). The impact on your benefits depends on the duration of your break, as follows:

- **If your employment ends and you return within 30 days:** you will be automatically re-enrolled in your previous coverage (or the most similar coverage offered under the Plan).
- **If your employment ends and you return after 30 days but before 13 weeks:** you will be automatically enrolled in the same coverage you had before you left, but your annual deductibles and out-of-pocket maximum will reset and you will be responsible for meeting the new deductibles and out-of-pocket maximum in their entirety. You will have 60 days after resuming employment to drop or otherwise change the coverage in which you were automatically re-enrolled.

If your employment ends and you return after 13 or more weeks: you will be treated as if you were a new associate. You will be required to complete the initial eligibility check before you may be eligible for benefits.

Dependent eligibility

Dependents who are eligible to enroll in coverage under the Plan (“eligible dependents”) are limited to:

- Your spouse, as long as you are not legally separated
- Your domestic partner (or “partner”), as long as you and your domestic partner:
 - Are in an exclusive and committed relationship similar to marriage and have been for at least 12 months and intend to continue indefinitely
 - Are not married to each other or anyone else
 - Meet the age for marriage in your home state and are mentally competent to consent to contract
 - Are not related in a manner that would bar a legal marriage in the state in which you live, and
 - Are not in the relationship solely for the purpose of obtaining benefits coverage.
- Any other person to whom you are joined in a legal relationship recognized as creating some or all of the rights of marriage in the state or country in which the relationship was created (also referred to as “partner”)
- Your dependent children through the end of the month in which the child reaches age 26. Your dependent children are:
 - Your natural children
 - Your adopted children or children placed with you for adoption
 - Your stepchildren
 - Your foster children
 - The children of your partner, provided your relationship qualifies under the definition of spouse/partner, or
 - Someone for whom you have legal custody or legal guardianship, provided he or she is living as a member of your household and you provide more than half of his or her support.

NOTE: Eligible part-time hourly associates, temporary associates and part-time truck drivers may cover their eligible dependent children, but they may not cover their spouses/partners.

You and your eligible dependents must be enrolled in coverage under the Plan before any benefits will be paid. You have an obligation to promptly drop from coverage any individual who does not satisfy the definition of eligible dependent. If you fail to do so, you may be subject to the loss of benefits and/or loss of employment. You may have only one spouse or partner at a time.

If a court order requires you to provide medical, dental and/or vision coverage for children, the children must meet the Plan’s eligibility requirements for dependent coverage. For more information on how the Plan handles a Qualified Medical Child Support Order (QMCSO), see the [Qualified Medical Child Support Orders \(QMCSO\)](#) section later in this chapter.

If you are enrolled in any of the Accountable Care Plan options, the Select Network Plan or an HMO, and you have a dependent living outside the service area of your medical plan, you may still enroll your dependent, but he or she will not have access to network providers in the geographic area and may have access only to emergency coverage. If you are enrolled in any of the Accountable Care Plan options, the Select Network Plan or an HMO and you are unsure if your dependent lives outside your medical plan's service area, call your health care advisor at the number on your plan ID card.

You may change coverage plans for both yourself and your eligible dependent(s) during annual enrollment or if you have a status change event (you and your eligible dependent must be enrolled in the same coverage plan).

IF YOUR CHILD IS INCAPABLE OF SELF-SUPPORT

Coverage for your eligible child may be continued beyond the end of the month in which the child reaches age 26 in the following situations:

If the child is covered as an eligible dependent under a Walmart-sponsored medical, dental, vision, critical illness insurance, accident insurance, AD&D or optional dependent life insurance prior to his or her 26th birthday and if both of the following conditions are met:

- The child is physically or mentally incapable of self-support, and
- The child's doctor provides written medical evidence of the child's disability and inability to provide self-support.

In addition, coverage for your dependent child may be added beyond the end of the month in which the child reaches age 26 if both the above conditions are met and the child experiences a valid status change event. Any changes requested as a result of the valid status change event must be consistent with the event and the gain or loss of coverage. For additional information regarding a status change event, refer to the [Changing your benefits during the year: status change events](#) section of this chapter.

Dependents who are not eligible

Your dependent is not eligible under your coverage if he or she is:

- Covered by the Plan as an associate of Walmart (an individual covered under the Plan may be either an associate or a dependent, but not both at the same time), except for optional dependent life insurance, AD&D, critical illness and accident insurance
- Covered by the Plan as a dependent of another associate of Walmart, except for optional dependent life insurance, AD&D, critical illness and accident insurance
- Enrolled in Medicare Part D (applicable only to eligibility for medical plan options, including HMOs and the eComm PPO Plan)

- Residing outside the United States, except those dependents attending college full-time outside of the United States or covered under a specific policy for expatriates or third-country nationals who are employed by the company (this statement does not apply to optional dependent life insurance or dependents of localized associates)
- An illegal immigrant, or
- Not an eligible dependent as defined under [Dependent eligibility](#) on the previous page.

Legal documentation for dependent coverage

You may be required to provide legal documentation to prove the eligibility of your dependent(s). The Plan reserves the right to conduct a verification audit and require associates to provide written documentation of proof of dependent eligibility upon request. It is the associate's responsibility to provide the written documentation as requested by the Plan. If necessary documentation is not provided in the time frame requested, the Plan has the right to cancel dependent coverage until the requested documentation is received. It is the associate's responsibility to notify the Plan of any changes in the eligibility of their dependent(s).

When your dependent becomes ineligible

You must notify People Services within 60 days from the date your dependent becomes ineligible for coverage under the Plan by calling **800-421-1362**. If you qualify, upon receiving proper and timely notification, the Plan will send an election notice, allowing you to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage. To enroll in COBRA coverage, your dependent must elect to receive this coverage within 60 days from the date of his or her election notice. See the [COBRA](#) chapter for more information.

Failure to notify the Plan when your dependent becomes ineligible for coverage may be considered an intentional misrepresentation of material facts, which may result in coverage being canceled retroactively. In that case, you may be responsible for any charges mistakenly paid by the Plan after the date that your dependent became ineligible. If coverage is canceled, you may be eligible to receive a refund for premiums you paid after coverage was canceled, but only if you notify People Services.

When you enroll for benefits

Once you have completed any applicable eligibility waiting period, you can enroll for benefits as follows (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):

- During your initial enrollment period, which is the first time you are eligible to enroll. The timing of your initial enrollment period will vary by job classification and will change if your job classification changes.
- During annual enrollment, which usually occurs in the fall of each year. Benefits you enroll in during annual enrollment are generally effective January 1 of the following year. However, if you enroll in optional associate life insurance or optional dependent life insurance during annual enrollment, coverage for those plans will be effective on the date Prudential approves your coverage, or at the end of your eligibility waiting period, whichever is later. (This date could be before or after January 1 of the following year.)
- When a status change event allows you to make changes to your coverage outside of annual enrollment and is in accordance with federal law.
- If you choose to enroll in the short-term disability enhanced plan or the long-term disability plan during annual enrollment or with a status change after your initial enrollment period, you will be considered a late enrollee and will be required to finish a 12-month waiting period before your coverage is effective.
 - If your late enrollment is due to a status change event, your 12-month waiting period will begin as of the date of the event.
 - If your late enrollment is during an annual enrollment, your 12-month waiting period will begin as of the date you enroll.

If you are an associate in Hawaii, your eligibility and benefits information is described in the [Eligibility and benefits for associates in Hawaii](#) chapter.

If you are eligible and do not enroll during your initial enrollment period, you will not be eligible for the following benefits until the next annual enrollment period, unless you have a status change event:

- Medical, including HMO plans and the eComm PPO Plan
- Dental
- Vision
- Critical illness insurance
- Accident insurance
- Short-term disability enhanced plan
- Long-term disability (LTD), and
- Accidental death and dismemberment (AD&D).

If you are eligible and do not enroll during your initial enrollment period, you may still enroll for optional associate life insurance and optional dependent life insurance during the year by going online through the [WIRE, WalmartOne.com](#) or [Workday](#). However, if you do not enroll in these benefits during your initial enrollment period, you will be required to provide Proof of Good Health.

NOTE: Guaranteed issue for optional life insurance for associates (\$25,000) and optional dependent life insurance for spouses/partners (\$5,000) is available only during your initial enrollment period. “Guaranteed issue” refers to the maximum amount of insurance that can be issued without the need to submit Proof of Good Health. Proof of Good Health requires completion of a questionnaire regarding medical history for you and/or your spouse/partner and possibly having a medical exam. The Proof of Good Health questionnaire is made available when you enroll. Proof of Good Health is not required when enrolling in child life insurance under the optional dependent life insurance program.

CONFIRMING YOUR ENROLLMENT

Once you enroll for coverage, you can view your confirmation statement on the [WIRE, WalmartOne.com](#) or [Workday](#). If you believe there is an error regarding which benefits you enrolled in, you should immediately contact People Services at **800-421-1362**.

YOUR PLAN ID CARD

When you enroll in any of the medical plan options available under the Associates’ Medical Plan, you will receive a plan ID card at your home address. If your Third Party Administrator (TPA) is BlueAdvantage of Arkansas, Aetna or HealthSCOPE Benefits, plan ID cards for dependents whose address is different from the associate’s address will be sent directly to the dependent’s address. If your TPA is UnitedHealthcare, plan ID cards for dependents will be sent to you even if their address is different from yours. Your plan ID card will also serve as your pharmacy ID card.

If you enroll for coverage under the Associates’ Medical Plan or the eComm PPO Plan (if applicable) and you also enroll in the dental plan and/or the vision plan, your plan ID card will also serve as your Delta Dental ID card and/or your VSP vision plan ID card.

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

You can update your address or that of your dependents who are under the age of 18 when you enroll online or at any time on the [WIRE, WalmartOne.com](#) or [Workday](#). If your dependent is age 18 or over, they will need to contact People Services at **800-421-1362** to update their address.

ATTEMPTS TO ENROLL AFTER HOURS OF OPERATION

If you attempt to enroll for coverage after the normal hours of operation through the [WIRE, WalmartOne.com](#) or [Workday](#), or you have tried to make contact with People Services on the final day of your initial enrollment period,

annual enrollment period or time frame for requesting a change as a result of a family status change, you may enroll on the next business day. However, in no event will you be allowed to enroll as a part of the annual enrollment period after the beginning of the new Plan year.

AUTOMATIC RE-ENROLLMENT IN THE ASSOCIATES' MEDICAL PLAN OPTIONS

If you currently have medical coverage and continue to be eligible for your current coverage, but do not actively enroll during annual enrollment, you will be automatically re-enrolled in coverage options closest to what you have currently, as described in the annual enrollment materials and posted online at WalmartOne.com, on the [WIRE](#) or on [Workday](#) during annual enrollment. This includes the eligible dependents you have elected to cover, unless you change your prior elections. You may call People Services at **800-421-1362** for more information.

You may change or drop your coverage during annual enrollment. If you do not actively enroll during annual enrollment and are automatically enrolled in a coverage plan, you will not be able to change this coverage once the annual enrollment period concludes, unless you experience a status change event or until the next annual enrollment period.

If you do not actively re-enroll during annual enrollment, you will be deemed to have consented to the automatic re-enrollment described in this section, and your payroll deductions will be adjusted accordingly.

NOTE: An important exception to the automatic re-enrollment terms described above applies to all associates from newly merged eCommerce groups who were not previously enrolled under Walmart-sponsored medical coverage. For the 2018 plan year, all such associates must actively complete an online enrollment session at WalmartOne.com, on the [WIRE](#) or on [Workday](#) in order to have coverage in 2018.

IMPORTANT



If you are a first-time enrollee, you must actively complete an online enrollment session at WalmartOne.com, on the [WIRE](#) or on [Workday](#) to receive the tobacco-free rates. For more information, see [Tobacco rates](#) in this chapter.

When coverage is effective

The charts on the following pages describe when coverage for benefits becomes effective. You must be actively at work on the day your coverage is effective for coverage to begin. If you are not at work on the day your coverage for medical, vision, dental, critical illness insurance, accident insurance and AD&D benefits becomes effective, your coverage will begin as long as you have reported for your first day of work, enrolled for the benefit and paid the applicable premiums. If

you have enrolled in optional associate life insurance, optional dependent life insurance, short-term disability enhanced plan and/or long-term disability, those coverages will not begin until you have returned to work. No enrollment is required for Resources for Living, business travel accident, short-term disability basic plan or company-paid life insurance.

If you are not actively at work, as described below, for any reason other than a scheduled vacation on the effective date of your coverage, it will be delayed until you return to active work. If you are an associate in Hawaii, information regarding eligibility and benefits is described in the [Eligibility and benefits for associates in Hawaii](#) chapter.

“ACTIVE WORK” OR “ACTIVELY AT WORK”

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

For company-paid life insurance, optional associate life insurance, optional dependent life insurance, business travel accident insurance and all types of disability coverage, being actively at work means you are actively at work with the company on a day that is one of your scheduled work days and performing all of the regular duties of your job on a full-time basis or part-time basis (depending on your classification as a full-time or part-time associate). You will be deemed to be actively at work on a day that is not one of your scheduled work days only if you were actively at work on the preceding scheduled work day.

DELAY OF COVERAGE

If you are on a leave of absence when your coverage is scheduled to become effective, your company-paid life insurance, optional associate life insurance, optional dependent life insurance, short-term disability and long-term disability coverages will be delayed until you return to active work. Your coverage options for medical, dental, vision, critical illness insurance, accident insurance, AD&D and Resources for Living will not be delayed as long as you have reported to your first day of work.

Effective dates for benefits under the Plan

The following [Enrollment and effective dates by job classification](#) charts provide your coverage effective dates if you enroll during your initial enrollment period. If you do not enroll during your initial enrollment period, you may enroll during annual enrollment or if you experience a status change event, as described in the section titled [Changing your benefits during the year: status change events](#) later in this chapter. If you are an associate in Hawaii, see [Eligibility and benefits for associates in Hawaii](#).

Enrollment and effective dates by job classification

FULL-TIME HOURLY ASSOCIATES

Includes pharmacists (except California pharmacists*), field Logistics, field supervisor positions in stores and clubs; excludes Vision Center managers

Plan	Enrollment Periods and Effective Dates
<ul style="list-style-type: none"> Medical HMO plans Vision Dental (enrollment is for two full calendar years) AD&D Critical illness insurance Accident insurance 	<p>Initial enrollment period: Between the date of your first paycheck and the day prior to your effective date, as described immediately below.</p> <p>When coverage is effective: The first day of the calendar month during which your 89th day of continuous full-time employment falls.</p>
<ul style="list-style-type: none"> Company-paid life insurance 	Automatically enrolled on the first day of the calendar month during which your 89th day of continuous full-time employment falls.
<ul style="list-style-type: none"> Business travel accident insurance Resources for Living 	Automatically enrolled on your date of hire.
<ul style="list-style-type: none"> Short-term disability basic plan (not available in California and Rhode Island; different coverage is available in Hawaii, New Jersey and New York) 	Automatically enrolled at your 12-month anniversary.
<ul style="list-style-type: none"> Optional associate life insurance Optional dependent life insurance 	<p>Initial enrollment period: Between the date of your first paycheck and the day prior to your effective date, as described immediately below.</p> <p>When coverage is effective:</p> <ul style="list-style-type: none"> If you enroll during your initial enrollment period: Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is the first day of the calendar month during which your 89th day of continuous full-time employment falls.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for yourself and/or your spouse/partner. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later. If you enroll after your initial enrollment period: You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential.
<ul style="list-style-type: none"> Short-term disability enhanced plan (not available in California and Rhode Island; different coverage is available in Hawaii and New Jersey; New York short-term disability enhanced plan is available in New York) Long-term disability (LTD) plan LTD enhanced plan 	<p>Initial enrollment period: Between the date of your first paycheck and the first day of the calendar month during which your 89th day of continuous full-time employment falls.</p> <p>When coverage is effective:</p> <ul style="list-style-type: none"> If your hire date is December 31, 2015, or before, and: <ul style="list-style-type: none"> You enroll during your initial enrollment period: Coverage is effective as of the first day of the calendar month during which your 89th day of continuous full-time employment falls. You enroll after your initial enrollment period: Coverage is effective after a 12-month waiting period from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.) If your hire date is January 1, 2016, or after, and: <ul style="list-style-type: none"> You enroll during your initial enrollment period: Coverage is effective as of your 12-month anniversary date. You enroll after your initial enrollment period: Coverage is effective after a 12-month waiting period from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.)

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

NOTE: Some benefits require you to meet the definition of active work. See the "[Active work](#)" or "[actively at work](#)" section in this chapter for more information.

FULL-TIME HOURLY VISION CENTER MANAGERS

Plan	Enrollment Periods and Effective Dates
<ul style="list-style-type: none"> • Medical • HMO plans • Vision • Dental (enrollment is for two full calendar years) • AD&D • Critical illness insurance • Accident insurance 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 60th day after your date of hire.</p> <p>When coverage is effective: Your date of hire.</p>
<ul style="list-style-type: none"> • Company-paid life insurance • Business travel accident insurance • Resources for Living • Short-term disability basic plan (not available in California and Rhode Island; different coverage is available in Hawaii, New Jersey and New York) 	<p>Automatically enrolled on your date of hire.</p>
<ul style="list-style-type: none"> • Optional associate life insurance • Optional dependent life insurance 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 60th day after your date of hire.</p> <p>When coverage is effective:</p> <ul style="list-style-type: none"> • If you enroll during your initial enrollment period: Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is your date of hire.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for yourself and/or your spouse/partner. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later. • If you enroll after your initial enrollment period: You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential.
<ul style="list-style-type: none"> • Short-term disability enhanced plan (not available in California and Rhode Island; different coverage is available in Hawaii and New Jersey; New York short-term disability enhanced plan is available in New York) • Long-term disability (LTD) plan • LTD enhanced plan 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 60th day after your date of hire.</p> <p>When coverage is effective:</p> <p>If you enroll during your initial enrollment period: Coverage is effective as of your date of hire.</p> <p>If you enroll after your initial enrollment period: Coverage is effective after a 12-month wait from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.)</p>

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

METRO PROFESSIONAL NON-EXEMPT ASSOCIATES

Plan	Enrollment Periods and Effective Dates
<ul style="list-style-type: none"> • Medical • HMO plans • Vision • Dental (enrollment is for two full calendar years) • AD&D • Critical illness insurance • Accident insurance 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 60th day after your date of hire.</p> <p>When coverage is effective: Your date of hire.</p>
<ul style="list-style-type: none"> • Company-paid life insurance • Business travel accident insurance • Resources for Living • Short-term disability plan 	<p>Automatically enrolled on your date of hire.</p>
<ul style="list-style-type: none"> • Optional associate life insurance • Optional dependent life insurance 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 60th day after your date of hire.</p> <p>When coverage is effective: If you enroll during your initial enrollment period: Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is your date of hire.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for yourself and/or your spouse/partner. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later.</p> <p>If you enroll after your initial enrollment period: You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential.</p>
<ul style="list-style-type: none"> • Long-term disability (LTD) plan • LTD enhanced plan 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 60th day after your date of hire.</p> <p>When coverage is effective: If you enroll during your initial enrollment period: Coverage is effective as of your date of hire.</p> <p>If you enroll after your initial enrollment period: Coverage is effective after a 12-month wait from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.)</p>

NOTE: Some benefits require you to meet the definition of active work. See the “[Active work](#)” or “[actively at work](#)” section in this chapter for more information.

PART-TIME HOURLY AND TEMPORARY ASSOCIATES

Plan	Enrollment Periods and Effective Dates
<ul style="list-style-type: none"> • Medical* • HMO plans • Vision • Dental (enrollment is for two full calendar years) • AD&D • Critical illness insurance • Accident insurance 	<p>Initial enrollment period: Between your 52-week anniversary date and the first day of the second calendar month following your 52-week anniversary date (or 60 days from your anniversary date).</p> <p>When coverage is effective: The first day of the second calendar month following your 52-week anniversary date.*</p> <p>*To be eligible for medical coverage, part-time hourly and temporary associates must work the required number of hours and pass the initial or annual benefits eligibility check (whichever is applicable) described under Associate eligibility earlier in this section. Part-time hourly pharmacists hired before February 1, 2012, are exempt from this requirement.</p>
<ul style="list-style-type: none"> • Business travel accident insurance • Resources for Living 	<p>Automatically enrolled on your date of hire.</p>
<ul style="list-style-type: none"> • Optional associate life insurance • Optional dependent life insurance 	<p>Initial enrollment period: Between your 52-week anniversary date and the first day of the second calendar month following your 52-week anniversary date (or 60 days after your anniversary).</p> <p>When coverage is effective:</p> <ul style="list-style-type: none"> • If you enroll during your initial enrollment period: Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is the first day of the second calendar month following your 52-week anniversary date.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later. • If you enroll after your initial enrollment period: You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential.

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

PART-TIME TRUCK DRIVERS

Plan	Enrollment Periods and Effective Dates
<ul style="list-style-type: none"> • Medical • HMO plans • Vision • Dental (enrollment is for two full calendar years) • Critical illness insurance • Accident insurance • AD&D 	<p>Initial enrollment period: Between the date of your first paycheck and the day prior to your effective date, as described immediately below.</p> <p>When coverage is effective: The first day of the calendar month during which your 89th day of continuous employment falls.</p>
<ul style="list-style-type: none"> • Business travel accident insurance • Resources for Living 	<p>Automatically enrolled on your date of hire.</p>
<ul style="list-style-type: none"> • Optional associate life insurance • Optional dependent life insurance 	<p>Initial enrollment period: Between the date of your first paycheck and the day prior to your effective date, as described immediately below.</p> <p>When coverage is effective:</p> <ul style="list-style-type: none"> • If you enroll during your initial enrollment period: Your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is the first day of the calendar month during which your 89th day of continuous employment falls.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later. • If you enroll after your initial enrollment period: You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential.

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

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

MANAGEMENT ASSOCIATES, MANAGEMENT TRAINEES, CALIFORNIA PHARMACISTS* AND FULL-TIME TRUCK DRIVERS

Plan	Enrollment Periods and Effective Dates
<ul style="list-style-type: none"> • Medical • HMO plans • Vision • Dental (enrollment is for two full calendar years) • AD&D • Critical illness insurance • Accident insurance 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 60th day after your date of hire.</p> <p>When coverage is effective: Your date of hire.</p>
<ul style="list-style-type: none"> • Company-paid life insurance • Business travel accident insurance • Resources for Living • Short-term disability plan** 	<p>Automatically enrolled on your date of hire.</p>
<ul style="list-style-type: none"> • Optional associate life insurance • Optional dependent life insurance 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 60th day after your date of hire.</p> <p>When coverage is effective:</p> <ul style="list-style-type: none"> • If you enroll during your initial enrollment period: Your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is your date of hire.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for yourself and/or your spouse/partner. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later. • If you enroll after your initial enrollment period: You may enroll or drop coverage at any time during the year, but, Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential.
<ul style="list-style-type: none"> • Long-term disability (LTD) plan • LTD enhanced plan • Truck driver LTD plan • Truck driver LTD enhanced plan 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 60th day after your date of hire.</p> <p>When coverage is effective:</p> <p>If you enroll during your initial enrollment period: Coverage is effective as of your date of hire.</p> <p>If you enroll after your initial enrollment period:</p> <ul style="list-style-type: none"> • LTD plan: Coverage is effective after a 12-month wait from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.) • Truck driver LTD plan: You will be required to provide Evidence of Insurability; coverage is effective the first day of the pay period after People Services receives approval from Lincoln (formerly Liberty).

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

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

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

Paying for your benefits

Payroll deductions will be withheld from your Walmart paycheck to pay for your benefits selections. Generally, the first paycheck after your effective date should reflect deductions for each day that you had coverage during that pay period. If a pay period spans two calendar years, your deductions will reflect the amount for the prior year through December 31 and the new amount for the new year, prorated for the number of days covered from January 1 until the end of the pay period.

Your payroll deductions reflect your cost for benefits for the payroll period ending printed on your paycheck. So, if you are paid biweekly (every other week), your deductions pay for coverage for the previous two weeks. Deductions are based on biweekly pay periods (except in Rhode Island, which has weekly pay periods).

If you are enrolled in the HSA Plan, you may also contribute to a Health Savings Account on a pretax basis, if you do not have other disqualifying coverage. See the [Health Savings Account](#) chapter for more information.


If your payroll deductions are not withheld for any reason, unpaid premiums must be paid in full from your original effective date. This could result in extra deductions taken from future paychecks.

It's important to check your paycheck stub to be sure that the proper deductions are being taken. Remember, you can view your paycheck stub online the Monday before payday by going to Online Paystub on [WalmartOne.com](#) or the [WIRE](#). If you believe the coverage and deductions you selected are not correct on your paycheck stub, call People Services immediately at **800-421-1362**. Requests for a review of premiums paid will be considered if submitted within one year from the date of a possible overpayment. A premium reconciliation up to a maximum of one year will be completed.

Many of your Walmart benefits are paid for with pretax dollars. Purchasing with pretax dollars means your payroll deductions for coverage are deducted from your paycheck before federal and, in most cases, state taxes are withheld. The result is that your benefits dollars go further and you get more for your money.

Because Social Security taxes are not withheld on any pretax dollars you spend for benefits, amounts you pay for benefits with pretax dollars will not be counted as wages for Social Security purposes. As a result, your future Social Security benefits may be reduced somewhat.

Deductions for premiums or contributions that are past due or for retroactive elections generally must be made on an after-tax basis.

 **See page 285** for important information about paying for benefits if your Walmart paycheck is not sufficient to cover the full cost of premiums due.

IMPORTANT NOTE ABOUT TAX CONSEQUENCES OF PARTNER BENEFITS

Partners generally do not qualify as spouses or dependents for federal income tax purposes. Therefore, the value of company-provided medical (including the HRA) coverage that relates to your partner, or your partner's child(ren), generally will be considered imputed income and will be taxable to you on each paycheck that the benefits are maintained. This value is subject to change from year to year as the underlying benefit values change. Tax and other withholdings will be made from your paycheck and the value of those benefits will be included in your Form W-2. During any period in which partner benefits that have an imputed income are maintained by you but you are not receiving a paycheck from the company, the company reserves the right to collect the employee FICA tax liability directly from you.

The above rules will not apply if your partner satisfies the requirements to be considered your tax dependent under the Internal Revenue Code.

Tobacco rates

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

- You and/or a covered spouse/partner do not use tobacco and are considered to be “tobacco free,” or
- You and/or a covered spouse/partner use tobacco and you will enroll in and complete participation in a quit-tobacco program of your choice between the time of annual enrollment and December 31, 2018; or, in the alternative, if you call Healthways, the administrator of Walmart's Quit Tobacco program, at **866-577-7169**, Healthways will work with you (and, if you wish, your doctor) to find a program that is right for you.

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

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

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

To review Walmart's policy about intentional dishonesty, please refer to the Statement of Ethics, which can be found on the [WIRE](#). If we receive a report of abuse, we will conduct an ethics investigation.

Walmart offers the free Quit Tobacco program to all associates. For more information, see [Quit Tobacco program](#) in [The medical plan](#) chapter.

Benefits continuation if you go on a leave of absence

A leave of absence provides you with needed time away from work while maintaining eligibility for benefits and continuity of employment. To accommodate situations that necessitate absence from work, the company provides three types of leave:

- **Family Medical Leave Act of 1993 (FMLA):** An approved FMLA leave provides you with time away from work so that you or your family members can receive medical treatment and/or recover from medical treatment, injury or disability. This includes disabilities; pregnancy; childbirth; other serious health conditions; to care for a child after childbirth or adoption; to care for a spouse, child or parent who has a serious medical condition; or to take care of certain needs when a spouse, child or parent is called to active military duty.
- **Personal leave:** An approved personal leave provides you with time away from work so that you can deal with personal situations, such as a family crisis, or to continue your education.
- **Military leave:** If you volunteer for or are required to perform active, full-time U.S. military duty, or to fulfill National Guard or Reserve obligations, you will be granted a military leave.

Walmart will maintain medical, dental, vision, critical illness insurance, accident insurance, optional associate life, optional dependent life, AD&D and Resources for Living coverage while you are on an FMLA, personal or military leave, where such coverage was provided before the leave was taken. Coverage generally will be maintained on the same terms and conditions as if you had continued to work during the leave. You must make arrangements by contacting People Services at **800-421-1362** to pay your premiums during your leave. If you cancel your coverage during your FMLA, personal or military leave and return to work, you may contact People Services at **800-421-1362** within 60 days of returning to work to reinstate your coverage. See the [If you go on a leave of absence](#) section in the respective chapters for each of the above-named benefits to learn more.

You may continue or suspend coverage for yourself and/or your eligible dependents while you are on military leave. You may also have a right to reinstate coverage upon your return. Contact People Services at **800-421-1362**.

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

You should contact a member of your management team or Sedgwick for additional information about FMLA, personal or military leave, or refer to Walmart's Leave of Absence Policy on the [WIRE](#) for more specific information. You may also contact your personnel representative if you have questions about the application of the FMLA, personal or military leave policy.

PAYING FOR BENEFITS WHILE ON A LEAVE OF ABSENCE



See page 285 for additional important information regarding paying for benefits while on a leave of absence.

To continue coverage for the following benefits, you must make payments for your portion of the contribution by paying those costs on an after-tax basis while you are on a leave of absence. Be sure to include your name, insurance ID and facility number on the payment to ensure proper credit. Please allow 10–14 days for processing. Premium payments you are responsible for include:

- Medical
- Dental
- Vision
- Critical illness insurance
- Accident insurance
- Optional associate life insurance
- Optional dependent life insurance
- Accidental death and dismemberment (AD&D).

When you make your payments, you are paying for coverage for the previous pay period. Thus, you may experience an interruption in the payment of medical, dental, pharmacy, vision, critical illness insurance, accident insurance, life insurance and AD&D claims. To avoid any interruption, you can pay for coverage in advance when you pay your regular premium. For more information, call People Services at **800-421-1362**.

Payments of premiums may be made by check or money order and should be made payable to Associates' Health and Welfare Trust and mailed to:

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

To ensure proper credit when you send payment, please be sure to include your name, insurance ID number (found on your plan ID card) and facility number. If you have HMO coverage, include your WIN (Walmart ID) number.

You may also pay by debit or credit card with a Visa, MasterCard or Discover card by calling **800-421-1362** and saying "make a payment."

If you are on a leave of absence and you owe payments for benefits to the Plan, any check issued by the company, including during or after your leave of absence (i.e., paid time off, incentive, etc.), will have the full amount of premiums deducted. Payment arrangements can also be made by notifying People Services prior to your return to work. Generally, payments to continue your coverage can only be accepted from you, a family member, including a partner, or a health care provider.

If your coverage is canceled, please see the applicable benefit section for information about reinstating coverage.

Benefits continuation if you have an approved disability claim

If an unplanned illness or injury prevents an associate from being able to do his or her job, the company provides disability coverage options for certain eligible associates. The disability chapters of this Summary Plan Description describe plan eligibility and details of coverage. For details regarding your responsibility for paying for benefits in the event you have an approved disability claim, refer to the [Continuing benefit coverage while disabled](#) section of each of those chapters.

Changing your benefits during the year: status change events

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

- Optional associate life insurance and optional dependent life insurance can be added or dropped at any time.
- The Associates' Medical Plan, HMO plans, the eComm PPO Plan, dental, vision, AD&D, critical illness insurance and accident insurance can be changed only during annual enrollment unless you have a status change event.
- Short-term disability enhanced, long-term disability and truck driver long-term disability can be dropped at any time. (The change will be effective the day after you drop coverage.) They can be added only at annual enrollment unless you have a status change event.

Federal tax law generally requires that your pretax benefit choices remain in effect for the entire calendar year for which the choice was made. This does not apply to pretax contributions to a Health Savings Account, which can be changed at any time.

However, you may make certain coverage changes if a status change event occurs. A status change event is an event that allows you to make changes to your coverage outside of annual or initial enrollment. Federal law generally requires that your requested election change be due to and correspond with your change in status, and affect eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the change you request.

Status change events include:

- Events that change your marital status:
 - Marriage
 - Death of your spouse
 - Divorce (including the end of a common-law marriage in states where a divorce decree is required to end a recognized common-law marriage)
 - Annulment, or
 - Legal separation.
- Events that change your domestic partnership status:
 - Commencement of domestic partnership
 - Termination of domestic partnership, or
 - Death of your domestic partner.
- Events that change the status of a legal relationship with a person other than a spouse or domestic partner, as specified in the definition of spouse/partner:
 - Commencement of legal relationship
 - Termination of legal relationship, or
 - Death of the other person to whom you are joined in legal relationship.
- Events that change the number of your dependents:
 - Birth
 - Adoption
 - Placement for adoption
 - Death of a dependent
 - Gain of custody of a dependent
 - Loss of custody of a dependent for whom you have previously been awarded legal custody or guardianship by a judge
 - Your paternity test result, or
 - When a dependent loses eligibility, such as at the end of the month in which the dependent reaches age 26.
- Employment changes experienced by you, your spouse/partner or your dependent:
 - Going on or returning from an approved leave of absence
 - Gain or loss of coverage due to starting or ending employment

- A change in work location that affects your medical coverage. If the change affects your medical coverage plan options (such as if a new HMO, the Accountable Care Plan, the Select Network Plan or the eComm PPO Plan is offered), you will have 60 calendar days from your transfer to submit a request to change your coverage. If you transfer work locations where your medical benefits are affected and do not submit a request, you will automatically be enrolled in a predetermined plan
- If you, your spouse/partner or your dependent(s) gain or lose coverage under any other employer plan, you may change your coverage in a manner consistent with the change. For example, if your spouse/partner enrolls in or drops coverage during an annual enrollment at his or her place of employment or due to a status change event, you may change your coverage in a manner consistent with your spouse/partner's change in coverage, or
- If you are a part-time hourly or temporary associate and your hours are reduced such that you work an average of less than 30 hours per week (regardless of whether the reduction in hours affects your eligibility for medical benefits) and you intend to enroll in another plan that provides minimum essential coverage that is effective no later than the first day of the second month following the month that your medical coverage under the Plan would end, you may drop coverage in the Associates' Medical Plan or an HMO plan or the eComm PPO Plan.

LOSS OF COVERAGE

- You may add medical, dental or vision coverage for you and/or your eligible spouse/partner and dependent(s) if:
 - You originally declined coverage because you and/or your spouse/partner and/or dependent(s) had COBRA coverage and that COBRA coverage has ended (nonpayment of premiums is not sufficient for this purpose)
 - You and/or your spouse/partner and/or dependent(s) had non-COBRA medical coverage and the other coverage has terminated due to loss of eligibility for coverage, or
 - Employer contributions toward the other coverage have terminated.
- A change may also be allowed if there is a significant loss of coverage under the benefits available at Walmart, such as an HMO plan in your area discontinues service or ceases to operate. The Plan will determine whether a significant loss of coverage has occurred.
- If you, your spouse/partner or your eligible dependents lose coverage under a governmental plan including Title XIX of the Social Security Act (Medicaid) or a state children's health plan under Title XXI of the Social Security Act, an educational institution's plan or a tribal government plan, you can add coverage under the Associates' Medical Plan, an HMO plan, the eComm PPO Plan, accident insurance or critical illness insurance within 60 days of the loss of coverage. (This does not apply to loss of coverage under a Health Insurance Marketplace plan.)
- A change may also be allowed pursuant to a court order.

GAIN OF OTHER COVERAGE

- If an order resulting from a divorce, legal separation, annulment or change in legal custody (including a Qualified Medical Child Support Order — See [Qualified Medical Child Support Orders \(QMCSO\)](#) later in this chapter) requires you to provide medical, dental and/or vision coverage for your eligible dependent child(ren), you may add coverage for your eligible dependent child(ren) (and yourself, if you are not already covered). If the order requires your spouse, former spouse or other person to provide medical, dental and/or vision coverage for your dependent child(ren), and that other coverage is in fact provided, you may drop coverage for the dependent child(ren).
- If you are eligible for a Special Enrollment Period to enroll in a qualified health plan through a Marketplace, or you seek to enroll in a qualified health plan through a Marketplace during the Marketplace's annual enrollment period, you can drop coverage in the Associates' Medical Plan, an HMO plan or the eComm PPO Plan, in accordance with rules set forth by the Department of Health and Human Services. You and any dependents who cease coverage under the Plan must provide evidence of your enrollment rights and state that you intend to enroll in a qualified health plan through a Marketplace effective no later than the day immediately following the last day of your coverage under the Associates' Medical Plan, HMO plan or eComm PPO Plan.
- If you, your spouse/partner or your eligible dependents are enrolled in the Associates' Medical Plan, an HMO plan, the eComm PPO Plan, accident insurance or critical illness insurance, you can drop that coverage if you, your spouse/partner or your dependents become entitled to Medicare or Medicaid benefits.
- If you, your spouse/partner or your eligible dependents gain eligibility under a governmental plan (other than Medicare, Medicaid or TRICARE), you cannot drop the Associates' Medical Plan, an HMO plan, the eComm PPO Plan, accident insurance or critical illness insurance coverage except during annual enrollment.
- If you, your spouse/partner or your eligible dependents become eligible for assistance for Plan coverage under Title XIX of the Social Security Act (Medicaid) or a state children's health plan under Title XXI of the Social Security Act, you must request coverage under the Plan within 60 days of becoming eligible for assistance.

ADDITIONAL CIRCUMSTANCES IN WHICH YOU MAY CHANGE YOUR BENEFITS

In addition to the circumstances under which you may change your benefits, as listed on the previous page, there are additional circumstances, including cost changes, reduction of coverage, and/or additions/improvements of a benefit option, in which the Plan, in its sole discretion, may allow you to make mid-year changes to your elections. For more information, contact People Services at **800-421-1362**.

Making changes in your coverage as a result of status change events

When you have a status change event, you must request your change within 60 days from the date of the event. Any changes you request as a result of the status change event must be consistent with the event and the gain or loss of coverage. This means there must be a logical relationship between the event and the change you request. For example, if you (the associate) and your spouse divorce, you can only drop coverage for your spouse. It would not be consistent to change another dependent's coverage due to this event.

Unless otherwise provided in the Plan, if you add a spouse or partner (as such term is defined earlier in this chapter) or other eligible dependent due to a status change event, each person must individually meet any applicable benefit waiting period (for example, for transplant coverage or weight loss surgery) and will be subject to any applicable Plan limitations. If you change medical plans due to a status change event, your annual deductible(s) and out-of-pocket maximum will reset, and you will be responsible for meeting the new deductible(s) and out-of-pocket maximum in their entirety. The exception to this rule is if you change from one of the HRA plans to another, in which case your annual deductible and out-of-pocket maximum will not reset as a result of your change in medical coverage options. If you change from one of the HRA plans to another during the Plan year as a result of a status change event, the amount credited to your HRA will be prorated according to the time remaining in the year. If you change from one of the HRA plans to a non-HRA plan, your HRA balance will be forfeited. See [The medical plan](#) chapter for more information.

If you are covered as a dependent and move to coverage as an associate during the Plan year, you will generally not receive credit under the Associates' Medical Plan for expenses incurred prior to the date of the change. However, if you are covered as a dependent and you experience a qualifying event that affects your status as a dependent and makes you eligible for your own continuation coverage under COBRA, you will receive credit toward your deductibles and

out-of-pocket maximum under the Associates' Medical Plan for expenses incurred as a covered dependent. You will also receive credit toward any waiting periods.

When dependents are added due to a status change event or during annual enrollment, each Plan participant will be subject to a one-year wait before becoming eligible for benefits such as the transplant and the weight loss surgery benefit.

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

HIPAA SPECIAL ENROLLMENT FOR MEDICAL COVERAGE

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

- If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself, and if you choose, yourself and your dependents in this Plan if you or your dependents lose eligibility for that coverage (or if the employer stops contributing toward your or your dependents' other coverage). You must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
- If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your eligible dependents. You must request enrollment within 60 days.
- If you or a dependent is no longer eligible for coverage under Title XIX of the Social Security Act (Medicaid) or a state children's health plan under Title XXI of the Social Security Act, or you or a dependent becomes eligible for assistance for Plan coverage under Title XIX of the Social Security Act (Medicaid) or a state children's health plan under Title XXI of the Social Security Act, you must request enrollment within 60 days of the prior coverage terminating or your becoming eligible for assistance. Such coverage will be effective upon the date you enroll in the Plan.
- To request special enrollment or obtain more information, refer to the information in this chapter regarding status change events or contact People Services at **800-421-1362**.

HOW TO CHANGE YOUR ELECTIONS DUE TO A STATUS CHANGE EVENT

You can make changes online within 60 days on the [WIRE](#), [WalmartOne.com](#) or [Workday](#) for status changes due to:

- Adoption
- Birth
- Commencement of domestic partnership as defined under [Dependent eligibility](#) earlier in this chapter
- Commencement of legal relationship with a person other than your spouse or domestic partner
- Death of spouse/partner
- Divorce or legal separation
- Gain of custody
- Gain or loss of coverage by you, your dependent(s) or your eligible spouse/partner
- Going on leave of absence
- Marriage
- Returning from leave of absence
- Special enrollment period
- Termination of domestic partnership, or
- Termination of legal relationship with a person other than a spouse or domestic partner.

For all other types of status changes, call People Services at **800-421-1362**.

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

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

Changes to your coverage will be effective on the event date or on the day after the status change event date. If a change is made due to your unpaid leave of absence, the change will be effective as of the effective date of your leave of absence.

This does not apply to optional associate life insurance, optional dependent life insurance, short-term disability enhanced plan coverage, long-term disability or truck driver long-term disability; see the respective chapters for information about effective dates.

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

If you do not notify People Services or go online and make a change within 60 days of the status change event, you will not be able to add or drop coverage until the next annual enrollment period or until you have a different status change event.

Also, if the status change event is due to your dependent losing eligibility, your dependent will lose the right to elect COBRA coverage for medical, dental and/or vision benefits if you do not notify People Services of the event within 60 days. Similarly, if the status change event is due to your divorce, the termination of a domestic partnership or the termination of a legal relationship with a person other than your spouse or domestic partner, your former spouse/partner will lose the right to elect COBRA coverage for medical, dental and/or vision benefits if People Services is not notified of the event within 60 days. See the [COBRA](#) chapter for more information.

If your job classification changes

If you transition from one job classification to another, you may be eligible (or ineligible) for certain benefits.

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

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

NOTE: If your job classification changes to part-time hourly or temporary associate, see the [Benefits eligibility checks for part-time hourly and temporary associates](#) section earlier in this chapter for more information.

Coverage effective dates when transferring from one job classification to another

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

If Your Transition Occurs	When Coverage Is Effective
<p>And you have been continuously employed for more than 52 weeks and were eligible for medical coverage under the Plan as a part-time hourly or temporary associate immediately prior to your transition</p>	<ul style="list-style-type: none"> • You will have 60 days to enroll from the first day of the pay period in which your transition occurs. • Your coverage will be effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll. If you enroll by phone call to People Services, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date. • You will be enrolled automatically in the short-term disability basic plan effective the first day of the pay period in which your transition occurs, and will be eligible to enroll in the short-term disability enhanced plan at the same time, unless you work in the states of California, Hawaii, New Jersey or Rhode Island, which have state-mandated disability plans. (Associates in New York will be able to enroll in the NY short-term disability enhanced plan.) • You will be enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs. • You will be eligible to enroll in optional dependent life insurance for your spouse/partner and long-term disability (LTD) plan coverage. • If you enroll for optional dependent life insurance for your spouse/partner during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended. • If you are currently enrolled in medical, dental, vision, AD&D, critical illness and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family as a result of your change in job classification. If you are not currently enrolled in medical, dental, vision, AD&D, critical illness and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next annual enrollment period or until you have a valid status change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types as a part-time hourly or temporary associate.

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

If Your Transition Occurs	When Coverage Is Effective
<p>And you have been continuously employed for more than 52 weeks and were not eligible for medical coverage under the Plan as a part-time hourly associate immediately prior to your transition</p>	<ul style="list-style-type: none"> • You will have 60 days to enroll from the first day of the pay period in which your transition occurs. • Your coverage will be effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll. If you enroll by phone call to People Services, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date. • You will be eligible to enroll in medical coverage. See The medical plan chapter for more information. • You will be enrolled automatically in the short-term disability basic plan effective the first day of the pay period in which your transition occurs, and will be eligible to enroll in the short-term disability enhanced plan at the same time, unless you work in the states of California, Hawaii, New Jersey or Rhode Island, which have state-mandated disability plans. (Associates in New York will be able to enroll in the NY short-term disability enhanced plan.) • You will be enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs. • You will be eligible to enroll in optional dependent life insurance for your spouse/partner and long-term disability (LTD) plan coverage. • If you enroll for optional dependent life insurance for your spouse/partner during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended. • If you are currently enrolled in dental, vision, AD&D, critical illness and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family as a result of your change in job classification. If you are not currently enrolled in dental, vision, AD&D, critical illness and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next annual enrollment period or until you have a valid status change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types as a part-time hourly or temporary associate.

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

If Your Transition Occurs	When Coverage Is Effective
<p>And you have been continuously employed for more than 90 days but less than 52 weeks</p>	<ul style="list-style-type: none"> • You will have 60 days to enroll from the first day of the pay period in which your transition occurs. • Your coverage will be effective (with the exception of short-term and long-term disability) either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll. If you enroll by phone call to People Services, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date. • You will be eligible to enroll in medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness and accident insurance. See the respective chapters in this Summary Plan Description for more information. • You will be enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs. • If you enroll for optional associate life insurance or optional dependent life insurance for your spouse/partner during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for you and/or your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended. • You will be eligible to enroll in the short-term disability enhanced plan and the long-term disability (LTD) plan during the 60-day period beginning on the first day of the pay period in which your transition occurs. Depending on your hire date, your coverage under the short-term disability enhanced plan and LTD plan will be effective either on the 12-month anniversary of your hire date (for associates hired on or after January 1, 2016) or as of the date you enroll (for associates hired on or before December 31, 2015). At that time you will also be automatically enrolled in company-provided short-term disability basic coverage. If you enroll in the short-term disability enhanced plan or LTD plan at any time after this initial enrollment period, your coverage will not be effective until after an additional 12-month waiting period from the date you enroll. (If you enroll due to a status change event, the waiting period will begin as of the date of the event.)

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

If Your Transition Occurs	When Coverage Is Effective
And you have been continuously employed for less than 90 days	<ul style="list-style-type: none"> • You will have 60 days to enroll from the first day of the pay period in which your transition occurs. • Your coverage will be effective (with the exception of short-term and long-term disability) as follows: <ul style="list-style-type: none"> - If you enroll online or by calling People Services during the 60-day period but before the first day of the month during which your 89th day of continuous employment falls, your effective date will be the first day of the calendar month during which your 89th day of continuous employment falls. - If you enroll online during the 60-day period but after the first day of the month during which your 89th day of continuous employment falls, your effective date will be the date you enroll. However, if you enroll by calling People Services you may choose to have your benefits effective the first day of the month during which your 89th day of continuous employment falls. • Premiums may be deducted from your paycheck on an after-tax basis retroactively to your effective date of coverage if you enroll after your 90th day of continuous employment. • You will be eligible to enroll in medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness and accident insurance. See the respective chapters in this Summary Plan Description for more information. • You will be enrolled automatically in company-paid life insurance on the first day of the calendar month during which your 89th day of continuous employment falls. • If you enroll for optional associate life insurance or optional dependent life insurance for your spouse/partner during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for you and/or your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended. • You will be eligible to enroll in the short-term disability enhanced plan and the long-term disability (LTD) plan during the 60-day period beginning on the first day of the pay period in which your transition occurs. Depending on your hire date, your coverage under the short-term disability enhanced plan and LTD plan will be effective either on the 12-month anniversary of your hire date (for associates hired on or after January 1, 2016) or as of the date you enroll (for associates hired on or before December 31, 2015). At that time you will also be automatically enrolled in company-provided short-term disability basic coverage. If you enroll in the short-term disability enhanced plan or LTD plan at any time after this initial enrollment period, your coverage will not be effective until after an additional 12-month waiting period from the date you enroll. (If you enroll due to a status change event, the waiting period will begin as of the date of the event.)

PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO MANAGEMENT

If Your Transition Occurs	When Coverage Is Effective
<p>And you have been continuously employed for more than 52 weeks and were eligible for medical coverage under the Plan as a part-time hourly associate immediately prior to your transition</p>	<ul style="list-style-type: none"> • You will have 60 days to enroll from the first day of the pay period in which your transition occurs. • Your coverage will be effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll. If you enroll by phone call to People Services, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date. • You will be enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs. • The maximum amount of optional associate life insurance coverage you can select will increase from \$200,000 to \$1,000,000. (If you increase your coverage, Proof of Good Health will be required.) • You will be eligible to enroll in optional dependent life insurance for your spouse/partner and long-term disability (LTD) insurance. See the respective chapters in this Summary Plan Description for more information. • If you enroll for optional dependent life insurance for your spouse/partner during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended. • If you are currently enrolled in medical, dental, vision, AD&D, critical illness and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family as a result of your change in job classification. If you are not currently enrolled in medical, dental, vision, AD&D, critical illness and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next annual enrollment period or until you have a valid status change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types as a part-time hourly or temporary associate. • You will be enrolled automatically in the salaried short-term disability plan effective the first day of the pay period in which your transition occurs.

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO MANAGEMENT (CONTINUED)

If Your Transition Occurs	When Coverage Is Effective
<p>And you have been continuously employed for more than 52 weeks and were not eligible for medical coverage under the Plan as a part-time hourly associate immediately prior to your transition</p>	<ul style="list-style-type: none"> • You will have 60 days to enroll from the first day of the pay period in which your transition occurs. • Your coverage will be effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll; if you enroll by phone call to the People Services Center, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date. • You will be eligible to enroll in medical coverage and long-term disability (LTD). See the respective chapters in this Summary Plan Description for more information. • You will be enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs. • The maximum amount of optional associate life insurance coverage you can select will increase from \$200,000 to \$1,000,000. (If you increase your coverage, Proof of Good Health will be required.) • You will be eligible to enroll in optional dependent life insurance for your spouse/partner. See the Optional dependent life insurance chapter in this Summary Plan Description for more information. • If you enroll for optional dependent life insurance for your spouse/partner during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended. • If you are currently enrolled in dental, vision, AD&D, critical illness and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family as a result of your change in job classification. If you are not currently enrolled in dental, vision, AD&D, critical illness and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next annual enrollment period or until you have a valid status change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types as a part-time hourly or temporary associate. • You will be enrolled automatically in the salaried short-term disability plan effective the first day of the pay period in which your transition occurs.
<p>And you have been continuously employed for less than 52 weeks</p>	<ul style="list-style-type: none"> • You will have 60 days to enroll from the first day of the pay period in which your transition occurs. • Your coverage will be effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll. If you enroll by phone call to the People Services Center, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date. • You will be eligible to enroll in medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness insurance, accident insurance and long-term disability. See the respective chapters in this Summary Plan Description for more information. • You will be enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs. • If you enroll for optional associate life insurance or optional dependent life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for you and/or your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended. • You will be enrolled automatically in the salaried short-term disability plan effective the first day of the pay period in which your transition occurs.

FULL-TIME HOURLY ASSOCIATES TRANSFERRING TO MANAGEMENT

If Your Transition Occurs	When Coverage Is Effective
And you have been continuously employed for 90 days or more	<ul style="list-style-type: none"> • The maximum amount of optional associate life insurance coverage you can select will increase from \$200,000 to \$1,000,000. (If you increase your coverage, Proof of Good Health will be required.) • The terms of your short-term disability coverage will change as follows: <ul style="list-style-type: none"> - You will be enrolled automatically in the salaried short-term disability plan effective the first day of the pay period in which your transition occurs. - Your eligibility for coverage under the short-term disability plan for hourly associates will terminate, effective the first day of the pay period in which your transition occurs. (This includes both short-term disability basic and enhanced coverage, and applies both if you were already covered under the plan or if you were awaiting the start of coverage.)
And you have been continuously employed for less than 90 days	<ul style="list-style-type: none"> • You will have 60 days to enroll from the first day of the pay period in which your transition occurs. • Your coverage will be effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll. If you enroll online, coverage will be effective the date you enroll; if you enroll by phone call to the People Services Center, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums will be deducted from your paycheck on an after-tax basis retroactively to your effective date. • You will be eligible to enroll in medical, dental, vision, AD&D, optional associate and dependent life insurance and long-term disability insurance, critical illness and accident insurance. See the respective chapters in this Summary Plan Description for more information. • If you enroll for optional associate life insurance or optional dependent life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for you and/or your spouse/partner. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required to increase any coverage above your guaranteed issue amount outside of your initial enrollment period. • The terms of your short-term disability coverage will change as follows: <ul style="list-style-type: none"> - You will be enrolled automatically in the salaried short-term disability plan effective the first day of the pay period in which your transition occurs. - Your eligibility for coverage under the short-term disability plan for hourly associates will terminate, effective the first day of the pay period in which your transition occurs. (This includes both short-term disability basic and enhanced coverage, and applies both if you were already covered under the plan or if you were awaiting the start of coverage.)

FULL-TIME HOURLY VISION CENTER MANAGERS TRANSFERRING TO MANAGEMENT

	When Coverage Is Effective
	<ul style="list-style-type: none"> • The terms of your short-term disability coverage will change as follows: <ul style="list-style-type: none"> - You will be enrolled automatically in the salaried short-term disability plan effective the first day of the pay period in which your transition occurs. - Your eligibility for coverage under the short-term disability plan for hourly associates will terminate, effective the first day of the pay period in which your transition occurs. (This includes both short-term disability basic and enhanced coverage, and applies both if you were already covered under the plan or if you were awaiting the start of coverage.)

MANAGEMENT ASSOCIATES AND METRO PROFESSIONAL NON-EXEMPT ASSOCIATES TRANSFERRING TO FULL-TIME HOURLY

If Your Transition Occurs	When Coverage Is Effective
<p>Within 60 days of your hire date and before you have enrolled for benefits</p>	<ul style="list-style-type: none"> You will have 60 days to enroll from the date your transition in status occurs. The terms of your benefit plans as a full-time hourly associate will be effective as of the date of your transition in status. You can find details about benefits available to full-time hourly associates in the Enrollment and effective dates by job classification charts earlier in this chapter. Premiums will be deducted from your paycheck on an after-tax basis retroactively to your coverage effective date. Salaried short-term disability coverage will be canceled effective the first day of the pay period in which your transition occurs. You will automatically be enrolled in company-provided short-term disability basic coverage for hourly associates as of the first day of the pay period in which your transition occurs (except in California, Rhode Island, Hawaii and New Jersey, where state-mandated short-term disability laws apply). You will be eligible to enroll in the short-term disability enhanced plan (where available) and the long-term disability plan (associates in New York will be able to enroll in the New York short-term disability enhanced plan). See the Short-term disability for hourly associates chapter for more information. If you enroll for optional associate life insurance or optional dependent life insurance, your guaranteed issue amount will become effective on your enrollment date. If you enroll for more than the guaranteed issue amount, you will have to provide Proof of Good Health for you and/or your spouse/partner, as applicable. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended.
<p>Within 60 days of your hire date and after you have enrolled for benefits</p>	<ul style="list-style-type: none"> You will have 60 days to make a new enrollment from the date your transition in status occurs. The terms of your benefit plans as a full-time hourly associate will generally be effective as of the date of your transition in status. You can find details about benefits available to full-time hourly associates in the Enrollment and effective dates by job classification charts earlier in this chapter. Premiums will be deducted from your paycheck as of your coverage effective date for any new benefit election you make. For benefit plans in which you were already enrolled, premiums will be adjusted to your full-time hourly status on an after-tax basis retroactively to the date of your transition in status. Optional associate life insurance amounts selected over \$200,000 will be reduced to \$200,000. If you were not previously enrolled in optional associate life insurance or optional dependent life insurance and choose to enroll in either plan after your transition in status, your guaranteed issue amount will be effective as of your enrollment date. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended. Salaried short-term disability coverage will be canceled effective the first day of the pay period in which your transition occurs. You will automatically be enrolled in company-provided short-term disability basic coverage for hourly associates as of the first day of the pay period in which your transition occurs (except in California, Rhode Island, Hawaii and New Jersey, where state-mandated short-term disability laws apply). You will be eligible to enroll in the short-term disability enhanced plan (where available) and the long-term disability plan (associates in New York will be able to enroll in the New York short-term disability enhanced plan). See the Short-term disability for hourly associates chapter for more information.

(Continued on the next page)

MANAGEMENT ASSOCIATES AND METRO PROFESSIONAL NON-EXEMPT ASSOCIATES TRANSFERRING TO FULL-TIME HOURLY (CONTINUED)

If Your Transition Occurs	When Coverage Is Effective
<p>More than 60 days after your hire date</p>	<ul style="list-style-type: none"> • If you are currently enrolled for benefits, you will have 60 days to make a new enrollment from the date your transition occurs. The terms of your benefit plans as a full-time hourly associate will be effective as of the date of your transition in status. You can find details about benefits available to full-time hourly associates in the Enrollment and effective dates by job classification charts earlier in this chapter. You can make limited changes only in plans you're already enrolled in. You cannot add or drop benefits until the next annual enrollment period or until you have a valid status change event. If you are not currently enrolled for benefits, you cannot enroll until the next annual enrollment period or until you have a valid status change event. • Optional associate life insurance amounts selected over \$200,000 will be reduced to \$200,000. • You may enroll in optional associate life insurance or optional dependent life insurance at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended. • Salaried short-term disability coverage will be canceled effective the first day of the pay period in which your transition occurs. • You will automatically be enrolled in company-provided short-term disability basic coverage for hourly associates as of the first day of the pay period in which your transition occurs (except in California, Rhode Island, Hawaii and New Jersey, where state-mandated short-term disability laws apply). You will be eligible to enroll in the short-term disability enhanced plan (where available) and the long-term disability plan (associates in New York will be able to enroll in the New York short-term disability enhanced plan). If you had not enrolled for benefits before your transition in status, your coverage under the LTD plan will not be effective until the 12-month anniversary of your hire date. See the Short-term disability for hourly associates and Long-term disability chapters for more information.

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

If Your Transition Occurs	When Coverage Is Effective
<p>And you have met your eligibility waiting period and were eligible for coverage under the Plan immediately prior to your transition</p>	<ul style="list-style-type: none"> • If you are enrolled in medical, dental, vision, AD&D, critical illness and/or accident insurance coverage, your coverage type will automatically be adjusted to associate-only or associate + child(ren) (depending on whether you have covered dependents) effective the first day of the pay period after your transition occurs. Associate + spouse/partner and associate + family coverage are not available to part-time associates. • Company-paid life, dependent life for your spouse/partner and disability coverage will be canceled effective the first day of the pay period after your transition occurs. You may be able to convert your company-paid life insurance and your dependent's life insurance to individual policies.
<p>But you have NOT met your eligibility waiting period</p>	<ul style="list-style-type: none"> • You will have 60 days to enroll from the first day of the pay period in which your transition occurs. • Your coverage will be effective as follows: <ul style="list-style-type: none"> - If you enroll online or by calling People Services during the 60-day period but before the first day of the month during which your 89th day of continuous employment falls, your effective date will be the first day of the calendar month during which your 89th day of continuous employment falls. - If you enroll online during the 60-day period but after the first day of the month during which your 89th day of continuous employment falls, your effective date will be the date you enroll. However, if you enroll by calling People Services, you may choose to have your benefits effective the first day of the month during which your 89th day of continuous employment falls. • Premiums may be deducted from your paycheck on an after-tax basis retroactively to your effective date of coverage if you enroll after your 90th day of continuous employment. • You will be eligible to enroll in medical, dental, vision, AD&D, optional associate life insurance and dependent life insurance for your children, critical illness and accident insurance. See the respective chapters in this Summary Plan Description for more information. • If you enroll for optional associate life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health. Your coverage will be effective upon approval by Prudential. You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended. • If you enrolled in the short-term disability enhanced plan for hourly associates during your initial enrollment period but you have not reached the 12-month anniversary of your hire date, coverage under the plan will not take effect as of that date. • If you enrolled in the LTD or LTD enhanced plan during your initial enrollment period, coverage will not take effect. • You will be eligible to enroll in associate-only or associate + child(ren) coverage types.

MANAGEMENT ASSOCIATES TRANSFERRING TO PART-TIME HOURLY OR TEMPORARY

If Your Transition Occurs	When Coverage Is Effective
Within 60 days of your hire date and before you have enrolled for benefits	<ul style="list-style-type: none"> You will have 60 days to enroll from the date your transition in status occurs. You can find details about benefits for part-time hourly and temporary associates in the Enrollment and effective dates by job classification charts earlier in this chapter. Premiums will be deducted from your paycheck on an after-tax basis retroactively to your coverage effective date. Company-paid life coverage and disability coverage will be canceled effective the first day of the pay period after your transition occurs. You may be able to convert your company-paid life insurance to an individual policy.
Within 60 days of your hire date and after you have enrolled for benefits	<ul style="list-style-type: none"> You will have 60 days to make a new enrollment from the date your transition in status occurs. You can find details about benefits for part-time hourly and temporary associates in the Enrollment and effective dates by job classification charts earlier in this chapter. Premiums will be adjusted to your new benefit elections on an after-tax basis retroactively to your coverage effective date. Optional associate life insurance amounts selected over \$200,000 will be reduced to \$200,000. Company-paid life, optional dependent life for your spouse/partner and disability coverage will be canceled effective the first day of the pay period after your transition occurs. You may be able to convert your company-paid life insurance and your dependent's life insurance to individual policies.
More than 60 days after your hire date	<ul style="list-style-type: none"> If you are currently enrolled for benefits, you will have 60 days to make a new enrollment from the date your transition in status occurs. The terms of your benefit plans as a part-time hourly or temporary associate will be effective as of the date of your transition. You can find details about benefits for part-time hourly and temporary associates in the Enrollment and effective dates by job classification charts earlier in this chapter. You can make limited changes only in plans you're already enrolled in. You cannot add or drop benefits until the next annual enrollment period or until you have a valid status change event. If you are not currently enrolled for benefits, you cannot enroll until the next annual enrollment period or until you have a valid status change event. Optional associate life insurance amounts selected over \$200,000 will be reduced to \$200,000. Company-paid life, optional dependent life for your spouse/partner and disability coverage will be canceled effective the first day of the pay period after your transition occurs. You may be able to convert your company-paid life insurance and your dependent's life insurance to individual policies.

You will have 60 days from the date of your transition to a part-time hourly, temporary or part-time truck driver position to elect any other medical coverage option available to you and/or your dependents under the Plan. You may not drop medical, dental, AD&D, critical illness, accident or vision coverage for yourself and/or your dependent children during the Plan year. If you do not elect to change your coverage option within the 60-day enrollment period, you will continue to be covered by the same full-time medical option, but excluding spouse/partner coverage. You may change elections during any future annual enrollment period or as the result of a status change event.

Qualified Medical Child Support Orders (QMCSO)

A QMCSO is a final court or administrative agency order that requires an associate or other parent or guardian to provide health care coverage for eligible dependents after a divorce or child custody proceeding. Federal law requires the Plan to provide medical, dental and/or vision benefits to any eligible dependent of a Plan participant required by a court order meeting the qualifications of a QMCSO.

The written procedures for determining whether an order meets the federal requirements may be obtained free of charge by contacting Medical Support Services at **877-930-5607**.

Once the Plan determines an order to be a QMCSO, coverage will begin the first day of the pay period in which the Plan receives the order, unless another date is specified in the order. Associates who are eligible for the medical, dental and/or vision plan and who did not elect coverage before the order was received will be enrolled in the 2018 default HRA Plan with associate + child(ren) coverage at the tobacco rate, unless the QMCSO specifies otherwise. For associates in the state of Hawaii, the default plan is Health Plan Hawaii (HMSA). For associates in a location where the eComm PPO Plan is offered, the default plan is the HSA Plan.

If you were enrolled for coverage before the order was received, your child will be added under your existing coverage, except if you are enrolled in an HMO plan, the Accountable Care Plan, or the Select Network Plan; if you are enrolled for coverage in any of these plans, your coverage will change to the HRA Plan, under which the child would have coverage regardless of where he or she lives. If you are in the state of Hawaii, your coverage will change to HMSA. You will have 60 days to call Medical Support Services at **877-930-5607** to select an alternative medical plan.

If the Plan receives a QMCSO 61–90 days prior to you satisfying your initial waiting period, the order will be put into effect when your initial waiting period is satisfied. If the Plan receives a QMCSO more than 90 days prior to you satisfying your initial waiting period, the order will be held until coverage takes effect.

When the Third Party Administrator is administering coverage for a court-ordered dependent, information regarding the court-ordered dependent will be shared only with the legal custodian. If you have questions, please contact Medical Support Services at **877-930-5607**.

DROPPING OR CHANGING QMCSO COVERAGE

You may drop the court-ordered coverage that was put into effect due to a QMCSO if the following applies:

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

The court-ordered coverage will end on the first day of the pay period in which the Plan receives the order or the date specified in the order. If the order to rescind coverage is received, coverage will be retroactively withdrawn and you will be returned to the coverage that you had before the QMCSO was enforced (or no coverage if you had no coverage prior to enforcement of the QMCSO), to the extent permitted by law.

When a QMCSO terminates, an associate may drop medical, dental and/or vision coverage for the children named in the QMCSO. However, you may not drop your own coverage or coverage for any dependent voluntarily added after the QMCSO became effective unless there is a change in status for you or your child(ren), or during annual enrollment. For dental coverage, you may not drop associate-level coverage at annual enrollment or due to a status change event, unless you have been covered for two full calendar years.

When your Plan coverage ends

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

- At termination of your employment
- The last day of coverage for which premiums were paid, if you fail to pay your premiums within 30 days of the date your premium is due
- On the date of your (the associate's) death, for you and your dependents
- On the date of death for a deceased dependent
- On the date you, a dependent spouse/partner or child loses eligibility
- When the benefit is no longer offered by Walmart
- Upon misrepresentation or the fraudulent submission of a claim for benefits or eligibility
- Upon an act of fraud or a misstatement of a material fact, or
- The day after you drop coverage.

Remember that premium deductions will be withheld from your final paycheck since your deductions are paying for coverage for the previous two weeks.

Eligibility and benefits for associates in Hawaii

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Eligibility and benefits for associates in Hawaii

As an associate in Hawaii, you have special rules for enrolling in the medical plan and two medical plan options: Health Plan Hawaii (HMSA) and the Kaiser Foundation Health Plan. Because Hawaii has a state-mandated disability plan, the company short-term disability plan for hourly associates is not an option for associates in Hawaii. Other than the eligibility and benefit differences described in this chapter, the information in this 2018 *Associate Benefits Book* applies to you.

RESOURCES FOR HAWAII ASSOCIATES

Find What You Need	Online	Other Resources
Health Plan Hawaii (HMSA)	Go to hmsa.com	808-948-6372
Kaiser Foundation Health Plan	Go to kaiserpermanente.org	800-966-5955
Enroll in Walmart benefits	Go to the WIRE , WalmartOne.com or Workday	Call People Services at 800-421-1362
Report a claim under the state-mandated disability insurance program	Go to WalmartOne.com or directly to MyLincolnPortal.com (formerly MyLibertyConnection.com)	Call Lincoln (formerly Liberty) at 800-492-5678
Notify People Services within 60 days of a status change event, such as a dependent losing eligibility under the Plan	Go to the WIRE , WalmartOne.com or Workday	Call People Services at 800-421-1362

What you need to know as a Hawaii associate

- Associates in Hawaii have varying initial eligibility periods for coverage based on their employment status, as described in this chapter.
- Associates in Hawaii have two medical coverage options: Health Plan Hawaii (HMSA) and the Kaiser Foundation Health Plan. For more information about these medical options, see your personnel representative.

Eligibility waiting periods for medical coverage

MANAGEMENT ASSOCIATES

For management associates in Hawaii, the eligibility terms described in the [Eligibility and enrollment](#) chapter are applicable; management associates and management trainees in Hawaii are eligible for medical coverage on their date of hire. For details on eligibility and enrollment in all of the benefits available under the Associates' Health and Welfare Plan, refer to the chart for management associates in the [Enrollment and effective dates by job classification](#) section of the [Eligibility and enrollment](#) chapter.

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

Full-time hourly associates (including full-time hourly pharmacists and field supervisor positions in stores and clubs) and part-time hourly and temporary associates in Hawaii are subject to state-mandated rules governing eligibility for medical coverage. For benefits other than medical, they follow the eligibility terms described in the [Eligibility and enrollment](#) chapter. For details, refer to the appropriate chart under [Enrollment and effective dates for Hawaii associates](#) later in this chapter.

Medical coverage options for Hawaii associates

Associates in Hawaii have two coverage options:

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

For specific information about these medical options, see your personnel representative.

Paying premiums during a leave of absence for Hawaii associates

Because the associate portion of your medical premium is wage-based, there will be no premium due if you are not receiving wages during an approved leave of absence. The only premium due for medical coverage while you are on an approved leave of absence with no wages will be the dependent portion of your premium. All other coverage options require payment as described in the [Eligibility and enrollment](#) chapter.

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

Enrollment and effective dates for Hawaii associates

FULL-TIME HOURLY ASSOCIATES

Includes full-time hourly pharmacists and field supervisor positions in stores and clubs

Plan	Enrollment Periods and Effective Dates
<ul style="list-style-type: none"> Medical 	<p>Initial enrollment period: Between the date of your first paycheck and the day prior to your effective date, as described immediately below.</p> <p>When coverage is effective: The earlier of:</p> <ul style="list-style-type: none"> The first day of the pay period following a period of working at least 20 hours per week for four consecutive weeks, or The first day of the calendar month during which your 89th day of continuous full-time employment falls.
<ul style="list-style-type: none"> Vision Dental (enrollment is for two full calendar years) AD&D Critical illness insurance Accident insurance 	<p>Initial enrollment period: Between the date of your first paycheck and the day prior to your effective date, as described immediately below.</p> <p>When coverage is effective:</p> <ul style="list-style-type: none"> The first day of the calendar month during which your 89th day of continuous full-time employment falls.
<ul style="list-style-type: none"> Company-paid life insurance 	<p>Automatically enrolled on the first day of the calendar month during which your 89th day of continuous full-time employment falls.</p>
<ul style="list-style-type: none"> Business travel accident insurance Resources for Living 	<p>Automatically enrolled on your date of hire.</p>
<ul style="list-style-type: none"> Optional associate life insurance Optional dependent life insurance 	<p>Initial enrollment period: Between the date of your first paycheck and the day prior to your effective date, as described immediately below.</p> <p>When coverage is effective:</p> <ul style="list-style-type: none"> If you enroll during your initial enrollment period: Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is the first day of the calendar month during which your 89th day of continuous full-time employment falls.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for yourself and/or your spouse/partner. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later. If you enroll after your initial enrollment period: You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential.
<ul style="list-style-type: none"> Long-term disability (LTD) plan LTD enhanced plan 	<p>Initial enrollment period: Between the date of your first paycheck and the first day of the calendar month during which your 89th day of continuous full-time employment falls.</p> <p>When coverage is effective:</p> <ul style="list-style-type: none"> If your hire date is December 31, 2015 or before, and: <ul style="list-style-type: none"> You enroll during your initial enrollment period: Coverage is effective as of the first day of the calendar month during which your 89th day of continuous full-time employment falls. You enroll after your initial enrollment period: Coverage is effective after a 12-month waiting period from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.) If your hire date is January 1, 2016 or after, and: <ul style="list-style-type: none"> You enroll during your initial enrollment period: Coverage is effective as of your 12-month anniversary date. You enroll after your initial enrollment period: Coverage is effective after a 12-month waiting period from the date you enroll. (If you enroll after a status change event, the waiting period begins as of the date of the event.)

PART-TIME HOURLY AND TEMPORARY ASSOCIATES

Plan	Enrollment Periods and Effective Dates
<ul style="list-style-type: none"> Medical* 	<p>Initial enrollment period: Between the date of your first paycheck and the day prior to your effective date, as described immediately below.</p> <p>When coverage is effective: The earlier of:</p> <ul style="list-style-type: none"> The first day of the pay period following a period of working at least 20 hours per week for four consecutive weeks, or The first day of the calendar month during which your 89th day of continuous employment falls. <p>* Part-time hourly and temporary associates in Hawaii are not subject to the requirements described under Part-time hourly and temporary associates: eligibility checks for medical coverage in the Eligibility and enrollment chapter.</p>
<ul style="list-style-type: none"> Vision Dental (enrollment is for two full calendar years) AD&D Critical illness insurance Accident insurance 	<p>Initial enrollment period: Between the date of your first paycheck and the day prior to your effective date, as described immediately below.</p> <p>When coverage is effective: The first day of the calendar month during which your 89th day of continuous employment falls.</p>
<ul style="list-style-type: none"> Business travel accident insurance Resources for Living 	Automatically enrolled on your date of hire.
<ul style="list-style-type: none"> Optional associate life insurance Optional dependent life insurance 	<p>Initial enrollment period: Between the date of your first paycheck and the day prior to your effective date, as described immediately below.</p> <p>When coverage is effective:</p> <ul style="list-style-type: none"> If you enroll during your initial enrollment period: Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. (Your eligibility date is the first day of the calendar month during which your 89th day of continuous employment falls.) If you enroll for more than the guaranteed issue amount, you will have to complete Proof of Good Health for yourself and/or your spouse/partner. Your coverage will be effective upon approval by Prudential or on your benefits eligibility date, whichever is later. If you enroll after your initial enrollment period: You may enroll or drop coverage at any time during the year, but Proof of Good Health will be required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage will be effective upon approval by Prudential.

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

Management associates: Refer to the chart for management associates in the [Enrollment and effective dates by job classification](#) section of the [Eligibility and enrollment](#) chapter.


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The medical plan

ASSOCIATES' MEDICAL PLAN RESOURCES

Find What You Need	Online	By Phone: Health Care Advisor	Other Resources
Third Party Administrator Aetna	Go to WalmartOne.com or aetna.com	855-548-2387	Aetna 151 Farmington Avenue Hartford, Connecticut 06156
BlueAdvantage Administrators of Arkansas	blueadvantagearkansas.com	866-823-3790	BlueAdvantage Administrators of Arkansas P.O. Box 1460 Little Rock, Arkansas 72203-1460
HealthSCOPE Benefits	healthscopebenefits.com	800-804-1272	HealthSCOPE Benefits P.O. Box 16367 Lubbock, Texas 79490-6367
UnitedHealthcare	myuhc.com	888-285-9255	UnitedHealthcare P.O. Box 30555 Salt Lake City, Utah 84130-0555
Locate a network provider	Go to the WIRE or WalmartOne.com	Call your health care advisor at the number on your plan ID card	
If you have questions about how your medical benefits are administered		Call your health care advisor at the number on your plan ID card	
Get the cost for medical coverage	Go to the WIRE or WalmartOne.com	Call People Services at 800-421-1362	
Medical advice from a registered nurse, available 24/7		Call your health care advisor at the number on your plan ID card	
For information on the Walmart Centers of Excellence program	Go to the WIRE or WalmartOne.com	Call your health care advisor at the number on your plan ID card	
For information on telehealth options	Go to the WIRE or WalmartOne.com	Call your health care advisor at the number on your plan ID card	
For information on the Walmart Care Clinic	WalmartCareClinic.com	Call People Services at 800-421-1362	
Castlight Health: For help finding medical care based on cost information and user reviews	Go to the WIRE or WalmartOne.com or directly to MyCastlight.com/Walmart	Call your health care advisor at the number on your plan ID card	 See page 285
For guidance from the Life with Baby program or comparable maternity program		Call your health care advisor at the number on your plan ID card	
Request a paper copy of this 2018 Associate Benefits Book		Call People Services at 800-421-1362	

What you need to know about medical benefits


- Under the Associates' Medical Plan, most eligible associates have the option to choose medical coverage under the HRA High Plan, the HRA Plan or the HSA Plan. In select regions, the HRA High Plan option is replaced by an Accountable Care Plan or by the Select Network Plan. This chapter describes how all these plans function and where they are available. If you have questions about how your medical benefits are administered, call your health care advisor at the number on your plan ID card.
- If you enroll in any of the plan options available under the Associates' Medical Plan, you'll be able to call your health care advisor — a single point of contact for a wide range of health benefit needs. This expert resource can help you work with network doctors and answer questions about your health care benefits. Plus, in some cases you'll be assigned a single, dedicated nurse care manager to help with all of your family's medical needs and questions.
- The HRA High Plan and the HRA Plan include a Health Reimbursement Account (HRA). An HRA is an "account" to which the company allocates a specified sum of money to help pay your eligible medical expenses before you have to pay for care out of your own pocket. (Your HRA is used to pay for all eligible care except for prescription drugs.) This chapter describes how company-provided dollars allocated to your HRA can help pay for eligible medical expenses.
- The HSA Plan allows you to open a Health Savings Account where you can make contributions through payroll deduction, which you can save or use to pay for eligible medical expenses (as defined by the IRS) on a tax-free basis. Walmart will match your contributions up to predetermined limits. For more information about a Health Savings Account, see the [Health Savings Account](#) chapter.
- The plan options available under the Associates' Medical Plan have no annual or lifetime maximum dollar limits.
- The Associates' Medical Plan does not have a pre-existing condition limitation.
- Walmart also offers HMO (Health Maintenance Organization) plans in 12 states and the District of Columbia. Refer to your personnel representative to find out if an HMO is available in your area and to request HMO plan information.
- Walmart also offers the eComm PPO Plan to associates in some locations. If the eComm PPO Plan is available at your work location, the plan benefits and terms are described in materials provided separately by Aetna, the Plan's Third Party Administrator.
- The Associates' Medical Plan provides prescription drug coverage through the pharmacy benefit. For more information, see [The pharmacy benefit](#) chapter.
- For information on benefits for localized associates, see [Localized associates](#) in the [Eligibility and enrollment](#) chapter.

The Associates' Medical Plan

The Associates' Medical Plan offers most eligible associates the option to enroll in one of three medical plan options that are generally available nationwide: the HRA High Plan, the HRA Plan and the HSA Plan. The Associates' Medical Plan also offers an Accountable Care Plan option to associates in select regions and the Select Network Plan to associates in select regions. Associates in regions served by an Accountable Care Plan or the Select Network Plan will not have access to the HRA High Plan, with the exception of portions of Arkansas, where the HRA High Plan will remain available. See your enrollment materials for details.

The chart below summarizes the coverage offered by the HRA High Plan, the HRA Plan and the HSA Plan. The charts on the next several pages summarize the coverage offered by the Accountable Care Plan options and the Select Network Plan. The sections that follow explain the important features of all the available plan options.

NATIONALLY AVAILABLE MEDICAL PLAN OPTIONS

	HRA High Plan		HRA Plan		HSA Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual deductible Associate only Associate + dependent(s) <i>Applies for all services except as noted</i> <i>Does not apply to eligible preventive care</i>	\$1,750 \$3,500	\$3,500 \$7,000	\$2,750 \$5,500	\$5,500 \$11,000	\$3,000 \$6,000	\$6,000 \$12,000
Walmart-provided dollars Associate only Associate + dependent(s)	\$500 \$1,000 <i>Maximum company contribution to HRA</i>		\$300 \$600		\$350 \$700 <i>Maximum company matching contribution to Health Savings Account</i>	
Annual out-of-pocket maximum	\$6,850 Per person \$13,700 Per family	None	\$6,850 Per person \$13,700 Per family	None	\$6,650 Per person \$13,300 Per family	None
Eligible preventive care	100% <i>No deductible</i>	50% <i>No deductible</i>	100% <i>No deductible</i>	50% <i>No deductible</i>	100% <i>No deductible</i>	50% <i>No deductible</i>
Doctor visits and diagnostic tests	75% <i>After deductible</i>	50% <i>After deductible</i>	75% <i>After deductible</i>	50% <i>After deductible</i>	75% <i>After deductible</i>	50% <i>After deductible</i>
Hospitalization Inpatient, emergency, outpatient	75% <i>After deductible</i>	50% <i>After deductible</i>	75% <i>After deductible</i>	50% <i>After deductible</i>	75% <i>After deductible</i>	50% <i>After deductible</i>
Behavioral health (Inpatient and outpatient)	75% <i>After deductible</i>	50% <i>After deductible</i>	75% <i>After deductible</i>	50% <i>After deductible</i>	75% <i>After deductible</i>	50% <i>After deductible</i>
Telehealth video visits (Doctor On Demand)	75% <i>After deductible</i>	N/A	75% <i>After deductible</i>	N/A	75% <i>After deductible</i>	N/A
 See page 285 for new cost-sharing terms effective Jan. 1, 2019						
Pharmacy	See The pharmacy benefit chapter for details about your prescription drug coverage.					
Centers of Excellence	See the Centers of Excellence section of this chapter for details.					
Walmart Care Clinic	See the Walmart Care Clinic section of this chapter for details.					

THE ACCOUNTABLE CARE PLAN OPTIONS

Accountable Care Plan options are available to associates who work in designated regions, and their dependents, as listed in the following chart:

PLAN	AVAILABLE FOR ASSOCIATES WHO WORK AT DESIGNATED FACILITIES IN THESE AREAS	THIRD PARTY ADMINISTRATOR
Banner Accountable Care Plan	Phoenix, Arizona metropolitan area	Aetna
Emory Accountable Care Plan	Atlanta, Georgia metropolitan area	HealthSCOPE Benefits
Mercy Arkansas Accountable Care Plan	Portions of Arkansas and McDonald County, Missouri	HealthSCOPE Benefits
Mercy Oklahoma Accountable Care Plan	Oklahoma City metropolitan area, Ada, and Ardmore areas	HealthSCOPE Benefits
Mercy Springfield Accountable Care Plan	Springfield, southwest and east-central Missouri	HealthSCOPE Benefits
Mercy St. Louis Accountable Care Plan	St. Louis metropolitan area and portions of eastern Missouri	HealthSCOPE Benefits
Presbyterian Accountable Care Plan	Albuquerque and Santa Fe, New Mexico metropolitan areas	UnitedHealthcare
St. Luke's Accountable Care Plan	Boise, Idaho metropolitan area	Aetna
UnityPoint Accountable Care Plan	Portions of Iowa, western Illinois and Peoria, Illinois area	HealthSCOPE Benefits



See page 285 for information on new Accountable Care Plan options effective Jan. 1, 2019 in the Houston, Texas area and in the Baton Rouge, New Orleans, and Slidell, Louisiana areas.

The Accountable Care Plan options are served by groups of providers who offer care that is specifically coordinated to the needs of participants to ensure that covered individuals get the right high-quality care at the right time. The Plan's terms for paying providers for their services may include financial incentives to manage care. Additional information about the Accountable Care options and where they are available can be found under [The Accountable Care Plan](#) later in this chapter.


The following charts summarize the coverage available under the Accountable Care Plan options. In the designated areas where an Accountable Care Plan option is available, it will generally replace the HRA High Plan as a coverage option for associates who work at facilities in those areas. In other words, if you elect medical coverage under the Associates' Medical Plan in any of these areas, you will be

able to choose coverage under the HRA Plan, the HSA Plan or the Accountable Care Plan, but in most areas you will not be able to choose the HRA High Plan. The exception is portions of Arkansas, where an Accountable Care Plan option is available and associates will continue to have access to the HRA High Plan.

The Accountable Care Plan does not cover the services of doctors, hospitals or other providers who are not in the Accountable Care Plan's network, except in cases of emergency (as defined by the Third Party Administrator). Note, however, that participants enrolled in an Accountable Care Plan option are eligible to participate in the Centers of Excellence program.

For details about coverage under the Accountable Care Plan options, see [The Accountable Care Plan](#) later in this chapter.

BANNER ACCOUNTABLE CARE PLAN

	In-Network Benefits Only <i>No benefits for services provided outside the network except for emergency services</i>
Annual deductible Associate only Associate + dependent(s) <i>Does not apply to eligible preventive care</i>	 \$3,000 \$6,000
Annual out-of-pocket maximum	\$6,850 Per person \$13,700 Per family
Eligible preventive care	100% <i>No deductible</i>
Doctor visits <i>Including routine same-day diagnostic x-rays and tests performed in the doctor's office</i> Primary care physician (PCP) office visit Specialist office visit Behavioral health office visit Urgent care visit	 \$35 copay \$75 copay \$35 copay \$75 copay
Diagnostic tests All nonpreventive tests ordered or performed outside a doctor's office	75% <i>After deductible</i>
Hospitalization Inpatient, emergency, outpatient	75% <i>After deductible</i>
Behavioral health Inpatient and outpatient <i>See above for doctor visits</i>	75% <i>After deductible</i>
Telehealth video visits (Doctor On Demand)	75% <i>After deductible</i>
	 See page 285 for new cost-sharing terms effective Jan. 1, 2019
Pharmacy	See The pharmacy benefit chapter for details.
Centers of Excellence	See the Centers of Excellence section of this chapter for details.
Walmart Care Clinic	See the Walmart Care Clinic section of this chapter for details.


EMORY, MERCY ARKANSAS, MERCY OKLAHOMA, MERCY ST. LOUIS, ST. LUKE'S AND UNITYPOINT ACCOUNTABLE CARE PLANS
EFFECTIVE JAN. 1, 2019: MEMORIAL HERMANN AND OCHSNER ACCOUNTABLE CARE PLANS

See page 285

	In-Network Benefits Only <i>No benefits for services provided outside the network except for emergency services</i>
Annual deductible Associate only Associate + dependent(s) <i>Does not apply to eligible preventive care</i>	 \$1,750 \$3,500
Annual out-of-pocket maximum	\$6,850 Per person \$13,700 Per family
Eligible preventive care	100% <i>No deductible</i>
Doctor visits* <i>Including routine same-day diagnostic x-rays and tests performed in the doctor's office</i> Primary care physician (PCP) office visit Specialist office visit* Behavioral health office visit Urgent care visit	 \$35 copay \$75 copay \$35 copay \$75 copay
Diagnostic tests All nonpreventive tests ordered or performed outside a doctor's office	75% <i>After deductible</i>
Hospitalization Inpatient, emergency, outpatient	75% <i>After deductible</i>
Behavioral health Inpatient and outpatient <i>See above for doctor visits</i>	75% <i>After deductible</i>
Telehealth video visits (Doctor On Demand)	75% <i>After deductible</i>
	See page 285 for new cost-sharing terms effective Jan. 1, 2019
Pharmacy	See The pharmacy benefit chapter for details.
Centers of Excellence	See the Centers of Excellence section of this chapter for details.
Walmart Care Clinic	See the Walmart Care Clinic section of this chapter for details.


*The Mercy Accountable Care Plans for Arkansas, Oklahoma and St. Louis, Missouri offer limited coverage for chiropractic care office visits. There is a maximum of 10 visits per calendar year.

MERCY SPRINGFIELD ACCOUNTABLE CARE PLAN

	In-Network Benefits Only <i>No benefits for services provided outside the network except for emergency services</i>
Annual deductible Associate only Associate + dependent(s) <i>Does not apply to eligible preventive care</i>	\$3,000 \$6,000
Annual out-of-pocket maximum	\$6,850 Per person \$13,700 Per family
Eligible preventive care	100% <i>No deductible</i>
Doctor visits <i>Including routine same-day diagnostic x-rays and tests performed in the doctor's office</i> Primary care physician (PCP) office visit Specialist office visit* Behavioral health office visit Urgent care visit	\$35 copay \$75 copay \$35 copay \$75 copay
Diagnostic tests All nonpreventive tests ordered or performed outside a doctor's office	75% <i>After deductible</i>
Hospitalization Inpatient, emergency, outpatient	75% <i>After deductible</i>
Behavioral health Inpatient and outpatient <i>See above for doctor visits</i>	75% <i>After deductible</i>
Telehealth video visits (Doctor On Demand)	75% <i>After deductible</i>
	 See page 285 for new cost-sharing terms effective Jan. 1, 2019
Pharmacy	See The pharmacy benefit chapter for details.
Centers of Excellence	See the Centers of Excellence section of this chapter for details.
Walmart Care Clinic	See the Walmart Care Clinic section of this chapter for details.

*The Mercy Springfield Accountable Care Plan offers limited coverage for chiropractic care office visits. There is a maximum of 10 visits per calendar year.

PRESBYTERIAN ACCOUNTABLE CARE PLAN

	In-Network Benefits Only	
	<i>No benefits for services provided outside the network except for emergency services</i>	
Annual deductible Associate only Associate + dependent(s) <i>Does not apply to eligible preventive care</i>	\$3,000 \$6,000	
Annual out-of-pocket maximum	\$6,850 Per person \$13,700 Per family	
Eligible preventive care	100% <i>No deductible</i>	
Doctor visits* <i>Including routine same-day diagnostic x-rays and tests performed in the doctor's office</i>	Presbyterian Tier 1	Presbyterian Tier 2
Primary care physician (PCP) office visit	\$35 copay	75% <i>After deductible</i>
Specialist office visit	\$75 copay	
Behavioral health office visit	\$35 copay	
Urgent care visit	\$75 copay	
Diagnostic tests All nonpreventive tests ordered or performed outside a doctor's office	75% <i>After deductible</i>	
Hospitalization Inpatient, emergency, outpatient	75% <i>After deductible</i>	
Behavioral health Inpatient and outpatient <i>See above for doctor visits</i>	75% <i>After deductible</i>	
Telehealth video visits (Doctor On Demand)	75% <i>After deductible</i>	
	 See page 285 for new cost-sharing terms effective Jan. 1, 2019	
Pharmacy	See The pharmacy benefit chapter for details.	
Centers of Excellence	See the Centers of Excellence section of this chapter for details.	
Walmart Care Clinic	See the Walmart Care Clinic section of this chapter for details.	

*For details about the Presbyterian Accountable Care Plan's network coverage for doctor visits, see **If you have coverage under the Presbyterian Accountable Care Plan** later in this chapter.


THE SELECT NETWORK PLAN

The Select Network Plan is administered by Aetna and available to associates who work in designated regions. The chart below summarizes the coverage under the Plan. In each of the areas where the Select Network Plan is available, it will replace the HRA High Plan as a coverage option for associates. In other words, if you elect medical coverage under the Associates' Medical Plan in any of the areas where the Select Network Plan is available, you will be able to choose coverage under the HRA Plan, the HSA Plan or the Select Network Plan, but you will not be able to choose the HRA High Plan.

The Select Network Plan does not cover the services of doctors, hospitals or other providers who are not in the Select Network (even if they are located in the Select Network Plan's service area), except in cases of emergency (as defined by the Third Party Administrator). Note, however, that participants enrolled in the Select Network Plan are eligible to participate in the Centers of Excellence program.

For details about coverage under the Select Network Plan see [The Select Network Plan](#) later in this chapter.

THE SELECT NETWORK PLAN

	In-Network Benefits Only <i>No benefits for services provided outside the network except for emergency services</i>
Annual deductible Associate only Associate + dependent(s) <i>Does not apply to eligible preventive care</i>	\$2,750 \$5,500
Annual out-of-pocket maximum	\$6,850 Per person \$13,700 Per family
Eligible preventive care	100% <i>No deductible</i>
Doctor visits <i>Including routine same-day diagnostic x-rays and tests performed in the doctor's office</i> Primary care physician (PCP) office visit Specialist office visit Behavioral health office visit Urgent care visit	\$35 copay \$75 copay \$35 copay \$75 copay
Hospitalization	75% <i>After deductible</i>
Behavioral health (Inpatient and outpatient) <i>See above for doctor visits</i>	75% <i>After deductible</i>
Telehealth video visits (Doctor On Demand)	75% <i>After deductible</i>
	 See page 285 for new cost-sharing terms effective Jan. 1, 2019
Pharmacy	See The pharmacy benefit chapter for details.
Centers of Excellence	See the Centers of Excellence section of this chapter for details.
Walmart Care Clinic	See the Walmart Care Clinic section of this chapter for details.

HMO plans

HMO plans are available in some locations, in addition to the plans offered under the Associates' Medical Plan. If an HMO is available at your work location, the plan benefits and terms are described in materials provided separately by the HMO provider. To find out if an HMO is available to you, contact your personnel representative. The policies for HMO plans include different benefits, limitations and exclusions, cost-sharing requirements and other features than the Associates' Medical Plan. (Note that HMOs are not part of the Associates' Medical Plan.) All HMO claim issues should be directed to the HMO for resolution.

In addition, HMO plans may have different eligibility requirements than the Associates' Medical Plan. If you enroll for coverage under an HMO, the HMO plan certificate you receive will describe the HMO's eligibility terms. Please note that if there is any difference between the HMO's eligibility terms and the eligibility terms of the Associates' Medical Plan, the Plan will apply its own eligibility requirements.

Some HMOs require participants to accept an arbitration agreement, where permitted by law, before benefits under the HMO can become effective. Your agreement must be received by the HMO within 60 days of your initial enrollment or your HMO benefits will not take effect.

The eComm PPO Plan

In addition to the medical plans offered under the Associates' Medical Plan, the eComm PPO Plan is available in some locations. If the eComm PPO Plan is available at your work location, the plan benefits and terms are described in materials provided separately by the eComm PPO Plan's Third Party Administrator. The benefits, limitations and exclusions, cost-sharing requirements and other features of the eComm PPO Plan are different from those of the Associates' Medical Plan. (Like the HMO plans, the eComm PPO Plan is not part of the Associates' Medical Plan.) The eComm PPO Plan will apply the eligibility requirements outlined in the [Eligibility and enrollment](#) chapter.

Administration of the Associates' Medical Plan

The Associates' Medical Plan is self-insured. This means there is no insurance company that collects premiums and pays benefits. Instead, participating associates make contributions to cover a portion of the cost of their benefits, and the rest of the cost is paid directly from company assets or from the Plan's Trust.

Walmart contracts with Third Party Administrators (TPAs) to handle administration of the Plan options available under the Associates' Medical Plan: BlueAdvantage Administrators of Arkansas, Aetna Life Insurance Company (Aetna),

UnitedHealthcare and HealthSCOPE Benefits, Inc. Walmart also contracts with Health Design Plus to serve as the Third Party Administrator for certain procedures under the Centers of Excellence program, as described under [Centers of Excellence](#) later in this chapter.

Your work location and the Plan option you select will determine which TPA will administer your coverage under the Associates' Medical Plan. The TPA makes medical claim determinations and processes claims based on the Plan's terms and the TPA's policies and procedures. The TPA also provides a network of providers that accept discounted rates for services they provide to Plan participants. See [Your provider network](#) later in this chapter for further details.

The HRA High Plan, the HRA Plan and the HSA Plan

HOW THE HRA HIGH PLAN AND THE HRA PLAN PAY BENEFITS

The HRA High Plan and the HRA Plan include a Health Reimbursement Account (HRA) that is paid for by the company. Each year, Walmart will allocate money to an HRA for you and any covered family members to use toward the portion of covered medical expenses that is subject to cost-sharing, including the annual deductible. You cannot contribute your own money to the HRA. The Plan will automatically pay your share of covered medical expenses until the HRA is exhausted (except for prescription charges, which cannot be paid for with HRA dollars). The amount your HRA pays toward eligible medical expenses applies toward your network and out-of-network annual deductibles as well as your out-of-pocket maximum.

Your HRA balance (including your Plan year allocation) may not exceed your network annual deductible for the Plan in which you are enrolled. The new Plan year allocation may be used only for services rendered within that Plan year. For example, if you enroll in one of the HRA plans and receive an allocation of HRA funds for 2018, you would be able to use those funds for services rendered in 2018 but not for services rendered prior to 2018 (such as a provider expense that you incurred in 2017 but that was not processed by the TPA until 2018). The HRA rollover balance can be utilized for any service date for which the associate was continuously enrolled in one of the HRA plans.

If you leave the company, cancel your coverage, lose eligibility or change from a plan with an HRA to one without, any funds remaining in your HRA are forfeited unless you enroll in COBRA coverage. If you enroll in COBRA coverage, your HRA balance goes with you and you will continue to receive company-provided HRA contributions. See the [COBRA](#) chapter for more information about COBRA continuation coverage.

HRA FOR MIDYEAR ENROLLMENTS

If you enroll midyear in an HRA plan (or change from one of the HRA plans to another, or from associate-only to associate + dependents coverage), Walmart will allocate a prorated amount to your HRA (although your annual deductibles and out-of-pocket maximum are not prorated). The prorated amount will equal the annual HRA amount divided by 12, multiplied by the number of months remaining in the year from the effective date of your coverage. The HRA balance may not exceed your in-network deductible. However, no change will be made to your HRA balance if you change from one HRA plan to another, or from associate + dependents coverage to associate-only coverage. If you drop HRA coverage, your HRA balance will be forfeited.

HOW THE HRA HIGH PLAN AND THE HRA PLAN ANNUAL DEDUCTIBLES WORK

Your annual deductible is the amount you are responsible for paying each year (January 1–December 31) before the Plan begins paying a portion of your covered expenses. You can meet your annual deductible with your Walmart-provided HRA funds from the current year and any rollover HRA dollars you may have from a previous year. When you have used all of your Walmart-provided HRA funds, you must use your own funds to meet the remainder of your annual deductible.

Under the HRA High Plan and the HRA Plan, you must meet separate annual deductibles for services provided by network providers and non-network providers, as stated in the medical summary chart at the beginning of this chapter. See [Your provider network](#) later in this chapter for more information on network and non-network providers.

The amount of your deductible is based on which plan you choose and whether you are covering just yourself (associate only) or any eligible dependents as well (associate + spouse/partner, associate + child(ren) or associate + family). Refer to the charts at the beginning of this chapter for a complete listing of the HRA plan deductibles. If you choose coverage for yourself and any dependents, the network deductible and the out-of-network deductible may be met by any combination of family members, but no benefits will be payable for any covered person until the entire applicable deductible has been met.

When you receive medical services covered by the Plan, amounts you pay toward meeting the network annual deductible apply toward meeting the out-of-network annual deductible, and vice versa.

Expenses that don't count toward the annual deductible.

The following expenses are not applied toward either the network or out-of-network annual deductible:

- Pharmacy copayments/coinsurance (including copay assistance from a third party)

- Non-network providers' charges that are above the maximum allowable charge
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your deductible)
- Charges excluded by the Plan
- Charges paid 100% by the Plan such as network preventive services and certain Centers of Excellence services, and
- Charges for out-of-network preventive services.

MEETING THE DEDUCTIBLE: AN EXAMPLE

Associate John Doe is married with one child. He has enrolled for associate + family coverage under the HRA High Plan, which has a \$3,500 annual deductible for network expenses. Under this plan, he receives \$1,000 in company-provided HRA funds. All three family members have covered network medical expenses. Two are \$750 each and one is \$2,000, for a total of \$3,500. The HRA pays for the first \$1,000 of expenses, leaving \$2,500 to be paid by John Doe. After he pays the \$2,500, his annual deductible is met. For any further network charges during the year, the Plan will pay 75% of covered expenses for network charges and John Doe will be responsible for the remaining 25%.

Or, if only one family member has a covered medical expense of \$3,500, the HRA will pay \$1,000 of the expense. When John Doe pays the remaining \$2,500, the family's annual deductible for network charges is met.



HOW COINSURANCE AND YOUR OUT-OF-POCKET MAXIMUM WORK UNDER THE HRA HIGH PLAN AND THE HRA PLAN

For the HRA High Plan and the HRA Plan, after your annual deductible for eligible network expenses is met, the Plan pays 75% of eligible network covered expenses and you pay 25%. For out-of-network expenses, after you meet the Plan's annual deductible for out-of-network expenses, the Plan pays 50% of the maximum allowable charge (except for emergency care, which is paid at the in-network coinsurance rate of 75%) and you pay the rest — i.e., you are responsible for the other 50% plus any amount charged above the maximum allowable charge.

After you've met the applicable out-of-pocket maximum for eligible network expenses, the Plan then pays 100% of covered network medical expenses for the rest of the calendar year. There is no annual out-of-pocket maximum for charges by non-network providers — you are responsible for paying your share of these charges in full.

The expenses you pay that apply toward your network annual out-of-pocket maximum include:

- Your network and out-of-network annual deductibles (including amounts paid by the HRA)
- Your coinsurance when using network providers, and
- Pharmacy copays/coinsurance.

Your network annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, will not count toward the annual out-of-pocket maximum, as listed below.

Expenses that don't count toward the network annual out-of-pocket maximum. The following expenses are not applied toward the network annual out-of-pocket maximum:

- Charges paid 100% by the Plan such as network preventive services and certain Centers of Excellence services
- Charges for out-of-network preventive services
- Your coinsurance when using non-network providers
- Non-network providers' charges that are above the maximum allowable charge
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your out-of-pocket maximum)
- Discounts, coupons, pharmacy discount programs or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges excluded by the Plan.

If you choose associate-only coverage under either the HRA High Plan or the HRA Plan, you will have an individual out-of-pocket maximum for network expenses of \$6,850. If you choose associate + spouse/partner, associate + child(ren) or associate + family coverage, you will have an out-of-pocket maximum for network expenses of \$13,700 per family.

Regardless of the benefit level you choose, each participant will have an individual out-of-pocket maximum of \$6,850. Once a participant's combined charges for covered services add up to that amount, that participant's eligible expenses will be paid at 100% for the remainder of the calendar year. If the associate's coverage includes any dependents, the family will have a family out-of-pocket maximum of \$13,700, which is a combination of all family members' covered expenses. Any combination of at least two or more individual family members can contribute to meet the family out-of-pocket maximum. Once the total family out-of-pocket maximum has been met, eligible network expenses for the entire family will be paid at 100% for the remainder of the calendar year.

HOW THE HSA PLAN ANNUAL DEDUCTIBLES WORK

If you enroll in the HSA Plan and contribute to a Health Savings Account, Walmart matches your payroll deductions into your Health Savings Account, dollar-for-dollar up to \$350 if you have individual coverage, or \$700 if you have family coverage. Your and Walmart's combined contributions to your Health Savings Account cannot exceed the 2018 annual limit (as determined by the IRS) of \$3,450 for individual coverage or \$6,900 for family coverage, plus a \$1,000 catch-up contribution if you are age 55 or over.

Like the HRA High Plan and the HRA Plan, the HSA Plan includes separate annual deductibles for network and out-of-network charges. These are the amounts you are responsible for spending each year (January 1–December 31) before the Plan begins paying a portion of your covered expenses. See [Your provider network](#) later in this chapter for more information on network and non-network providers.

Preventive care services, as described in the [Preventive care program](#) section later in this chapter, are covered even if you have not met the annual deductible.

The amount of your deductible depends on whether you are covering just yourself under the HSA Plan (associate only) or any eligible dependents as well (associate + spouse/partner, associate + child(ren) or associate + family). Refer to the chart at the beginning of this chapter for a complete listing of deductibles. If you choose coverage for yourself and any dependents, the network and out-of-network deductibles may be met by any combination of family members, but no benefits will be payable for any covered person until the entire applicable deductible has been met.

You can choose to use money in your Health Savings Account to pay expenses that are subject to the annual deductibles under the HSA Plan, or you can pay them yourself out of your own pocket and save your Health Savings Account money for future expenses.

If you enroll in the HSA Plan, you will generally pay full cost for prescriptions until you meet your annual deductible. The exception is medications on Express Scripts' list of approved preventive medications, which are not subject to the HSA Plan's annual deductible — these medications can be purchased at the appropriate copay or coinsurance level, even if you have not met the HSA Plan's network annual deductible. In addition, certain over-the-counter drugs are available at 100% coverage if you obtain a prescription, even if you have not satisfied your deductible. See [The pharmacy benefit](#) chapter for details. With the exception of these charges for approved preventive medications, your pharmacy charges under the HSA Plan will apply toward your network annual deductible and out-of-pocket maximum.

When you receive medical services covered by the Plan, amounts you pay toward meeting the network annual deductible apply toward meeting the out-of-network annual deductible, and vice versa.

Expenses that don't count toward the annual deductible.

The following expenses are not applied toward either the network or out-of-network annual deductible:

- Copays for preventive medications not subject to the annual deductible
- Non-network providers' charges that are above the maximum allowable charge
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your deductible)
- Discounts, coupons, pharmacy discount programs or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug charges paid directly to pharmacies on your behalf through discount programs/coupons)
- Charges excluded by the Plan
- Charges paid 100% by the Plan such as network preventive services and certain Centers of Excellence services, and
- Charges for out-of-network preventive services.

HOW COINSURANCE AND YOUR OUT-OF-POCKET MAXIMUM WORK UNDER THE HSA PLAN

For the HSA Plan, after your annual deductible for eligible network expenses is met, the Plan pays 75% of covered expenses and you pay 25%. For out-of-network expenses (except for emergency care, as defined by the Third Party Administrator), after you meet the Plan's annual deductible for out-of-network expenses, the Plan pays 50% of the maximum allowable charge and you pay the rest (i.e., you are responsible for the other 50% plus any amount charged above the maximum allowable charge).

After you've met your out-of-pocket maximum for network expenses, the Plan then pays 100% of covered network medical expenses for the rest of the calendar year.

There is no annual out-of-pocket maximum for charges by non-network providers — you are responsible for paying your share of these charges.

HOW YOUR COVERAGE WORKS UNDER THE HRA HIGH PLAN, THE HRA PLAN AND THE HSA PLAN

	HRA High Plan and HRA Plan	HSA Plan
Paying from your account	Covered expenses (except prescriptions) are automatically paid from your HRA, including any rollover balance until it is used up. Any money left in your HRA at the end of the Plan year remains in your account for the next Plan year as long as you continue to enroll in one of the HRA plans. Your HRA balance will never exceed the network deductible for the plan in which you are enrolled.	You can choose to pay your covered medical expenses from your Health Savings Account, or you can pay them out of your own pocket and save your Health Savings Account money. Any unspent money left in your Health Savings Account remains in your account for your future use, and can be taken with you upon termination of your employment.
Meeting your annual deductible	After your HRA is used up, you pay covered medical expenses out of your own pocket until your annual deductible is met.	You pay expenses out of your own pocket or from your Health Savings Account until your annual deductible is met.
The Plan pays a percentage of covered expenses	After your network annual deductible is met, the Plan pays 75% of your covered network expenses and you pay 25%. After your out-of-network annual deductible is met, the Plan pays 50% of covered out-of-network expenses up to the maximum allowable charge and you pay 50%. You are responsible for paying all amounts above the maximum allowable charge.	After your network annual deductible is met, the Plan pays 75% of your covered network expenses and you pay 25%. After your out-of-network annual deductible is met, the Plan pays 50% of covered out-of-network expenses up to the maximum allowable charge and you pay 50%. You are responsible for paying all amounts above the maximum allowable charge.
The Plan pays 100% of covered network services after you meet your out-of-pocket maximum	After you have met your out-of-pocket maximum for the year (as defined by the Plan), the Plan pays 100% of covered network expenses for the rest of the calendar year. (Charges by non-network providers after you have met your out-of-network annual deductible do not apply to your out-of-pocket maximum — you continue to be responsible for paying your share of these charges in full.)	After you have met your out-of-pocket maximum for the year (as defined by the Plan), the Plan pays 100% of covered network expenses for the rest of the calendar year. (Charges by non-network providers after you have met your out-of-network annual deductible do not apply to your out-of-pocket maximum — you continue to be responsible for paying your share of these charges in full.)

The expenses you pay that apply toward your network annual out-of-pocket maximum include:

- Pharmacy copays/coinsurance
- Your network and out-of-network annual deductibles (including amounts you choose to pay out of your Health Savings Account)
- Your coinsurance when using network providers, and
- Pharmacy charges before your network annual deductible is met.

Your network annual out-of-pocket maximum may be met by any combination of covered medical services.

Expenses that don't count toward the network annual out-of-pocket maximum. The following expenses are not applied toward the network annual out-of-pocket maximum:

- Charges paid 100% by the Plan such as network preventive services and certain Centers of Excellence services
- Charges for out-of-network preventive services
- Your coinsurance when using non-network providers
- Non-network providers' charges that are above the maximum allowable charge
- Charges for service provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your out-of-pocket maximum)
- Discounts, coupons, pharmacy discount programs or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges excluded by the Plan.

If you choose associate-only coverage under the HSA Plan, you will have an individual out-of-pocket maximum for network expenses of \$6,650. If you choose associate + spouse/partner, associate + child(ren) or associate + family coverage, you will have an out-of-pocket maximum for network expenses of \$13,300.

Regardless of the benefit level you choose, each participant will have an individual out-of-pocket maximum of \$6,650. Once a participant's combined charges for covered services add up to that amount, that participant's eligible expenses will be paid at 100% for the remainder of the calendar year. If the associate's coverage includes any dependents, the family will have a family out-of-pocket maximum of \$13,300, which is a combination of all family members' covered expenses. Any combination of at least two or more individual family members can contribute to meet the family out-of-pocket maximum. Once the total family out-of-pocket maximum has been met, eligible network expenses for the entire family will be paid at 100% for the remainder of the calendar year.

The Accountable Care Plan

The Accountable Care Plan options are available to associates who work in designated regions and their eligible dependents. The associate's work location will determine if an Accountable Care Plan option is available to the associate and his or her dependents. See [The Accountable Care Plan options](#) earlier in this chapter for a listing of the plans and the areas they serve.

NOTE: In areas where associates can select the Accountable Care Plan, they will generally not have access to the HRA High Plan option. The exception is portions of Arkansas, where associates will continue to have access to the HRA High Plan.

The Accountable Care Plan options draw upon the services of "accountable care organizations." These are groups of doctors, clinics, hospitals and other providers who work together in an effort to coordinate efficient and high-quality care for participants within the organization's service area. Care is coordinated through care management processes and through a close relationship between participants and their primary care physicians.

IF YOU HAVE COVERAGE UNDER THE PRESBYTERIAN ACCOUNTABLE CARE PLAN

When you have a covered visit to a doctor's office, your charge will depend on whether your provider participates in the Plan's Tier 1 or Tier 2. Your charge for an office visit to Tier 1 providers (primary care physicians or specialists) will be a copayment, as listed in the Presbyterian Accountable Care Plan summary chart earlier in this chapter. If your provider is a Tier 2 provider, the visit will be subject to the annual deductible and coinsurance.

Tier 1 providers are generally primary care physicians in the Presbyterian Healthcare Services network, Optum Behavioral Health specialists and UnitedHealthcare premium specialists. Tier 2 providers are UnitedHealthcare primary care physicians and specialists. For details on locating providers in either network, visit WalmartOne.com.



An important difference between the Accountable Care Plan and the HRA Plan, the HRA High Plan and the HSA Plan is that under the Accountable Care Plan you must always use the specific doctors, hospitals and other providers that are in the Accountable Care Plan network. If you receive services from a provider outside the Accountable Care Plan network, your expenses will not be covered, except in cases of emergency (as defined by the Third Party Administrator).

Note, however, that participants enrolled in an Accountable Care Plan option are eligible to participate in the Centers of Excellence programs. If you have dependents who live and seek care outside the network coverage area, their charges will not be covered by the Plan, except in cases of emergency (as defined by the Third Party Administrator).

HOW THE ACCOUNTABLE CARE PLAN'S ANNUAL DEDUCTIBLE WORKS

Under the Accountable Care Plan, you must meet an annual deductible before certain services are covered under the Plan. Other services such as visits to network doctors are exempt from the deductible, but are subject to a copayment — a fixed fee you must pay each time you use the service. The amount of your deductible is based on whether you are covering just yourself or any eligible dependents as well. Refer to the Accountable Care Plan summary charts at the beginning of this chapter for a listing of the coverage under the Accountable Care Plan options, including deductibles and copayments.

If you choose coverage for yourself and any dependents, the annual deductible may be met by any combination of family members, but no benefits will be payable for any covered person until the entire deductible has been met.

Expenses that don't count toward the annual deductible.

The following expenses are not applied toward the annual deductible:

- Medical copayments
- Pharmacy copayments/coinsurance (including copay assistance from a third party)
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your deductible)
- Charges excluded by the Plan
- Charges paid 100% by the Plan such as preventive services and certain Centers of Excellence services, and
- Non-network providers' charges.

HOW COINSURANCE, COPAYMENTS AND YOUR OUT-OF-POCKET MAXIMUM WORK UNDER THE ACCOUNTABLE CARE PLAN

For any of the Accountable Care Plan options, after your annual deductible for eligible network expenses is met, the Plan pays 75% of eligible network covered expenses subject to coinsurance and you pay 25%. (For services subject to a copayment, such as doctor visits, you must continue to pay the copayment until your annual out-of-pocket maximum is met.)

After you've met the out-of-pocket maximum for eligible expenses, the Plan then pays 100% of covered medical expenses for the rest of the calendar year.

The expenses you pay that apply toward your out-of-pocket maximum include:

- Your annual deductible
- Your copayments and coinsurance charges, and
- Pharmacy copays/coinsurance.

Your out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, will not count toward the annual out-of-pocket maximum, as listed below.

Expenses that don't count toward the annual out-of-pocket maximum. The following expenses are not applied toward the annual network out-of-pocket maximum:

- Charges paid 100% by the Plan such as preventive services and certain Centers of Excellence services
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your out-of-pocket maximum)
- Discounts, coupons, pharmacy discount programs or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug discount/coupons provided to pharmacies when you fill a prescription)
- Non-network providers' charges, and
- Charges excluded by the Plan

If you choose associate-only coverage under the Accountable Care Plan, you will have an individual out-of-pocket maximum of \$6,850. If you choose associate + spouse/partner, associate + child(ren) or associate + family coverage, you will have an out-of-pocket maximum of \$13,700 per family.

Regardless of the benefit level you choose, each participant will have an individual out-of-pocket maximum of \$6,850. Once a participant's combined charges for covered services add up to that amount, that participant's eligible expenses will be paid at 100% for the remainder of the calendar year. If the associate's coverage includes any dependents, the family will have a family out-of-pocket maximum of \$13,700, which is a combination of all family members' covered expenses. Any combination of at least two or more individual family members can contribute to meet the family out-of-pocket maximum. Once the total family out-of-pocket maximum has been met, eligible network expenses for the entire family will be paid at 100% for the remainder of the calendar year.

The Select Network Plan

Associates who work in designated regions will have access to the Select Network Plan, administered by Aetna. In each of the areas where the Select Network Plan is available, associates will not have access to the HRA High Plan option.

As in the Accountable Care Plan, Select Network Plan participants must always use the specific doctors, hospitals and other providers that are in the Select Network Plan's network. With the exception of emergency services (as defined by the Third Party Administrator), coverage is provided only for care received from providers in the Plan's network. Note, however, that participants enrolled in the Select Network Plan are eligible to participate in the Centers of Excellence program. If you have dependents who live or seek care outside the network coverage area, their charges will not be covered by the Plan, except in cases of emergency (as defined by the Third Party Administrator).

HOW THE SELECT NETWORK PLAN'S ANNUAL DEDUCTIBLE WORKS

The Select Network Plan includes an annual deductible you must meet each year (January 1–December 31) before the Plan begins paying a portion of your covered expenses.

The amount of your deductible is based on whether you are covering just yourself or any eligible dependents as well. Refer to the chart at the beginning of this chapter for a listing of the coverage under the Select Network Plan, including deductibles.

If you choose coverage for yourself and any dependents, the deductible may be met by any combination of family members, but no benefits will be payable for any covered person until the entire applicable deductible has been met.

Expenses that don't count toward the annual deductible.

The following expenses are not applied toward the annual deductible:

- Medical copayments
- Pharmacy copayments/coinsurance (including copay assistance from a third party)
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your deductible)
- Charges excluded by the Plan
- Charges paid 100% by the Plan such as preventive services and certain Centers of Excellence services, and
- Non-network providers' charges.

HOW COINSURANCE AND YOUR OUT-OF-POCKET MAXIMUM WORK UNDER THE SELECT NETWORK PLAN

Under the Select Network Plan, after your annual deductible for eligible network expenses is met, the Plan pays 75% of eligible network covered expenses and you pay 25%.

After you've met the out-of-pocket maximum for eligible expenses, the Plan then pays 100% of covered medical expenses for the rest of the calendar year.

The expenses you pay that apply toward your out-of-pocket maximum include:

- Your annual deductible
- Your copayments and coinsurance charges, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, will not count toward the annual out-of-pocket maximum, as listed below.

Expenses that don't count toward the annual out-of-pocket maximum. The following expenses are not applied toward the annual network out-of-pocket maximum:

- Charges paid 100% by the Plan such as preventive services and certain Centers of Excellence services
- Charges for services provided at any Walmart Care Clinic that is not a network provider under your plan (however, any eligible tests performed outside the clinic will count toward your out-of-pocket maximum)
- Discounts, coupons, pharmacy discount programs or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug discount/coupons provided to pharmacies when you fill a prescription)
- Non-network providers' charges, and
- Charges excluded by the Plan.

If you choose associate-only coverage under the Select Network Plan, you will have an individual out-of-pocket maximum of \$6,850. If you choose associate + spouse/partner, associate + child(ren) or associate + family coverage, you will have an out-of-pocket maximum of \$13,700 per family.

Regardless of the benefit level you choose, each participant will have an individual out-of-pocket maximum of \$6,850. Once a participant's combined charges for covered services add up to that amount, that participant's eligible expenses will be paid at 100% for the remainder of the calendar year. If the associate's coverage includes any dependents, the family will have a family out-of-pocket maximum of \$13,700, which is a combination of all family members' covered expenses. Any combination of at least two or more individual family members can contribute to meet the family out-of-pocket maximum. Once the total family

out-of-pocket maximum has been met, eligible network expenses for the entire family will be paid at 100% for the remainder of the calendar year.

What is covered by the Associates' Medical Plan

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

- Not in excess of the maximum allowable charge, which is determined by the Third Party Administrator (TPA), as described below
- Medically necessary (as defined below)
- Not excluded under the Plan — see [What is not covered by the Associates' Medical Plan](#) later in this chapter, and
- Not in excess of Plan limits.

MAXIMUM ALLOWABLE CHARGE

The “maximum allowable charge” (MAC) is the maximum amount the Plan will cover or pay for any health care services, drugs, medical devices, equipment, supplies or benefits covered by the Plan. The MAC applies to both in-network services and out-of-network services.

For covered in-network services, the MAC is that portion of a provider's charge covered by the Plan, as determined by the provider's contract with the Third Party Administrator (TPA). In the case of BlueAdvantage Administrators of Arkansas, this includes contracts with an independent licensee company of the Blue Cross and Blue Shield Association; in the case of UnitedHealthcare, this includes Medica and Harvard Pilgrim Health Care, independent licensees of UnitedHealthcare. For information about the TPA for your medical plan coverage, see [Your provider network](#) later in this chapter.

For covered out-of-network services, the MAC is determined by each TPA, as described below. In certain circumstances, network benefits may be paid for out-of-network services, as described later in this section under [When network benefits are paid for out-of-network expenses](#).

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

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

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

BlueAdvantage Administrators of Arkansas: The method for establishing the MAC for covered out-of-network services varies, depending on whether the service was delivered by an individual health care provider (e.g., a physician), by an ambulance or air ambulance service, or by an inpatient or outpatient hospital or facility. For services of individual health care providers, and for ambulance and air ambulance transport, the MAC is 125% of the amount that the federal Medicare program allows for such services on the date administered. For hospital and facility services, or for any other covered benefits (e.g., drugs, medical devices, products or implants, equipment or supplies), the Plan's MAC for covered out-of-network services is limited to the allowance set by BlueAdvantage Administrators of Arkansas in its discretion, utilizing such methods or benchmarks as BlueAdvantage Administrators of Arkansas may choose to employ; or, if BlueAdvantage Administrators of Arkansas does not have its own method or benchmark in a given case, then the Plan's MAC for covered out-of-network services is limited to the pricing or allowance offered by the Blue Cross and Blue Shield Plan in the state where services were provided (known as the “Host Plan”).

For covered out-of-network services, the Plan will pay the lesser of MAC or the provider's actual billed charges. If the provider's billed charges exceed the Plan's MAC, you are responsible for paying your provider the difference. For additional information, call your health care advisor at the number on your plan ID card.

MEDICALLY NECESSARY

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

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

“Most appropriate” means:

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

Aetna, UnitedHealthcare, BlueAdvantage Administrators of Arkansas, HealthSCOPE Benefits and Mercy Health Springfield Communities (with respect to all the Mercy Accountable Care Plans) follow policies and procedures in determining whether a procedure, service, equipment or supply is medically necessary. Your Plan benefits are subject to the terms of these policies, which may vary by Third Party Administrator.

You and your health care provider can access the coverage policies of Aetna, UnitedHealthcare and BlueAdvantage Administrators of Arkansas at their respective websites, listed in the [Associates’ Medical Plan Resources](#) chart at the beginning of this chapter. Access the coverage policies of HealthSCOPE Benefits by calling **800-804-1272**.

For all TPAs, your Plan benefits are subject to all terms, conditions, limitations and exclusions set forth in the Plan-specific coverage policies administered by the TPAs regarding medical necessity.

Your provider network

Depending on each covered associate’s work location and choice of medical plan, participants in the Associates’ Medical Plan have their benefits administered by one of the following Third Party Administrators:

- BlueAdvantage Administrators of Arkansas
- Aetna
- UnitedHealthcare, or
- HealthSCOPE Benefits.

The Plan has contracted with each of the above Third Party Administrators and also with Mercy Health Springfield Communities (for all Mercy Accountable Care Plans), Emory and UnityPoint to provide a network of health care providers (for example, doctors and hospitals) from whom participants can receive medical services and supplies covered under the Associates’ Medical Plan at discounted prices. Network providers accept an amount negotiated by the Third Party Administrator for covered expenses as payment in full (this is the maximum allowable charge for in-network services), subject to the annual deductible and cost-sharing terms applicable to the coverage you have chosen.

If you are covered under the HRA High Plan, the HRA Plan or the HSA Plan: When you see a network provider, the Plan will pay 75% of covered expenses after you have met the applicable annual deductible; you are responsible for paying the remaining 25% of the covered expenses. (Network providers do not charge more than the maximum allowable charge amount for covered expenses.)

When you see a non-network provider, the Plan will pay 50% of the maximum allowable charge after you have met the applicable annual deductible; you are responsible for paying all remaining amounts (i.e., your 50% share of the maximum allowable charge plus any amount above the maximum allowable charge).

If you are covered under the Accountable Care Plan: When you see a network provider, the Plan will pay 75% of certain covered expenses after you have met the applicable annual deductible; you are responsible for paying the remaining 25% of covered expenses. For services not subject to the annual deductible — e.g., doctor visits — you are responsible for paying the applicable copayment. (Note, however, that certain doctor visits under the Presbyterian Accountable Care Plan are subject to deductible and coinsurance, as described earlier under [If you have coverage under the Presbyterian Accountable Care Plan.](#))

When you see a non-network provider, the Plan pays no benefits except in cases of emergency, as defined by the Third Party Administrator.

If you are covered under the Select Network Plan: When you see a network provider, the Plan will pay 75% of covered expenses after you have met the applicable annual deductible; you are responsible for paying the remaining 25% of the covered expenses. (Network providers do not charge more than the maximum allowable charge amount for covered expenses.)

When you see a non-network provider, the Plan pays no benefits except in cases of emergency, as defined by the Third Party Administrator.

In all plan options available under the Associates' Medical Plan: Eligible preventive care is paid at 100%. In addition, eligible expenses are paid at 100% when you have reached applicable out-of-pocket maximums.

Online provider directories are available on [WalmartOne.com](https://www.walmartone.com) or the [WIRE](#).

If your provider leaves the network, your benefit will be adjusted accordingly, based on the terms of your Plan. If you are covered under the HRA High Plan, the HRA Plan or the HSA Plan, services provided by a provider who has left the network will generally be treated as an out-of-network benefit; you may be required to pay any amount over what the Plan allows for covered expenses (that is, amounts above the maximum allowable charge), unless you choose another provider who is in the network. If you are covered under an Accountable Care Plan or the Select Network Plan, which provide no coverage for non-network providers except in cases of emergency, as defined by the Third Party Administrator, your provider's services will not be covered under the Plan.

The Plan does not furnish hospital or medical services and is not liable for any act or omission of any provider or agent of such provider, including failure or refusal to render services. All medical decisions are between you and your provider. The Plan makes no representations regarding the quality of care or services rendered by any provider.

NOTE: As part of their contracts with some network providers, the Third Party Administrators or the Plan and the providers have agreed to certain financial incentive arrangements (which may pay bonuses or withhold payments to the providers) that are designed to reward high-quality and cost-effective treatments in connection with certain services. All of the Accountable Care Plan contracts include such arrangements. You may contact your Third Party Administrator for more information regarding these arrangements.

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

A covered expense you have incurred with a provider that is not in the network may, in the following circumstances, be treated as a network expense subject to the maximum allowable charge:

- If your dependent child(ren) under age 19 requires treatment at a Children's Miracle Network hospital
- When there are no network providers with the relevant specialty within 30 miles of the participant's home. (This does not apply to the Accountable Care Plan options)
- Services from a non-network provider involving a pregnant participant will be treated as network charges for up to six weeks after delivery if she began receiving care from the provider when the provider was a network provider and there had not been an interruption of the doctor/patient relationship
- Services from a non-network provider, until the effective date of the next annual enrollment period, for a course of treatment that began when the provider was a network provider, where there has not been an interruption of the doctor/patient relationship (for example, if you change Third Party Administrators during the year because of a change in work location and are in the middle of a course of treatment)
- Services for laboratory, anesthesia, radiology or pathology, but only if such services are received in connection with care from a network provider or from a network hospital
- Services for treatment received while on vacation or business travel in the U.S., where such treatment either could not have reasonably been foreseen prior to the travel or the course of treatment began prior to the travel and for medical reasons must be continued during such travel, or
- Until the next annual enrollment period, when coverage under the Plan is added and utilizing a non-network provider in a course of treatment begun prior to effective date, where there has not been an interruption of the doctor/patient relationship.

NOTE: The Plan will cover emergency care services provided in an emergency room of a hospital at a network coinsurance rate of 75% without any prior authorization and without regard to whether the services are provided in a network facility or by a network provider. Emergency care is defined by the Third Party Administrator according to Affordable Care Act guidelines.

If your Third Party Administrator determines that any of the above circumstances apply, services will be covered at the network coinsurance rate of 75%. Keep in mind that since the provider is not in the network, you may have to pay for treatment when you receive it and file a claim for reimbursement, which will be based on the maximum allowable charge. This means that the provider may bill you for the difference between the maximum allowable charge paid by the Plan and the provider's actual charge.

In addition, in each of the situations listed below, your out-of-network covered expenses may be treated as network covered expenses. The amounts paid by the Plan for the following will be based on up to 200% of the maximum allowable charge:

- Transport by ambulance or air ambulance
- The participant is directly admitted to the hospital from an emergency room, or
- The participant dies prior to hospital admission.

Amounts in excess of 200% of the maximum allowable charge will be your responsibility and will not count toward your annual deductible or out-of-pocket maximum. Maximum allowable charge exceptions will not be granted in circumstances other than those described in this section. For additional information about air ambulance coverage, call your health care advisor at the number on your plan ID card.

COVERAGE WHEN YOU TRAVEL TO A FOREIGN COUNTRY

If you travel abroad, follow these steps:


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



Special provider networks

In some locations, participants in the Associates' Medical Plan will have access to special provider networks that have coverage provisions differing in certain ways from the Plan provisions detailed on the preceding pages. General information about these special networks follows.

ADVANCED IMAGING NETWORK

 **See page 285** for information regarding an alternate network for advanced imaging services available to participants in the HRA High Plan, HRA Plan or HSA Plan options.

ALTERNATE NETWORKS THROUGH BLUEADVANTAGE ADMINISTRATORS OF ARKANSAS

Associates in certain locations nationwide who have BlueAdvantage Administrators of Arkansas as their Third Party Administrator will have access to alternate networks of providers. An alternate network is essentially a network within a network, a subgroup of providers within the Plan's larger network in a particular service area. In locations in

which an alternate network operates, associates will need to see the alternate network providers in order to receive network terms under the Plan – i.e., network annual deductibles and network-level coinsurance.

If associates seek services from medical providers who are within the area served by the alternate network but who have not agreed to be providers within the alternate network, those services will be treated as out-of-network and covered accordingly.

The alternate networks through BlueAdvantage Administrators of Arkansas are as follows:

- Florida: NetworkBLUE
- Georgia: Blue Open Access POS
- Kansas City, Missouri: Preferred-Care Blue
- Maryland, Northern Virginia, District of Columbia: BlueChoice Advantage Open Access
- Missouri: Blue Preferred POS
- New Hampshire: BlueChoice Open Access POS
- New Jersey: Horizon Managed Care Network
- Pennsylvania: Community Blue Network.
- Tennessee: Network S
- Wisconsin: Blue Preferred POS

For additional information about the alternate networks listed above, including details about service areas, go to the [WIRE](#) or [WalmartOne.com](#) or call your health care advisor at the number on your plan ID card.

ADDITIONAL NETWORKS THROUGH UNITEDHEALTHCARE

Medica Choice Network. Associates who have UnitedHealthcare as their Third Party Administrator and who live in the following locations will have access to the Medica Choice Network (through Dec. 2018 only):

 **See page 285**

- Minnesota
- North Dakota
- South Dakota
- Wisconsin, in the following counties only: Polk, Pierce, St. Croix, Burnett, Douglas, Bayfield-Ashland, Washburn, Sawyer, Barron, Dunn, Chippewa and Eau Claire.

HPHC Insurance Company. Associates who have UnitedHealthcare as their Third Party Administrator and who live in Massachusetts, Maine or New Hampshire will have access to HPHC Insurance Company, an affiliate of Harvard Pilgrim Health Care.

Preventive care program


Associates enrolled in the Associates' Medical Plan will have 100% coverage for the cost of eligible preventive care services when network providers are used. If an

associate enrolled in the HRA High Plan, the HRA Plan or the HSA Plan uses a non-network provider for eligible preventive care services, the Plan will reduce the benefit to 50%, and coinsurance amounts will not apply toward your out-of-pocket maximum. (If an associate enrolled in one of the Accountable Care Plan options or the Select Network Plan uses a non-network provider for preventive care services, no benefits will be provided, and any out-of-pocket costs will not count toward your out-of-pocket maximum).

In order for a service to be considered an eligible preventive care service, it must be a preventive care service recommended by one of the government agencies responsible for development of U.S. preventive care guidelines, as required under the Affordable Care Act. Many of the guidelines are specific to gender, age or your personal risk factors for a disease or condition.

Please check with your Third Party Administrator for additional details and for answers to questions regarding available preventive care services.

Covered services include those listed below.

 **See page 285** for changes to the list of preventive services effective Jan. 1, 2019.

For the most up-to-date list of covered preventive services, go to the [WIRE](#) or [WalmartOne.com](#) or call your Third Party Administrator at the number on your plan ID card. Refer to your Third Party Administrator for information about coverage terms when you receive preventive care services in addition to services listed here.

COVERED PREVENTIVE SERVICES FOR ADULTS

- **Abdominal aortic aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol misuse** screening and counseling
- **Aspirin** use for men and women of certain ages (prescription required). Please see [The pharmacy benefit](#) for more information.
- **Blood pressure** screening for all adults
- **Cholesterol screening** for adults of certain ages or at higher risk
- **Colorectal cancer** screening for adults over 50
- **Depression** screening for adults
- **Diabetes (type 2)** screening for adults with high blood pressure, adults age 40–70 who are overweight or obese, and counseling for patients with abnormal blood glucose
- **Diet and physical activity** counseling for adults at higher risk for chronic disease
- **Exercise or physical therapy** for community-dwelling adults age 65 and older who are at increased risk for falls
- **Hepatitis B** screening for adults at high risk
- **Hepatitis C** screening for adults at high risk
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults — doses, recommended ages and recommended populations vary:

- Haemophilus influenzae type b
- Hepatitis A
- Hepatitis B
- Herpes zoster
- Human papillomavirus
- Influenza (flu shot)
- Measles, mumps, rubella
- Meningococcal
- Pneumococcal
- Tetanus, diphtheria, pertussis
- Varicella

Learn more about immunizations and see the latest vaccine schedules at: [cdc.gov/vaccines/schedules](https://www.cdc.gov/vaccines/schedules).

- **Latent tuberculosis infection (LTBI)** screening in populations at increased risk
- **Lung cancer** screening for certain adults age 55–80 who have a smoking history
- **Obesity** screening and counseling for all adults
- **Sexually transmitted infection (STI)** prevention counseling for adults at higher risk
- **Skin cancer** counseling for young adults to age 24
- **Syphilis** screening for all adults at higher risk
- **Tobacco use** screening for all adults and cessation interventions for tobacco users
- **Vitamin D** for participants age 65 and older (prescription required)

COVERED PREVENTIVE SERVICES FOR WOMEN, INCLUDING PREGNANT WOMEN

- **Aspirin (low dose)** for women 12 weeks pregnant who are at high risk for preeclampsia (prescription required). Please see [The pharmacy benefit](#) for more information.
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk; and, if indicated after counseling, BRCA testing
- **Breast cancer chemoprevention** counseling for women at higher risk
- **Breast cancer mammography** screenings every 1–2 years for women over 40
- **Breast cancer risk-reducing prescription medications** (such as Tamoxifen or Raloxifene) for certain women at increased risk for breast cancer
- **Breastfeeding** comprehensive support and three counseling visits from trained providers, as well as access to breastfeeding supplies for pregnant and nursing women. Please check with your Third Party Administrator for details on how to obtain a breast pump.
- **Cervical cancer** screening for women age 21–65
- **Chlamydia infection** screening for younger women and other women at higher risk

- **Contraception** Food and Drug Administration–approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs. Please see [The pharmacy benefit](#) for information about contraception.
- **Domestic and interpersonal violence** screening and counseling for all women and, when needed, initial intervention services
- **Folic acid** supplements for women who may become pregnant (prescription required). Please see [The pharmacy benefit](#) for more information.
- **Gestational diabetes** screening for women 24–28 weeks pregnant and those at high risk of developing gestational diabetes
- **Gonorrhea** screening for younger women and other women at increased risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human immunodeficiency virus (HIV)** screening and counseling
- **Osteoporosis** screening for women over age 65, and younger women depending on risk factors
- **Rh incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Sexually transmitted infections (STI)** counseling for sexually active women
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Tobacco use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Well-woman visits** to obtain recommended preventive services for women

COVERED PREVENTIVE SERVICES FOR CHILDREN

- **Anemia** screening for children at 12 months
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages
- **Bilirubin** screening for newborns
- **Blood pressure** screening for children of all ages
- **Blood** screening for newborns
- **Cervical dysplasia** screening for sexually active females
- **Congenital hypothyroidism** screening for newborns
- **Critical congenital heart defect screening** for newborns
- **Depression** screening for adolescents
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride chemoprevention** supplements for children without fluoride in their water source and fluoride varnish to the primary teeth of all infants and children (prescription required)

- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all children
- **Height, weight, length, head circumference, weight for length and body mass index** measurements for children
- **Hematocrit or hemoglobin** screening for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **Hepatitis B** screening in adolescents at high risk
- **HIV** screening for adolescents
- **Immunization** vaccines for children from birth to age 18 — doses, recommended ages and recommended populations vary:
 - Diphtheria, tetanus, pertussis (DTaP and Dtap)
 - Haemophilus influenzae type b
 - Hepatitis A
 - Hepatitis B
 - Human papillomavirus
 - Inactivated poliovirus
 - Influenza (flu shot)
 - Measles, mumps, rubella
 - Meningococcal
 - Pneumococcal
 - Rotavirus
 - Varicella

Learn more about immunizations and see the latest vaccine schedules at cdc.gov/vaccines/schedules.

- **Lead** screening for children at risk of exposure
- **Medical history** for all children throughout development
- **Obesity** screening and counseling
- **Oral health** risk assessment for young children, newborn to 10 years
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Physical examination** for children of all ages
- **Sexually transmitted infection (STI)** prevention counseling and screening for adolescents at higher risk
- **Skin cancer** counseling for young adults to age 24
- **Tobacco use** interventions in school-aged children and adolescents
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children.

FLU VACCINE PROGRAM

Walmart provides an annual flu vaccination, covered at 100%, during the September–March flu season. Details of the program include:

- Vaccinations may be provided in participating Walmart and Sam's Club pharmacies.

- Associates' Medical Plan participants must show their plan ID card to receive the covered flu vaccine.
- Associates enrolled in the Associates' Medical Plan can go to any network provider and receive the flu vaccine, covered at 100%, through the preventive care program. If you are enrolled in the HRA High, HRA or HSA Plan and go to a provider who is not in the network, the benefit is 50% of the maximum allowable charge, and you will be responsible for the other 50% plus any amount above the maximum allowable charge. If you are enrolled in one of the Accountable Care Plan options or the Select Network Plan, you must go to a network provider to be eligible for the benefit.

BEHAVIORAL HEALTH: MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM

The Plan includes coverage for mental health and substance abuse services in the same manner as other medical and hospitalization benefits, including care at a behavioral health facility. To be covered, mental health and substance abuse procedures, supplies, equipment and services must be medically necessary.

Under the HRA High Plan, HRA Plan and HSA Plan, covered network services are paid at 75% after you've met your annual deductible. Covered network services are also paid at 75% after you've met your annual deductible for participants in the Presbyterian Accountable Care Plan who see providers in Presbyterian Tier 1. Under all other plan options, behavioral health office visits are charged at a \$35 copay for each visit.

For participants in the HRA High Plan, the HRA Plan and the HSA Plan, if you use a non-network provider, covered services are paid at 50% of the maximum allowable charge after you've met your annual deductible. You will be responsible for your 50% share plus any charges above the maximum allowable charge. The amount you pay for out-of-network services will apply toward your network deductible until it has been met, and will also apply to your out-of-network annual deductible. Your network deductible will apply toward your annual out-of-pocket maximum. Coinsurance for out-of-network services does not apply to your out-of-pocket maximum.

For participants in the Accountable Care Plan and the Select Network Plan, services from non-network providers are not covered except in cases of emergency, as defined by the Third Party Administrator.

Coverage is provided for:

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

Prenotification

Where your TPA does not otherwise require prior authorization of a service (see [Preauthorization](#) below), you or your provider may voluntarily contact your Third Party Administrator for information regarding coverage prior to your obtaining most medical and behavioral health services by calling the number on your plan ID card. If you or your provider chooses to notify your Third Party Administrator of a scheduled medical or behavioral health admission, you should do so at least 24 hours prior to the scheduled admission. For all emergency medical and behavioral health services, Third Party Administrators should be notified as soon as possible, but no later than 24 hours after admission. Providing notification within 24 hours after admission is not, however, required as a condition of coverage.

The Third Party Administrator's responses to your inquiries in a prior-notification call do not guarantee payment or ensure coverage under the Associates' Medical Plan, nor do any statements made by the Third Party Administrator in telephone calls, conversations or emails waive any term or condition of the Plan that applies to your claim for Plan benefits. While the Third Party Administrator will work to answer your questions regarding coverage, the Third Party Administrator cannot make a final claim determination on the telephone or by email. This means that any responses given by telephone or email will always be subject to further review under the written terms, conditions, limitations and exclusions of the Plan.

Your coverage may be limited or denied if, when the claims for the services are received, review shows that a benefit exclusion or limitation applies, the covered participant ceased to be eligible for benefits on the date services were provided, coverage lapsed for nonpayment of premiums, out-of-network limitations apply, or any other basis exists for denial of the claim under the terms of the Plan.

Preauthorization

Under the terms of the Associates' Medical Plan, network providers are required to obtain prior authorization of certain services. The types of services subject to prior authorization include, but are not limited to:

- Inpatient admissions (to hospital, hospice and other facilities) for medical benefits, including residential treatment facilities
- Inpatient admissions (to behavioral health facilities) for mental health and substance abuse benefits
- Maternity inpatient stays that exceed the Third Party Administrator's standard length of stay
- Home health care
- Outpatient surgery, radiology services, dialysis

- Outpatient services for mental health and substance abuse, including:
 - Detoxification
 - Electroconvulsive therapy (ECT)
 - Applied behavior analysis (ABA)
 - Biofeedback
 - Neuropsychological testing
 - Partial hospitalization day treatment
 - Intensive outpatient treatment
 - Psychiatric home care
- Non-emergency ambulance (air or ground)
- Reconstructive procedures that may be considered cosmetic
- BRCA genetic testing
- Rehabilitation services (physical therapy, occupational therapy, speech therapy)
- Certain prosthetic devices and durable medical equipment
- Clinical trials
- Specialty drugs issued by provider
- Services provided under the Centers of Excellence program, including:
 - Heart surgery
 - Breast, lung and colorectal cancer medical record review
 - Spine surgery
 - Hip and knee replacement
 - Transplants (including organ, stem cell and bone marrow)
 - Ventricular assist devices (VADs) and total artificial hearts
 - Weight loss surgery

Please note that the prior authorization requirements may vary based on Third Party Administrator. For a complete list of services for which preauthorization is required, please call your health care advisor at the phone number listed on your plan ID card.

Your network provider will seek preauthorization of these services on your behalf. For non-network services, you may need to seek preauthorization yourself. If your preauthorization request is approved, that means the requested services will be treated as covered services under the Plan as long as you are otherwise eligible to receive Plan benefits.

If your preauthorization request is denied, you and your provider will be notified, and either you or your provider may appeal the denial, although your provider is not required to do so. If you decide to proceed with a service that is not preauthorized, you may be responsible for paying all of your provider's charges. For more information on how to appeal a denied request for preauthorization, see the [Claims and appeals](#) chapter.

Helping you manage your health

When you need to communicate with your Third Party Administrator for any reason — whether to locate providers, seek preapproval for a planned service, speak to a registered nurse, inquire about a claim or for another matter — you should call the number on your plan ID card. This will be your health care advisor, your single point of contact for all inquiries and communication with your Third Party Administrator. Depending on the nature of your issue, the health care advisor will answer your question or route you to the appropriate department. (In some locations, a health care advisor may also be available at your work location to provide similar services.) This process will help ensure that all covered associates and their dependents can receive consistent information and guidance for all coverage-related inquiries.

CARE MANAGEMENT

All associates and dependents who are enrolled in one of the plans offered by the Associates' Medical Plan will have the benefit of voluntary care management services, including your own personal nurse care manager. These services are intended to bring consistency to the full range of care and services provided to Plan participants. Successful care management aims to look at the whole individual rather than just the symptoms or conditions being diagnosed; it can result in higher quality of care, an improvement in your experience with your providers and Third Party Administrator, as well as potentially lower out-of-pocket medical expenses overall.

When appropriate, a specially trained and registered nurse care manager will help you, the associate, as well as your covered dependents. Circumstances in which a nurse care manager will work with you might include any of the following:

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

Under the care management program provided by your Third Party Administrator, your nurse care manager, in collaboration with your medical provider, has the authority to approve services that are not otherwise covered by the Plan because they exceed a treatment limit (i.e., number of days or visits), or maternity-related services, but only if the

otherwise excluded services are deemed to be medically necessary. The Plan's general rules regarding annual deductibles and coinsurance will continue to apply to any additional benefits authorized by your nurse care manager.

In addition, your nurse care manager will follow your Third Party Administrator's applicable policies and procedures for determining medical necessity in making its decisions.

Your nurse care manager may also be able to assist you with your medical costs incurred for "involuntary" out-of-network services. "Involuntary" means that you could not control your choice of provider (for example, if you had surgery in an in-network hospital, but your anesthesia was administered by an anesthesiologist who was a non-network provider) or had no reasonable basis for believing that your provider was a non-network provider. In some cases, out-of-network benefits may be paid as network benefits (see [When Network Benefits Are Paid For Out-Of-Network Expenses](#) earlier in this chapter). In other cases, your Third Party Administrator may negotiate with non-network providers either before or after services are rendered to reduce the billed charges that you are responsible for paying under the Plan's out-of-network benefit in exchange for a larger payment by the Plan (i.e., a payment higher than the otherwise applicable maximum allowable charge). There are no guarantees that care managers will obtain any reduction in the out-of-network costs you are responsible for.

When you communicate with your Third Party Administrator, depending on the nature of your inquiry, you may be routed to your nurse care manager for assistance. On other occasions, your nurse care manager may reach out to you, for example to invite you to participate in a health management program that may be appropriate for you.

When you receive a call from your nurse care manager, please take the call or return it at your earliest convenience so that your nurse care manager can begin to help you. To reach your nurse care manager, call the phone number on your plan ID card. Participation in the program is voluntary and does not affect your eligibility to participate in the Associates' Medical Plan.

QUIT TOBACCO PROGRAM

Tobacco use is a leading cause of preventable disease and death in the United States, and using tobacco dramatically increases the risk of heart disease and many types of cancer. To help you kick the habit, Walmart offers a free Quit Tobacco program for associates and their covered dependents age 18 and older who are enrolled in a Walmart-sponsored medical plan. The program uses treatment methods to give you personal support and help you quit for good.

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

- **Online support** from coaches and other quitters.
- **Phone-based coaching** with a trained health coach.
- **Quit Guide** handbook, available online or mailed to your home.

- **Email support** with tips to help you quit, stay motivated and celebrate quit milestones.
- **Over-the-counter (OTC) quit medications**, including free patches, gum, lozenges or mini-lozenges. (You may hear this referred to as "nicotine replacement therapy" or "NRT.")

To enroll in a Quit Tobacco program, associates can call **866-577-7169**.

If you are enrolled in an HMO, contact your provider to learn what quit-tobacco programs are offered through your plan at no cost to you.

All Walmart associates can learn more about the Quit Tobacco program at the Quit Tobacco link at [WalmartOne.com](#).

LIFE WITH BABY MATERNITY PROGRAM

Life with Baby is an exclusive prenatal care program offered at no cost to you, your spouse/partner and dependents covered under the Plan. The program is available to all associates enrolled in the Associates' Medical Plan, with the exception of some Accountable Care Plans, which provide a comparable maternity program for their participants. (Call your health care advisor at the phone number on your plan ID card for more information.)

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

CASTLIGHT

Effective Jan. 1, 2019, the functions and services described in this Castlight section will be provided by Grand Rounds.

 **See page 285 for details.**

Castlight is a personalized tool that lets you search for doctors and medical services online and make decisions based on cost information and user reviews. Walmart associates and adult dependents (age 18 and over) who are enrolled in one of the plans offered by the Associates' Medical Plan are eligible to use Castlight with the exception of participants in the Mercy Accountable Care Plans, Emory Accountable Care Plan, Presbyterian Accountable Care Plan and UnityPoint Accountable Care Plan.

As a new user, start using Castlight by registering at [MyCastlight.com/Walmart](#), by mobile app or by calling a health care advisor at the number on your plan ID card. Registered users can return to the application at any time to access Castlight. There is no cost to you when you use Castlight.

With Castlight you can:

- Compare nearby doctors, medical facilities and health care services based on the price you'll pay
- See personalized cost estimates based on your location and your health plan
- Review your Plan details, including your progress toward meeting your deductible and out-of-pocket maximum
- Review explanations of past medical spending so you know how much you paid and why
- Receive recommendations about ways to save money and find quality care
- Access useful information about prescription drugs

NOTE: If you are enrolled in one of the Accountable Care Plan options, contact your health care advisor at the number on your plan ID card to obtain information on network doctors and Plan details, and to obtain explanations on past medical spending. You can also find information on network providers on WalmartOne.com.

SECOND OPINIONS AND SPECIALIST SEARCH THROUGH GRAND ROUNDS

Under certain circumstances, when you have received a diagnosis or been recommended for surgery or a certain treatment, the Plan will cover second opinions provided online through Grand Rounds, a medical technology company. Grand Rounds helps you find high-quality specialists and can match you with specialists to help you get the best possible diagnosis or treatment plan. When you use this service, you can get a written opinion from a qualified physician based on your medical records or an in-person visit, plus recommendations for your care.

Grand Rounds is available to associates covered under the Associates' Medical Plan and their covered dependents, with the exception of associates covered under any of the Accountable Care Plan options. For more information about services and technical requirements, visit Grand Rounds online at GrandRounds.com/Walmart or call 800-941-1384. You can also download the app from the Apple App Store or Google Play.

TELEHEALTH VIDEO VISITS THROUGH DOCTOR ON DEMAND

Under certain circumstances, the Plan will cover doctor consultations using telecommunication technologies such as video visits. Participants enrolled in the Associates' Medical Plan have access to Doctor On Demand, a telehealth service offering video medical visits. Doctor On Demand's contracted providers can diagnose, treat and write prescriptions for a wide range of non-emergency medical or behavioral health issues. The service is available in all 50 states, 24 hours a day, seven days a week by computer, tablet or smartphone. Doctor On Demand cannot provide treatment for chronic conditions like diabetes, or medical emergencies like chest pain or severe burns.

Doctor On Demand will submit claims for services directly to covered participants' Third Party Administrators. Services

provided through Doctor On Demand are subject to the same coverage terms as conventional doctor visits (deductible, coinsurance, etc.).

 **See page 285 for coverage terms effective Jan. 1, 2019.**

For more information about services and technical requirements, visit Doctor On Demand online at doctorondemand.com or call 800-997-6196.

Walmart Care Clinic

The Walmart Care Clinic is a primary health care clinic that can be found in select Walmart stores. It offers retail primary care services including office visits, laboratory tests and some preventive care services, for persons age two and older.

Office visits are offered at the discounted price of a \$4 copayment per visit for participants in the HRA plans, the Select Network Plan or the Accountable Care Plan options, regardless of residency or work location. Due to IRS rules governing health plans that are used with Health Savings Accounts, associates enrolled in the HSA Plan option are required to pay the posted retail price when using the Walmart Care Clinic, unless the clinic visit is limited to preventive services. HSA dollars may be used as payment for qualified medical expenses received at the clinic.

Lab tests and immunizations that are not covered as preventive care under the Plan but are performed entirely within the clinic setting are available at a separate charge in addition to the visit charge. Tests ordered within the Walmart Care Clinic but performed outside the clinic setting are treated as covered network charges under the Associates' Medical Plan. These charges are subject to the maximum allowable charge paid by the Plan and you would be responsible for any difference between the Plan's maximum allowable charge and the provider's actual charge.

Certain preventive services available at the Walmart Care Clinic are covered under all of the Associates' Medical Plan options. These preventive services are covered at no cost to enrolled associates and their dependents. (See the [Preventive care program](#) section earlier in this chapter for a list of services covered at 100% for associates enrolled for medical coverage under the Associates' Medical Plan. For more information, please visit WalmartCareClinic.com.)

NETWORK COVERAGE FOR CERTAIN WALMART CARE CLINICS

Your Third Party Administrator may contract with certain individual Walmart Care Clinics to be network providers under the Plan, but not all Walmart Care Clinics are network providers. The manner in which the Plan will treat your out-of-pocket expenses at a Walmart Care Clinic depends on the clinic's network status, as follows:

If the Walmart Care Clinic is a network provider under your Plan option. The clinic will file insurance claims with your Third Party Administrator. Any eligible out-of-pocket costs you incur in that clinic (after your \$4 visit copay) will be subject to

your annual deductible and out-of-pocket maximum under the same rules that apply to a network provider.

If the Walmart Care Clinic is not a network provider under your Plan option. The clinic will not file insurance claims with your Third Party Administrator. Any out-of-pocket costs you incur are not reimbursable under the Plan and will not be credited against your annual deductible or out-of-pocket maximum.

As stated, eligible preventive care services are fully covered regardless of the Walmart Care Clinic's network status. To find out whether a Walmart Care Clinic is a network provider, view your network provider directory or contact your Third Party Administrator.

Centers of Excellence See page 285

The Centers of Excellence program works with specific facilities to provide medical services related to a range of treatments and procedures. Through this program, associates and dependents enrolled in the Associates' Medical Plan have access to highly specialized providers and facilities selected for their demonstrated expertise in certain high-risk or high-cost procedures. This important program is offered by the Associates' Medical Plan so that participants facing certain serious medical conditions can receive high-quality care. The Centers of Excellence program covers:

- Surgeries for certain heart conditions (age 18 and up)
- Surgeries for certain spine conditions (age limitations apply to some spine conditions)
- Hip replacement surgery (age 18 and up)

- Knee replacement surgery (age 18 and up)
- Medical record review by a Centers of Excellence facility for certain types of cancer (all ages) to determine if an on-site evaluation would be recommended
- Organ and tissue transplants (except kidney, cornea and intestinal), including ventricular assist devices (VADs) and total artificial hearts, and
- Gastric bypass and gastric sleeve weight loss surgeries.


The section that follows describes the program in greater detail, including important conditions and restrictions. The **Centers of Excellence** summary chart below summarizes general terms for the specific medical services covered under the program. See also the **Transplant** and **Weight loss surgery** sections later in this chapter for details about those benefits.

As shown in the **Centers of Excellence** summary chart below, certain eligible services performed at one of the medical centers included in the program are covered at 100% with no annual deductible (excluding weight loss surgery). However, if you are enrolled in the HSA Plan, you must meet your annual deductible before the Plan will make any payments, due to federal tax laws.

If you believe you may be a candidate to participate in the Centers of Excellence program, call your health care advisor at the phone number on your plan ID card. To participate in the Centers of Excellence program:

- Services must be scheduled and preauthorized by one of the Plan's administrators for the Centers of Excellence program in order to be covered under the Plan. The particular administrators from whom preauthorization

CENTERS OF EXCELLENCE

 See page 286 for Centers of Excellence terms effective Jan. 1, 2019, replacing the chart below. Please take special note of changes to spine surgery coverage.

	Centers of Excellence Providers	Your Medical Plan Network	Out-of-Network <i>Out-of-network benefits not available under Accountable Care Plans and Select Network Plan</i>
Heart surgery			
Breast, lung and colorectal cancer medical record review (Onsite travel if recommended)	100% <i>No deductible*</i>	75% <i>After deductible</i>	50% <i>After deductible</i>
Spine surgery		50% After deductible <i>(Subject to out-of-network deductible for HRA Plan, HRA High Plan and HSA Plan; network deductible for Accountable Care Plan and Select Network Plan)</i>	
Hip and knee replacement	100% <i>No deductible*</i>		50% <i>After deductible</i>
Transplant (Mayo Clinic only. Excludes kidney, cornea and intestinal transplant)	100% <i>No deductible*</i>	No coverage**	No coverage**
Weight loss surgery (Gastric bypass and gastric sleeve)	75% <i>After deductible</i>	No coverage**	No coverage**

* Due to federal tax law, participants in the HSA Plan must meet their annual deductible before 100% benefits can be provided.

** See the adjacent **Centers of Excellence** text for circumstances when exceptions may apply. Additional program conditions and restrictions are described in the adjacent **Center of Excellence** text.

must be obtained will vary, depending on the specific Centers of Excellence service to be provided and in certain cases the associate's medical coverage, as listed in the [Centers of Excellence administration](#) chart below.

- If your request for preauthorization of a Centers of Excellence service is denied, you have the right to appeal that denial. See the [Claims and appeals](#) chapter for more information. Note that services performed at a Centers of Excellence facility that are not covered services under the terms and conditions of the Centers of Excellence program will be subject to regular coverage and payment terms under the Associates' Medical Plan.
- For most eligible services, the participant must identify a designated caregiver who must agree to (and be able to) meet caregiver requirements.
- The participant must be safe to travel for medical care and must not require emergency care at the time of travel.
- The medical center in which the participant will receive services is determined by geographical location of residence and indicated service.
- The participant acknowledges that the medical center must receive necessary medical records prior to acceptance into the program.
- The participant must supply contact information for a local physician who has agreed to manage follow-up care after the participant returns home from the Centers of Excellence facility.

CENTERS OF EXCELLENCE ADMINISTRATION

NOTE: If you are enrolled in an Accountable Care Plan, please call your health care advisor to be directed to the appropriate administrator.

Heart surgery	Health Design Plus
Breast, lung and colorectal cancer medical record review (Effective Jan. 1, 2019, also including prostate and blood cancers; onsite travel if recommended)	HealthSCOPE Benefits
Spine surgery	Health Design Plus
Hip and knee replacement	Health Design Plus
Transplant (Mayo Clinic only. Excludes kidney, cornea and intestinal transplant)	HealthSCOPE Benefits
Weight loss surgery (Gastric bypass and gastric sleeve)	Health Design Plus

Travel, lodging and a daily allowance will be provided for the recipient and a caregiver for all services covered under the Centers of Excellence program except weight loss surgery. These travel services must be pre-authorized and scheduled through the Centers of Excellence program. Payment is subject to otherwise applicable limits.

NOTE: Travel benefits may not be available in certain circumstances if you are enrolled in one of the Accountable Care Plan options.

If a medical director of a Third Party Administrator recommends that a Plan participant be treated at a specific facility based on the individual's condition, even if this facility is not a Centers of Excellence facility, the Plan will cover the same travel benefits as those paid for travel to a Centers of Excellence facility. These travel services must be pre-authorized by the Third Party Administrator's medical director and scheduled through the Plan. Reimbursement for medical treatment or services at the facility will be paid under otherwise applicable Plan terms, and will not be reimbursed as Centers of Excellence services at the rates listed in the chart on the previous page.

If you believe you may be a candidate to participate in the Centers of Excellence program, call your health care advisor at the phone number on your plan ID card.


If you have a medical condition that is eligible for care under the Centers of Excellence program and you choose to receive treatment in a facility outside the Centers of Excellence program, your care will not be covered at the Centers of Excellence rates, but instead will generally be subject to the regular coverage terms under the Associates' Medical Plan. These terms are summarized in the [Centers of Excellence](#) chart on the previous page and described in greater detail in [Administration of the Associates' Medical Plan](#) earlier in this chapter. Similarly, services you receive prior to arrival or following discharge from a Centers of Excellence facility, including those approved by the Centers of Excellence program administrator, will be subject to regular coverage terms under the Plan.

NOTE: See [page 286](#) for important information effective Jan. 1, 2019, which replaces the immediately following text describing coverage terms if you are eligible for Centers of Excellence benefits for spine surgery or hip or knee joint replacement and choose to receive treatment outside the Centers of Excellence program. In cases of spine surgery or hip or knee joint replacement, if you are eligible for Centers of Excellence benefits and you choose to receive treatment in a facility outside the Centers of Excellence program, your treatment will be considered out-of-network, even if the provider is a network provider for other purposes. In such circumstances, the Plan will pay 50%, subject to the following limitations:

- If you have coverage under the HRA High Plan, HRA Plan or the HSA Plan and have your procedure performed by a network provider, you will be subject to the out-of-network deductible before benefits are payable.
- If you have coverage under any of the Accountable Care Plan options or the Select Network Plan and have your procedure performed by a network provider, you will be subject to your plan's annual deductible.

- If you have coverage under any of the Accountable Care Plan options or the Select Network Plan and have your procedure performed by an out-of-network provider, no benefits will be payable.

Requests for exceptions to Plan coverage terms for spine surgery and hip and knee replacement

 For information about updated coverage terms effective Jan. 1, 2019, **see page 286**. These new terms replace the text in the remainder of this column.

In cases of spine surgery and hip and knee replacement, you may request an exception to the rules described on the previous page, which state how the Plan will cover these procedures when they are performed outside the Centers of Excellence program. You may request an exception so that procedures performed by a network provider that is not a Centers of Excellence network provider be covered at a coinsurance rate of 75% of the network discounted rate. Depending on whether you have already received treatment when you make your request, it will be treated as a pre-service claim or post-service claim (as described below) and decided under special rules for granting exceptions to the Plan's coverage terms for spine surgery and hip and knee replacement under the Centers of Excellence program, as described in the [Claims and appeals](#) chapter.

Pre-service exception request: If you have not yet received treatment but are considering receiving services from a non-Centers of Excellence provider, you may file a prior authorization request (a pre-service claim) to have spine surgery or hip or knee replacement performed by a provider who is not a Centers of Excellence provider if travel to the Centers of Excellence provider would likely result in loss of life, paralysis or further injury, or if the Centers of Excellence facility does not recommend spine surgery or hip or knee replacement because it is not deemed the appropriate medical course of treatment or you are not an appropriate candidate for surgery. Your request will be considered by an Independent Review Organization following the procedures described under [Special procedures for approval of exceptions to Plan coverage terms for spine surgery and hip and knee replacement](#) in the [Claims and appeals](#) chapter. If your request is granted, coverage will be at the otherwise applicable network rate, including any deductibles, coinsurance or limitations. If your request is denied because the Independent Review Organization determines that travel to a Centers of Excellence provider is safe, based on the documentation received, coverage at a non-Centers of Excellence facility will be paid at 50% as outlined on the previous page.

Decisions not to move forward with spine surgery or hip or knee replacement by the respective Centers of Excellence providers will not be subject to review under this process if the Centers of Excellence provider's decision is based on a determination that the procedure is not appropriate because you refuse to comply with medical restrictions or requirements, including weight loss, smoking cessation, alcohol cessation, social support or similar factors.

Post-service exception request: If you already have received services from a non-Centers of Excellence provider, you may file a post-service claim with your Third Party Administrator, as described in the [Claims and appeals](#) chapter. Your claim may be approved if:

- You experienced a traumatic injury resulting in the need for immediate surgery or were in need of immediate surgery, without which you would have likely incurred loss of life or paralysis, or
- Services were provided by a network provider that began a course of treatment prior to the effective date of this provision and there has not been an interruption of the doctor-patient relationship.


If your claim is approved, coverage will be at the otherwise applicable network or non-network rate, depending on your provider, including any deductibles, coinsurance or limitations. If your claim is denied, you may request an appeal as described in the [Claims and appeals](#) chapter.

LIMITED COORDINATION OF BENEFITS

The Associates' Medical Plan generally does not coordinate benefits with respect to claims under the Centers of Excellence program, other than coordination with Medicare in the case of certain transplant benefits or as otherwise required by law. For all other Centers of Excellence services, if any portion of a Centers of Excellence benefit could have been paid by another health plan, the Associates' Medical Plan will not pay any amount of the claim.

TRANSPLANTS

To be eligible for transplant and lung volume reduction surgery (LVRS) benefits under the Centers of Excellence program, participants must be enrolled in the Associates' Medical Plan for at least 12 months.

 **See page 286** for additional information on covered treatments under the transplant benefit, including CAR-T cell treatment.

Associates enrolled in the eComm PPO Plan or an HMO plan are not eligible for transplant benefits, but if they later become covered under one of the plans available under the Associates' Medical Plan, their time enrolled in the eComm PPO Plan or an HMO will count toward the 12-month waiting period. For associates not enrolled in one of the plans available under the Associates' Medical Plan, any time enrolled in critical illness insurance or accident insurance will not count toward the 12-month waiting period.

The 12-month waiting period will not apply to insertion of durable ventricular assist devices (VADs) or artificial hearts, regardless of whether the VAD is related to a transplant.

The 12-month waiting period applies to the associate and, separately, to most covered dependents — i.e., the covered associate and each covered dependent must meet his or her own 12-month waiting period. If the covered associate adds coverage under the Plan for a new dependent through birth, or adoption of the child as of the child's date of birth, the new dependent's 12-month waiting period will be waived.

The 12-month waiting period will be waived for localized associates and their covered dependents. In addition, the 12-month waiting period may be waived in cases where your doctor certifies that in the absence of a transplant, the covered participant's death is imminent within 48 hours. See the [Claims and appeals](#) chapter for information on requesting a waiver.

If your doctor recommends a transplant, please call HealthSCOPE Benefits at **479-621-2830** or **800-421-1362**.

Guidelines for covered transplants

- All associates and dependents enrolled for coverage under the Associates' Medical Plan who are transplant recipients (except for kidney, cornea and intestinal recipients) must undergo a pretransplant evaluation at Mayo Clinic. In performing this evaluation, Mayo Clinic is not acting as an agent of the Plan. It is the Plan's intent that this evaluation be made pursuant to the doctor/patient relationship between Mayo Clinic and the participant. Travel, lodging and a daily allowance will be provided for the recipient and a caregiver for required transplant evaluations at Mayo Clinic.
- Liver, heart (including durable ventricular assist devices [VADs] and total artificial hearts), lung, pancreas, simultaneous kidney/pancreas, multiple organ, lung volume reduction surgery (LVRS) and bone marrow/stem cell transplants must be performed at Mayo Clinic or an approved facility, or no benefits will be paid unless travel will result in death.
- Claims for eligible transplant services performed at Mayo Clinic (including pediatric) should be filed with HealthSCOPE Benefits and are covered at 100% with no annual deductible. However, if you are enrolled in the HSA Plan, you must meet your annual deductible before the Plan will make any payments due to federal tax laws. Additionally, travel, lodging and a daily allowance will be provided for the recipient and a caregiver. Payment is subject to otherwise applicable limits.
- The Plan does not cover the transplantation of body parts (e.g., face, hands, feet, legs, arms) under any circumstances. Experimental and/or investigational transplant-related services are not covered unless those services are recommended and performed by Mayo Clinic or an approved facility.
- Benefits for a covered transplant procedure at Mayo Clinic and related expenses, including travel, lodging and a daily allowance, will end one year post-transplant or after a one-year post-transplant evaluation is performed.
- Coverage for procedures and devices unrelated to a transplant, as determined by Mayo Clinic, are not covered at 100% and will be subject to the otherwise applicable Plan terms and limitations, including annual deductibles and coinsurance (network and out-of-network). This will include certain gastric-sleeve procedures performed at Mayo Clinic during a liver transplant.

- Non-transplant services performed at Mayo Clinic are not covered at 100% and will be subject to the otherwise applicable Plan terms and limitations, including annual deductible and coinsurance (network and out-of-network).
- Travel for transplant-related services must be arranged by a transplant coordinator. For travel arrangements, please call HealthSCOPE Benefits at **479-621-2830** or **800-421-1362**.
- Claims for transplants and LVRS that are not performed in accordance with the guidelines stated in this chapter and in the [Claims and appeals](#) chapter will be denied.
- Coverage is limited to transplantation of human organs.

Requests for organ transplants at facilities other than Mayo Clinic

- You may file a claim with an Independent Review Organization to request an organ transplant at a facility other than Mayo Clinic if:
 - There is significant risk that travel to Mayo Clinic could result in death, or
 - Mayo Clinic determines that it will not recommend and perform a transplant because it is not the appropriate medical course of treatment or you are not an appropriate candidate for a transplant.

Your claim must be received by the Plan within 120 calendar days of the initial denial of the transplant by Mayo Clinic. Your claim will be decided under the special rules for transplant claims at a facility other than Mayo Clinic, as described in the [Claims and appeals](#) chapter.

- The Independent Review Organization will be made up of individuals appointed by the Plan Administrator and will not include any employee of Walmart, Mayo Clinic or a Third Party Administrator of the Plan. The Independent Review Organization will review any relevant medical files that were reviewed or generated by Mayo Clinic, as well as any additional materials you submit, and will consider various factors, including alternative courses of treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures and the potential benefit the transplant would have.
- If the Independent Review Organization determines that the transplant and related course of treatment are medically necessary, the Independent Review Organization will approve an exception to pursue a transplant outside of Mayo Clinic, under regular medical benefits.
- Claims will be covered at 75% for network providers after the annual deductible has been met.
- If you are enrolled in the HRA High Plan, HRA Plan or HSA Plan, claims will be covered at 50% of the maximum allowable charge if you use a non-network provider, even after you've reached your out-of-pocket maximum. You will be responsible for your 50% share

plus any charges above the maximum allowable charge. The amount you pay for out-of-network services will apply toward your network deductible until it has been met, and will also apply to your out-of-network annual deductible. Your network deductible will apply toward your annual out-of-pocket maximum. (Note that the Accountable Care Plan options and the Select Network Plan do not cover services provided by non-network providers except in cases of emergency, as defined by the Third Party Administrator, or when Mayo Clinic or the Independent Review Organization determines that the services are medically necessary.)

- The Plan will not cover the cost of travel or lodging or provide a daily allowance for such transplants.

Transplant denials by Mayo Clinic will not be subject to review under this process if Mayo Clinic's decision is based on a determination that the transplant is not appropriate because you refuse to comply with medical restrictions or requirements, including weight loss, smoking cessation, alcohol cessation, social support or similar factors. Any transplant-related claims where treatment has already been rendered will be decided under the regular medical claims and appeals procedures found in the [Claims and appeals](#) chapter.

Pediatric transplant recipients under age 19

- Pediatric transplant recipients under age 19 (except for kidney, cornea and intestinal transplants) must undergo a pre-transplant review and, upon request by Mayo Clinic, an evaluation by Mayo Clinic.
- Claims will be covered at 75% for network providers after the annual deductible has been met.
- If your medical plan option provides coverage for non-network providers, claims will be covered at 50% of the maximum allowable charge if you use a non-network provider, even after you've reached your out-of-pocket maximum. You will be responsible for your 50% share plus any charges above the maximum allowable charge. The amount you pay for out-of-network services will apply toward your network deductible until it has been met, and will also apply to your out-of-network annual deductible. Your network deductible will apply toward

your annual out-of-pocket maximum. (Note that the Accountable Care Plan options and the Select Network Plan do not cover services provided by non-network providers except in cases of emergency, as defined by the Third Party Administrator.)

- Travel, lodging and a daily allowance will be provided only if the transplant is performed at Mayo Clinic.

Transplant donor expenses

- Eligible transplant donor expenses with respect to a living donor are covered when the recipient is an Associates' Medical Plan participant who is eligible for transplant coverage and the living donor's medical plan or insurance provider does not pay for transplant donor charges and/or expenses.
- Eligible transplant donor expenses with respect to travel and lodging benefits must be arranged by a transplant coordinator. It is the responsibility of the transplant recipient to provide the contact information for the transplant benefit administrator to the eligible transplant donor, prior to appointments.
- Covered donor charges will be paid at the same benefit level as the recipient according to the transplant guidelines previously stated, up to 120 days post-transplant.
- Cadaver organ acquisition and procurement expenses are covered only when the expenses are part of the provider's base contracted rate with the Plan's Third Party Administrator.

WEIGHT LOSS SURGERY BENEFIT

Certain weight loss surgeries are covered under the Associates' Medical Plan Centers of Excellence program, subject to specific criteria, including but not limited to certain terms. Note that the following criteria have been updated effective Jan. 1, 2019:

See page 286

- Services must be provided by a physician and facility designated by the Plan

KIDNEY, CORNEA AND INTESTINAL TRANSPLANTS

Kidney, cornea and intestinal transplants are not included in the Centers of Excellence transplant program and can be performed at the network facility of your choice, according to these terms:

- Claims will be covered at 75% for network providers after the annual deductible has been met.
- If your medical plan option provides coverage for non-network providers, claims will be covered at 50% of the maximum allowable charge if you use a non-network provider, even after you've reached your out-of-pocket maximum. You will be responsible for your 50% share plus any charges above the maximum allowable charge. The amount you pay for out-of-network services will apply toward your network deductible until it has been met, and will also apply to your out-of-network annual deductible. Your network deductible will apply toward your annual out-of-pocket maximum. (Note that the Accountable Care Plan options and the Select Network Plan do not cover services provided by non-network providers except in cases of emergency, as defined by the Third Party Administrator.)
- No travel, lodging or daily allowance will be provided for these transplants (even if performed at Mayo Clinic).



- The participant wishing to utilize the weight loss surgery benefit must be enrolled for medical benefits in the Associates' Medical Plan for one continuous year before becoming eligible for the benefit and must be willing to travel to the facility designated by the Plan at their own expense (travel reimbursement is not provided)
- You must be an associate or an eligible covered spouse/partner of an associate (coverage is not available to dependent children, regardless of age)
- You must be at least 18 years of age
- You must have a body mass index (BMI) of 40 or greater
- You must currently be diagnosed with type 2 diabetes, and
- You must agree to comply with all requirements for the duration of the weight loss surgery treatment.

 **See page 286 for updates to the preceding terms.**

Coverage for weight loss surgery is provided at the network benefit level; after your annual deductible for eligible network expenses is met, the Plan pays 75% and you pay 25%. If you meet the requirements stated above and your doctor recommends weight loss surgery, please call your health care advisor at the number on your plan ID card to obtain a Request Form, which must be completed by you and your physician. You must send the completed Request Form to Health Design Plus at the address listed on the form. A claim will be considered filed when the Request Form is received by Health Design Plus. The claim will be determined under the procedures for pre-service claims described in the [Claims and appeals](#) chapter.

When limited benefits apply to the Associates' Medical Plan

Some services are also subject to specific restrictions and limitations in addition to annual deductible and coinsurance/copayment requirements, as described below. If you have a question on the coverage of a particular service, please contact the Third Party Administrator. Contact information is provided on your plan ID card.

The limitations and restrictions described are in addition to other Plan rules, including annual deductibles, coinsurance/copayments and exclusions. Consideration may be given for additional coverage when authorized by your nurse care manager, as described in the [Care management](#) section.

Please refer also to [What is not covered by the Associates' Medical Plan](#), later in this chapter.

AMBULANCE

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

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

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

Ambulance not covered: Ambulance charges for the sole convenience of the participant, caregiver or provider will not be covered.

BIRTH CONTROL/CONTRACEPTIVES

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

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

The Plan will cover generic contraceptives only when prescribed by a physician (and brand-name contraceptives when medically necessary). If your attending physician believes a brand-name contraceptive is medically necessary, you may file a claim for coverage of the brand-name drug.

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

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

CLINICAL TRIALS

Routine patient costs otherwise covered by the Plan that are associated with participation in Phases I–IV of approved clinical trials to treat cancer or other life-threatening conditions, as determined by the Third Party Administrator and as required by law. These costs will be subject to the Plan's otherwise applicable deductibles and limitations and do not include costs of the investigational item, device or service, items that are provided for data collection, or services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

DURABLE MEDICAL EQUIPMENT (DME)/HOME MEDICAL SUPPLIES

Durable medical equipment (DME) that satisfies all of the following criteria is covered under the Plan, unless listed under **DME not covered**. DME is equipment that:

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

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

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

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

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

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

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

FOOT CARE

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

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

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

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

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

GENDER DYSPHORIA TREATMENT

The Plan covers medically necessary benefits for the treatment of gender dysphoria. If medically necessary, the following benefits are covered:

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

Gender reassignment surgery will be covered only if you are age 18 or older. The Plan will not cover cosmetic treatment of gender dysphoria.

HOME NURSING CARE

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

HOSPICE CARE

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

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

INFERTILITY TREATMENT

Services for the diagnosis and correction of an underlying condition of infertility are covered. Refer to [What is not covered by the Associates' Medical Plan](#) later in this chapter for a list of non-covered infertility services.

INTERNATIONAL BUSINESS TRAVEL MEDICAL COVERAGE

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

NUTRITIONAL COUNSELING

Nutritional counseling for children is covered if it is medically necessary for a chronic disease (e.g., PKU, Crohn's disease, celiac disease, galactosemia, etc.) in which dietary adjustment has a therapeutic role when it is prescribed by a physician and furnished by a provider (e.g., a registered dietician, licensed

nutritionist or other qualified licensed health professional) recognized under the Plan. Benefits are limited to three visits per condition per year. Please see the [Preventive care program](#) section for additional benefits related to nutritional and obesity counseling for adults and children.

OFF-LABEL USE OF CANCER CHEMOTHERAPY INJECTABLE DRUGS

These drugs will be considered to meet coverage criteria when they are medically necessary as defined by the Plan, recommended by one of the following three drug compendia, and not recommended against by one or more of the same compendia (appropriate to the date of service):

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

If you or your physician are unsure about the Plan's coverage for any type of prescription drug, verify coverage details by calling the Third Party Administrator of your medical plan at the number on your plan ID card. You can also call Express Scripts at **800-887-6194**.

OFF-LABEL USE OF NON-CANCER CHEMOTHERAPY INJECTABLE DRUGS

These drugs will be considered to meet coverage criteria when they are medically necessary as defined by the Plan and recommended under one of the following drug compendia (appropriate to the date of service):

- *American Hospital Formulary Service (AHFS) Drug Information*, or
- Clinical Pharmacology Online.

The Plan will not cover any drug when the FDA has determined its use to be contra-indicated or not advisable. Coverage for FDA-approved drugs will be subject to the Plan's otherwise applicable requirements and limitations.

ORAL TREATMENT

Charges for the care of teeth and gums are covered by the Associates' Medical Plan when submitted by a doctor or dentist, including but not limited to:

- Prescriptions
- Emergency room services for mouth pain
- Treatment of fractures/dislocations of the jaw resulting from an accidental injury

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

OUTPATIENT PHYSICAL/OCCUPATIONAL THERAPY

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

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

This benefit is payable up to a maximum of 20 visits for physical therapy and 20 visits for occupational therapy per calendar year. Additional visits may be covered if deemed appropriate by the care manager.

PREGNANCY BENEFITS

Pregnancy expenses are covered the same as any other medical condition. (Eligible prenatal services are covered under the preventive care program.)

Benefits will be paid for pregnancy-related expenses of dependent children. The newborn will be covered only if the newborn is a covered dependent of the covered associate. See [How to change your elections due to a status change event](#) in the [Eligibility and enrollment](#) chapter for information on enrolling a newborn for coverage.

PROSTHETICS

Prosthetic devices (such as artificial limbs) are covered if medically necessary and prescribed by a physician, subject to the terms of the Third Party Administrators of the Plan. Replacement prostheses will be allowed only with a change of prescription. A licensed prosthetician must perform replacements of artificial limbs.

REHABILITATIVE CARE

The Associates' Medical Plan covers inpatient and/or day rehabilitation limited to 120 days per condition for the following clinical groups if clinical criteria are met:

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

SPECIALTY CARE

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

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

Benefits are limited to a maximum of 60 calendar days per disability period.

Successive periods of confinement due to the same or related causes are considered one disability period unless separated by a complete recovery.

SPEECH THERAPY

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

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

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

- A cerebral vascular accident
- Head or neck injury
- Paralysis of voice cord(s) or larynx, partial or complete
- Head or neck surgery, or
- Congenital and severe developmental speech disorders in children up to age 6 (note, however, that effective Jan. 1, 2018, this age limit no longer applies, as stated on page 286).

 **See page 286**

VIDEO VISITS

Video visits are covered for participants enrolled in the Associates' Medical Plan only when provided through the Doctor On Demand service. See [Telehealth video visits](#) earlier in this chapter for more information.

VISION SERVICES

The diagnosis and treatment of injury or disease of the eye, including but not limited to diabetic retinopathy, glaucoma and macular degeneration, are covered. Charges for routine eye care, including but not limited to vision analysis, eye examinations or eye surgeries for nearsightedness or correction of vision, are not covered, except for vision screening for children covered under preventive care guidelines.

WEIGHT LOSS TREATMENT

Weight loss surgery is covered by the Associates' Medical Plan only when participants meet specific eligibility guidelines and clinical criteria under the Centers of Excellence program. Weight loss treatments, including but not limited to medications, diet supplements and surgeries outside the scope of the weight loss surgery benefit are not covered. See the [Centers of Excellence](#) section of this chapter for more information about weight loss surgery.

What is not covered by the Associates' Medical Plan

In addition to the exclusions and limitations listed in the [When limited benefits apply to the Associates' Medical Plan](#) section of this chapter, the following list represents services and charges that are not covered by the Plan and cannot be paid through your HRA (if you are covered under one of the HRA plans). Network discounts will not apply to these services and charges.

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

If you have a question regarding whether a particular service is covered under the Plan, please call the Third Party Administrator on your plan ID card or see the inside back cover of this book for contact information.

Acupuncture

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

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

Autopsy

Beyond the scope of licensure or unlicensed: Services rendered by a non-credited or a non-licensed physician, health care worker or institution, or services rendered beyond the scope of such person or entity's license.

Biofeedback

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

Any expenses or charges resulting from breast reductions, implantations or total breast removal, whether male or female, are not covered, unless directly related to treatment of a mastectomy, as provided for under the Women's Health and Cancer Rights Act of 1998 (see [Women's Health and Cancer Rights Act of 1998](#) later in this chapter), or unless the Plan conducts a medical review and determines that the procedure is medically necessary.

Chiropractic care: Coverage for spinal manipulation, joint manipulation or soft-tissue manipulation, regardless of the type of provider performing the service, except that participants enrolled in the Mercy Accountable Care Plans for Arkansas, Oklahoma, Springfield and St. Louis have limited coverage when services are performed by a network provider.

Copays and/or discounts, deductibles and/or coinsurance

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

Custodial or respite care: Custodial care is services that are given merely as "care" in a facility or home to maintain a person's present state of health, which cannot reasonably be expected to significantly improve.

Drugs, items and equipment not FDA-approved

Educational services: Including any services for learning and educational disorders (which include but are not limited to reading disorders, alexia, developmental dyslexia, dyscalculia, spelling disorders and other learning difficulties).

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

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

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

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

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

Health and behavior assessment/intervention: Evaluation of psychosocial factors potentially impacting physical health problems and treatments except behavioral assessments outlined under the preventive care program.

Hearing devices: Charges for routine hearing tests, including but not limited to hearing aids, except for hearing screening for children, covered under preventive care guidelines.

HMO copays

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

Infertility services: Treatment by artificial means for the purpose of creating a pregnancy. Assistive reproductive technology (ART) and other non-covered services include but are not limited to:

- Infertility prescription drugs
- Charges to reverse a sterilization procedure
- Charges for, or related to, the services of a surrogate mother, egg donor or sperm donor, and
- In-vitro fertilization, GIFT, ZIFT, IVC, gamete intra-cryopreservation, frozen embryo transfer and artificial insemination, including all related charges.

Judgments/settlements

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

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

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

Neurofeedback

Nonaccredited/nonlicensed providers or institutions

Non-covered services:

- Services not specifically included as a benefit in this Summary Plan Description
- Services provided after exceeding the benefit maximum for specified services
- Services for which the participant is responsible for payment, such as non-covered out-of-network charges
- Charges for services above the contracted rates to providers, or
- Charges for medical records.

Out-of-pocket expenses

Over-the-counter medications and equipment: Except for specific preventive care medications. See [The pharmacy benefit](#) chapter for more information.

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

Prostate-specific antigen (PSA) tests

Services provided by a member of the patient's family

Services provided by a government entity while incarcerated

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

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

Surrogate parenting: Whether paying for another's services or serving as a surrogate.

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

Termination of pregnancy: Charges for procedures, services, drugs and supplies related to abortions or termination of pregnancy are not covered, except when the health of the mother would be in danger if the fetus were carried to term, the fetus could not survive the birthing process or death would be imminent after birth.

Travel and lodging, except as specified under Centers of Excellence benefits (excluding weight loss surgery)

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

Walmart Care Clinic: Charges for nonpreventive services, except where the Walmart Care Clinic is considered a network provider or for lab services provided outside the clinic by an external vendor.

Work hardening or similar vocational programs

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

Filing a medical claim

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

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

You must file within 18 months from date of service or your claim will be denied. Claims will be determined under the time frames and requirements outlined in the [Claims and appeals](#) chapter.

Please see your plan ID card for the correct address to mail your claim. Failure to mail your claim to the correct address may result in the denial of your claim.

In addition, you may complete a claim form located on the [WIRE](#) or [WalmartOne.com](#) and submit the form to the appropriate address.

Failure by you or the provider to file a claim within 18 months from the date of service will result in denial of your claim. There are laws that govern the review of your claims.

Claims will be determined under the same time frames and requirements set out in the [Claims and appeals](#) chapter.

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

If your plan provides coverage for non-network providers and you use a non-network provider, payment may be made directly to you upon your showing proof of payment in full to the provider. You will be responsible for your 50% share of the maximum allowable charge, plus any amount over and above the maximum allowable charge. As a convenience to you, payment may also be made to a non-network provider, if you expressly authorize such payment. Your provider, whether network or non-network, may not pursue appeals on your behalf unless you designate your provider as your authorized representative, as described in the [Claims and appeals](#) chapter. The Plan prohibits the assignment of any benefit or any legal claim or cause of action (whether known or unknown). Please note that any direct payment to a provider is undertaken by the Plan solely for your convenience.

You have the right to appeal a claim denial. See the [Claims and appeals](#) chapter for details.

If you have coverage under more than one medical plan

The Associates' Medical Plan has the right to coordinate with "other plans" under which you are covered so the total medical benefits payable will not exceed the level of benefits otherwise payable under the Associates' Medical Plan. "Other plans" refers to the following types of medical and health care benefits:

- Coverage under a governmental program provided or required by statute, including no-fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation
- Group insurance or other coverage for a group of individuals, including coverage under another employer plan or student coverage obtained through an educational institution
- Any coverage under labor-management trustee plans, union welfare plans, employer organization plans or employee benefit organization plans
- Any coverage under governmental plans, such as Medicare or Tricare, but not including a state plan under Medicaid or any governmental plan when, by law, its benefits are secondary to those of any private insurance, nongovernmental program, and
- Any private or association policy or plan of medical expense reimbursement that is group or individual rated.

When you are covered by more than one plan, one of the plans is designated the primary plan. The primary plan pays first and ignores benefits payable under other plans when determining benefits. Any other plan is designated as a secondary plan that pays benefits after the primary plan. A secondary plan reduces its benefits by those benefits payable under "other plans" and may limit the benefits it pays.

You must follow the primary insurance terms in order for the Plan to pay as secondary payer.

These rules apply whether or not a claim is made under the other plan. If a claim is not made, benefits under the Associates' Medical Plan will be delayed or denied until an explanation of benefits is received showing a claim made with the primary plan.

The Associates' Medical Plan will not coordinate as a secondary payer for any copays you pay with respect to another plan or with respect to prescription drug claims or transplants (except where the other plan is Medicare).

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

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

HOW THE ASSOCIATES' MEDICAL PLAN (AMP) COORDINATES WITH OTHER PLANS

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

DETERMINING WHICH PLAN IS THE PRIMARY PLAN

A plan without a coordinating provision is always primary. The Associates' Medical Plan has a coordinating provision. If all plans have a coordinating provision, the following will apply:

- The Plan always is the secondary payer to any motor vehicle policy that may be available to you, including personal injury protection or no-fault coverage. If the Plan pays benefits as a result of injuries or illnesses you sustained and another party (e.g., an insurance company) bears primary responsibility for your covered medical expenses, the Plan has a legal right to reimbursement of benefits. Please see the [Claims and appeals](#) chapter for more information.
- The plan covering the participant for whom the claim is made, other than as a dependent, pays first and the other plan pays second.
- If the plan participant is covered under a retiree medical plan that includes a coordination of benefits provision, the provision governs.
- For dependent children's claims, the plan of the parent whose birthday occurs earlier in the calendar year is primary.
- When the birthdays of both parents are on the same day, the plan that has covered the dependent for the longer period of time is primary.
- When the parents of a dependent child are divorced or separated, or the domestic partnership or legal relationship is terminated, and the parent with custody has not remarried, that parent's plan is primary.
- When the parent with custody has remarried, or entered into a domestic partnership with another individual, that parent's plan is primary, the stepparent's plan pays second and the plan of the parent without custody pays last.
- When there is a court decree that establishes financial responsibility for the health care expenses of the

- child, the plan that covers the parent with financial responsibility is primary.
- If these rules do not establish an order of benefit determination, the plan that has covered the participant for whom the claim is made for the longest period of time will be primary.
- If you are covered under a right of continuation coverage pursuant to federal or state law (for example, COBRA continuation coverage), and you are also covered under another plan that covers you as an employee, member subscriber or retiree (or as that person's dependent), the latter plan is primary and the continuation coverage is secondary. If the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule does not apply.

IF YOU OR A DEPENDENT IS COVERED UNDER MEDICAID

If you or your dependent is a participant in the Plan and also covered under Medicaid, the Plan will pay before Medicaid. The Plan will not take the Medicaid coverage into account for purposes of enrollment or payment of benefits.

If, while you are covered under Medicaid, benefits are required to be paid by the Plan, but are first paid by the state plan, payment by the Plan will be made as required by any applicable state law which provides that payment will be made to the state.

IF YOU OR A DEPENDENT IS ELIGIBLE FOR OR ENROLLED IN MEDICARE

If you are enrolled in Medicare Part D, you are not eligible to enroll in the Associates' Medical Plan. Additionally, if your dependent is enrolled in Medicare Part D and you are not, you are eligible to enroll in a Walmart medical plan, but your dependent would not be eligible for such coverage.

In general, the Social Security Act requires that the Associates' Medical Plan be the primary payer if you or your dependent is eligible for or enrolled in Medicare Part A, or Parts A and B, and meet one of the following criteria:

- You are currently employed by the company and are age 65 or older
- You are currently employed by the company and your spouse/partner is age 65 or older
- You are an active participant or COBRA participant entitled to Medicare on the basis of end-stage renal disease, but only for the first 30-month period of eligibility for Medicare coverage (whether or not actually enrolled in Medicare throughout this period)

- You are under age 65 and are entitled to Medicare due to disability and are covered under the Plan due to being employed by the company, or
- Your dependent is under age 65 and is entitled to Medicare due to his or her disability and is covered under the Plan due to your being employed by the company.

The Plan will be secondary if you or your dependent is enrolled in Medicare and meets one of the following criteria:

- You or your dependent is a COBRA participant, except in the case of Medicare enrollment due to end-stage renal disease, for which the Plan is primary for the first 30-month period of eligibility for Medicare coverage, or
- You or your dependent is an active participant or COBRA participant enrolled in Medicare due to end-stage renal disease, after the 30-month coordination period with Medicare is exhausted.

IF YOU ARE AGE 65 OR OLDER AND AN ACTIVE ASSOCIATE

If you are still working for the company, you may continue your coverage under the Associates' Medical Plan. If you also have Medicare, the Associates' Medical Plan will generally be primary and Medicare will be secondary. File your claim with the Associates' Medical Plan first.

You may also elect to end your coverage under the Associates' Medical Plan and choose Medicare as your primary coverage.

If you choose Medicare as your primary coverage, you may not elect this Plan as your secondary plan.


STATE-MANDATED AUTOMOBILE PERSONAL INJURY OR MEDICAL PAYMENT COVERAGE

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

If you go on a leave of absence

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums either before the leave begins or during the leave. For information about making payments while on a leave of absence, see the [Eligibility and enrollment](#) chapter.

BREAK IN COVERAGE

 **Please see page 289** for information replacing the following two paragraphs.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status within one year from cancellation, you will be enrolled for the same coverage plans (or, if this coverage is not available, the coverage that is most similar to your prior coverage). Your coverage will be effective the first day of the pay period that you return to active work as defined by the Plan. For more information, contact People Services at **800-421-1362**.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status after one year from cancellation, you will be considered newly eligible; you may enroll for coverage within the applicable time period and under the conditions described in the **Eligibility and enrollment** chapter.

When coverage ends

Your coverage and your eligible dependents' coverage ends on your last day of employment, or when you are no longer eligible under the terms of the Plan. However, you may be able to continue your coverage under COBRA.

See the **Eligibility and enrollment** chapter for a complete list of events that may cause coverage to end. See the **COBRA** chapter for additional details regarding COBRA coverage.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be re-enrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan). If your break is 30 days or less, the annual deductible, out-of-pocket maximum and HRA (if applicable) will not reset. If your break is greater than 30 days, your annual deductibles, out-of-pocket maximum and HRA (if applicable) will reset. If your break is greater than 30 days but less than 13 weeks, you will have 60 days after resuming work to drop or otherwise change the coverage in which you were automatically re-enrolled.

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

If you drop coverage and re-enroll

If you drop coverage and re-enroll within 30 days, you will automatically be re-enrolled for the same coverage you had (or the most similar plans offered under the Plan). In this case, the annual deductible and waiting periods will not reset.

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

Other information about the medical plan

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prosthesis 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 People Services at **800-421-1362**.

A NOTE ABOUT MATERNITY ADMISSIONS

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

The pharmacy benefit

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The pharmacy benefit

The pharmacy benefit is an important part of your benefits package. Prescription drugs play a critical role in treating illness and can help you and your eligible dependents maintain good health.

PHARMACY BENEFIT RESOURCES

Find What You Need	Online	Other Resources
<ul style="list-style-type: none"> Find a Walmart or Sam's Club pharmacy 	Go to the WIRE , WalmartOne.com or Express-Scripts.com/Walmart	
<ul style="list-style-type: none"> Find an Express Scripts network pharmacy 	Go to Express-Scripts.com/Walmart	Call Express Scripts at 800-887-6194
<ul style="list-style-type: none"> Get the list of covered brand-name drugs Get the list of medications that require the collection of additional information 	Go to the WIRE , WalmartOne.com or Express-Scripts.com/Walmart	

What you need to know about the pharmacy benefit

- You are covered under the pharmacy benefit if you enroll in any of the medical plan options available under the Associates' Medical Plan. Associates enrolled in an HMO plan or the eComm PPO Plan receive pharmacy benefits through their medical plan.
- Except as noted in this chapter, associates must use a Walmart or Sam's Club pharmacy for pharmacy benefits to be paid. Benefits are generally not payable if you use another pharmacy.
- If your work location is more than five miles from a Walmart or Sam's Club pharmacy, associates who have medical coverage under the HRA High Plan, HRA Plan or HSA Plan have the option to have prescriptions filled at an Express Scripts network pharmacy, in addition to a Walmart or Sam's Club pharmacy.
- Under the Associates' Medical Plan, specialty drugs must be purchased from a Walmart Specialty Pharmacy or Accredo (the specialty pharmacy of Express Scripts).

The pharmacy benefit

The Associates' Medical Plan covers eligible prescriptions from both retail and mail-order network pharmacies. You and your covered dependents are eligible for prescription coverage on the date your medical coverage is effective.

To purchase prescriptions under your pharmacy benefit plan, simply present your plan ID card at a Walmart or Sam's Club pharmacy. If you are covered under the HRA High Plan, HRA Plan or HSA Plan and your work location is more than five miles from a Walmart or Sam's Club pharmacy, you may also purchase drugs at any Express Scripts network retail pharmacy.

Under certain limited circumstances, as described below, associates can fill prescriptions at an Express Scripts network retail pharmacy even if your work location is within five miles of a Walmart or Sam's Club Pharmacy. When purchasing drugs by mail order, as described later in this chapter, you can use either Walmart or Express Scripts Mail Order.

No benefits will be paid if you use a non-network pharmacy. Visit [WalmartOne.com](https://www.walmartone.com) to find information about:

- Walmart or Sam's Club pharmacies
- Retail pharmacies in the Express Scripts network
- Mail-order network pharmacies
- Covered generic, brand-name and specialty drugs, and
- Preventive medications.

You can also call Express Scripts at **800-887-6194**.

WHEN PRESCRIPTIONS CAN BE FILLED AT AN EXPRESS SCRIPTS NETWORK PHARMACY

If you have medical coverage under the HRA High Plan, HRA Plan or HSA Plan and your work location is more than five miles from a Walmart or Sam's Club pharmacy, you have the option of using an Express Scripts network pharmacy to fill your prescriptions, in addition to a Walmart or Sam's Club pharmacy, at the rates shown in the chart on the following page.

Associates may also have prescriptions filled at an Express Scripts network pharmacy regardless of their work location in certain limited circumstances, including the following:

- If a drug is out of stock and will not be available at a Walmart or Sam's Club pharmacy for an extended time (as defined by the Plan), you may transfer the prescription to an Express Scripts network pharmacy.
- If a covered drug is unavailable at a Walmart or Sam's Club pharmacy, it can be filled at an Express Scripts network pharmacy.
- If an emergency prescription fill is needed outside Walmart or Sam's Club store pharmacy hours, you may be able to fill your prescription at an Express Scripts network pharmacy.

NOTE: Certain restrictions apply to filling prescriptions for narcotics and other controlled substances.

For information on other exceptions and steps you must take, call Express Scripts at **800-887-6194**.

How the pharmacy benefit works

The pharmacy benefit covers only prescription drugs that are specifically listed on the closed formulary list maintained by Express Scripts. You can view an abbreviated list on the [WIRE](#) or at [WalmartOne.com](https://www.walmartone.com), or you may call Express Scripts at **800-887-6194** for a full list. If you don't see your drug listed, please call Express Scripts to see if it is on the formulary.

- If you are a participant in the HRA High Plan, the HRA Plan, any of the Accountable Care Plan options or the Select Network Plan, you purchase eligible prescriptions by paying the copays out of your own pocket. See the [Pharmacy benefits](#) chart on the next page for complete details about copays. (Money in your HRA account, if applicable to your medical coverage option, cannot be used to purchase prescriptions.) Your copays will be applied toward your medical plan's annual out-of-pocket maximum. Once your annual out-of-pocket maximum is met, eligible prescriptions will be paid at 100% for the remainder of the calendar year.
- If you are a participant in the HSA Plan, you pay the full retail/mail-order price for your prescriptions until you meet your medical plan's network annual deductible. Once you have met your network annual deductible, you pay the copays listed in the [Pharmacy benefits](#) chart. (The exceptions are medications on the Express Scripts list of approved preventive medications, which are not subject to the HSA Plan's network annual deductible. See [Preventive medications not subject to the HSA Plan's network annual deductible](#) later in this chapter for details.) Your copays will be applied toward your medical plan's annual out-of-pocket maximum. Once your annual out-of-pocket maximum is met, eligible prescriptions will be paid at 100% for the remainder of the calendar year.

Under its agreement with Express Scripts, the Plan has negotiated discounted prices on generic and brand-name drugs that are available when eligible prescriptions are filled at retail and mail-order network pharmacies. If, at the time your prescription is filled, the discounted price available is lower than the copay, you will be charged the lower amount, which may include a dispensing fee. Participants in the HSA Plan pay the full retail/mail-order price for most prescriptions until the medical plan's network annual deductible is met.

Refer to the [Pharmacy benefits](#) chart on the next page for details about copays and coinsurance.

PHARMACY BENEFITS

Generic drugs Up to 30-day supply 31- to 60-day supply 61- to 90-day supply	\$4 copay \$8 copay \$12 copay	Filling your prescriptions <ul style="list-style-type: none"> • Simply present your plan ID card at a Walmart or Sam's Club pharmacy. • If you are covered under the HRA High Plan, HRA Plan or HSA Plan and your work location is more than 5 miles from a Walmart or Sam's Club pharmacy, you may also purchase drugs at an Express Scripts network retail pharmacy. • See When prescriptions can be filled at an Express Scripts network pharmacy on the previous page for additional information.
Brand-name drugs	Greater of \$50 or 25% of allowed cost	
Specialty drugs <i>Available only at Walmart Specialty Pharmacy or ESL/Accredo</i>	Greater of \$50 or 20% of allowed cost	

Under the HSA Plan: The charges listed above apply after the HSA Plan's network annual deductible has been met, with the exception of medications that are on the Express Scripts list of approved preventive medications, which are not subject to the deductible. See **Preventive medications not subject to the HSA Plan's network annual deductible** later in this chapter for details.

Mail-order drugs:

- Your cost for a 90-day supply is three times the cost of a 30-day supply purchased at a Walmart or Sam's Club pharmacy, as listed above.
- For brand-name drugs, 31-day supplies or greater must be purchased through mail order, through Walmart or Express Scripts mail order.

TYPES OF DRUGS

To be covered under the Plan, prescription drugs must be on the Plan's formulary, which is a list of generic and brand-name medications covered by the Plan. The formulary includes medications that have been tested for quality and effectiveness and are believed to be a necessary part of a quality treatment program. The formulary is reviewed quarterly and can change. You can view an abbreviated list on the **WIRE** or at **WalmartOne.com**, or you may call Express Scripts at **800-887-6194** for a full list.

Note that the Plan has a closed formulary. This means that your prescription drugs, whether they fall under the generic, brand-name or specialty drug category, must be

included on the Plan's formulary for pharmacy benefits to be paid under the Plan.

Generic drug: When a brand-name drug's patent expires, a generic equivalent of the drug may become available. When a generic equivalent becomes available, the brand-name drug will no longer be covered. Generic equivalents work like the brand-name drug in dosage, strength, performance and use, and must meet the same quality and safety standards. All generic drugs must be reviewed by the United States Food and Drug Administration (FDA). For more information, visit **WalmartOne.com**.

IMPORTANT NOTES ABOUT YOUR PRESCRIPTION DRUG BENEFITS LISTED IN THE CHART ABOVE

- Refills of retail prescriptions are available after 75% of your previous prescription for the same drug has been used.
- Certain eligible preventive over-the-counter medications are fully covered if prescribed by a physician. See **Preventive over-the-counter medications** later in this section.
- If you are eligible for and choose to enroll in an HMO or the eComm PPO Plan, you will receive your prescription drug benefits through your medical plan.
- Prescription drug copays and coinsurance charges count toward your medical plan's annual out-of-pocket maximum. If you have coverage under the HSA Plan, eligible pharmacy charges you pay before you meet your network annual deductible also count toward the HSA Plan's annual out-of-pocket maximum. Once you meet the out-of-pocket maximum applicable to your coverage, eligible prescription drug charges are paid at 100% for the remainder of the calendar year.
- Discounts, coupons, pharmacy discount programs or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug discount/ coupons provided to pharmacies when you fill a prescription) will not count toward the medical plan's annual out-of-pocket maximum. In addition, if you have coverage under the HSA Plan, such charges will not count toward the HSA Plan's network annual deductible.



Brand-name drug: A covered brand-name drug is a drug manufactured by a single manufacturer that has been evaluated for safety and effectiveness when compared to similar drugs treating the same condition and identified for inclusion on the covered brand-name drug list.

Specialty drug: Specialty medications are drugs that are used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Whether they are administered by a health care professional, self-injected or taken by mouth, specialty medications require an enhanced level of service. (Medications used to treat diabetes are not considered specialty medications.)

MAIL-ORDER PRESCRIPTIONS

Mail-order prescriptions can save you a trip to the pharmacy and provide the convenience of prescription drugs delivered to your home. Mail-order prescriptions can be purchased through Walmart or Express Scripts mail order (under any of the Associates' Medical Plan coverage options). If you have a chronic condition, such as diabetes or asthma, and require the same or similar prescriptions throughout the year, you may want to consider the mail-order option for your pharmacy needs. Your mail-order cost for a 90-day supply is three times the cost of a 30-day supply purchased at a Walmart or Sam's Club pharmacy. For brand-name drugs, 31-day supplies or greater must be purchased through mail order only, through Walmart or Express Scripts mail order. Contact your Walmart or Sam's Club pharmacy or Express Scripts, or call People Services at **800-421-1362** for additional information regarding the mail-order prescription service.

CONTRACEPTIVES FOR WOMEN

The Plan covers all FDA-approved contraceptive methods, including approved over-the-counter (OTC) variations for women, as required by the Affordable Care Act. Contraception has additional health benefits such as reduced risk of cancer and protection against osteoporosis. Under the terms of the Affordable Care Act, all generic contraceptives (and brand-name contraceptives when medically necessary) will be covered at 100%, when prescribed by a physician. If your attending physician believes a brand-name contraceptive is medically necessary, you may file a claim for coverage of the brand-name drug. See [Filing a pharmacy benefit claim](#) at the end of this chapter.

PREVENTIVE MEDICATIONS NOT SUBJECT TO THE HSA PLAN'S NETWORK ANNUAL DEDUCTIBLE

Certain preventive medications will be covered under the HSA Plan before the Plan's network annual deductible is satisfied. Prescription drugs that can keep you from developing a health condition are called "preventive medications." These drugs can help you maintain your quality of life and avoid expensive treatment, helping to reduce your overall health care costs. If you are taking prescribed drugs for certain health issues, such as high blood pressure, high cholesterol, etc., you may be eligible to get these medications before your HSA Plan's network annual deductible is satisfied. Eligible medications will be allowed at the applicable copays listed in the [Pharmacy benefits](#) chart on the previous page. A list of these medications can be found on the [WIRE](#) or [WalmartOne.com](#).

PREVENTIVE OVER-THE-COUNTER MEDICATIONS

If you are enrolled in the Associates' Medical Plan, costs of certain generic OTC medications are covered at 100% when they are prescribed by a physician and you purchase them at retail network pharmacies. Covered OTC preventive care medications are those required by regulations issued under the Affordable Care Act. (Please note that the Plan's coverage of OTC preventive care medications may change as additional regulations are issued.) For the covered generic OTC medications to be paid at 100% by the pharmacy benefit plan, you must purchase them at one of the retail network pharmacies and present your plan ID card and a prescription from your physician at the time of purchase. The Plan covers preventive generic medications at 100%. If your physician believes a brand-name preventive OTC medication is medically necessary, the physician can file an appeal directly with Express Scripts for coverage of the brand-name drug, or you may file a claim for the brand-name drug under the procedures listed in the [Filing a pharmacy benefit claim](#) section of this chapter.

Some of the most common preventive OTC medications identified by the United States Preventive Services Task Force (USPSTF) are listed in the chart on the following page. For the most up-to-date list of covered preventive care OTC medications, go to the [WIRE](#) or [WalmartOne.com](#) or call Express Scripts at **800-887-6194**.

PREVENTIVE OVER-THE-COUNTER MEDICATIONS

Recommended by the U.S. Preventive Services Task Force (USPSTF)

 **See page 286**

Oral fluoride	By prescription when appropriate for children 6 months to 6 years of age
Folic acid	By prescription for all women planning or capable of pregnancy
Generic aspirin	By prescription for adults age 45 to 59 who have 10% or greater 10-year cardiovascular disease risk, are not at increased risk for bleeding, have life expectancy of at least 10 years and are willing to take low-dose aspirin for at least 10 years; low-dose aspirin (81mg/d) by prescription after 12 weeks of gestation in pregnant women at high risk for preeclampsia
Vitamin D	By prescription for individuals age 65 and over <i>Effective Jan. 1, 2019, vitamin D is no longer included on this list of available preventive over-the-counter medications.</i>
Generic statin	By prescription for adults age 40 to 75 with no history of cardiovascular disease, 1 or more risk factors and a calculated 10-year CVD event risk of 10% or greater
Bowel prep agents	By prescription when appropriate for a preventive colonoscopy for adults over age 50

MEDICATIONS THAT REQUIRE PRIOR AUTHORIZATION

Prior authorization is required for some medications in order for them to be covered by the Plan. Express Scripts, the Plan Administrator, may ask your physician to provide additional information, which is considered “a coverage authorization.”

After receiving the required information, Express Scripts will notify you and your doctor (usually within two business days) to confirm whether or not coverage has been authorized. If it is determined that the prescription is not a covered benefit under your pharmacy plan, it will not be paid. You may appeal this decision, as described in the [Claims and appeals](#) chapter. If you elect to fill the prescription without prior authorization, you will be responsible for the full retail cost.


For questions about prior authorizations, call Express Scripts at **800-887-6194**.

MEDICATIONS WITH QUANTITY LIMITS

Certain medications have limits on the quantity you can receive per prescription. These limits are based upon the approved FDA dosage guidelines for the medication. A list of these medications can be found on the [WIRE](#) or [WalmartOne.com](#).

Prescriptions written for no more than the designated quantity of the drug will be processed by your pharmacy benefit plan at the appropriate copay. Prescriptions for quantities greater than the FDA-approved quantity will not be processed by your pharmacy benefit plan, and you will be responsible for 100% of the cost.

THE CASTLIGHT TOOL AND PRESCRIPTION DRUGS

 **See page 286**

Castlight, the tool described in the following paragraph, is no longer available effective Jan. 1, 2019.

Castlight, the personalized tool that lets you make price and quality-of-care comparisons of medical providers based on user reviews, can also be a useful tool for learning about prescription drugs. With Castlight you can compare prices of prescription drugs, track your out-of-pocket costs, compare generics and brand-name drugs, get personalized alerts based on your past prescriptions and access extensive educational resources. See the [Castlight](#) section in [The medical plan](#) chapter for information on getting started with Castlight.

What is not covered by the pharmacy benefit

Medications or services not covered by the pharmacy benefit include but are not limited to the following:

- Compound medications: Drugs that consist of two or more ingredients that are weighed, measured, prepared or mixed according to a prescription order. Compound drugs include ingredients that are either over-the-counter or are not approved by the FDA and as such are not covered by the Plan.
- Over-the-counter drugs (with the exception of insulin, when a state does not require a prescription for it, and those covered as part of the preventive care benefit under the Affordable Care Act, when a prescription is provided).
- Prescriptions filled at a pharmacy other than a Walmart or Sam’s Club pharmacy (except as noted in this chapter).
- Prescriptions filled by non-network pharmacies for your particular medical plan option.
- Prescription drugs with available over-the-counter equivalents.
- Prescription drugs purchased through a pharmacy discount program.
- Drugs for which prior authorization has not been secured, in cases where prior authorization is required under the Plan.

The above list is not meant to be a comprehensive or all-inclusive list of excluded benefits. For questions about excluded benefits, call Express Scripts at **800-887-6194**.

Pharmacy discounts for prescriptions not covered

Associates enrolled in the Associates' Medical Plan are eligible for a retail pharmacy discount on certain drugs not covered by the pharmacy benefit. The retail pharmacy discount provides discounts on the pharmacy's retail price on virtually all prescriptions not covered by the pharmacy benefit. The discount will vary depending on the drug prescribed. Keep in mind that any prescription not covered by the pharmacy benefit, including those purchased with the retail pharmacy discount, will not count toward your network annual deductible or out-of-pocket maximum.

To use the retail pharmacy discount, present your medical plan ID card to the pharmacy when you pick up your prescription. If the prescription is covered by the pharmacy benefit, the corresponding copay will apply. If the prescription is not covered by the pharmacy benefit, the retail pharmacy will automatically discount the cost of the drug. If the prescription is covered under the Associates' Medical Plan but is being filled too soon, is prescribed for off-label use or does not follow other similar Plan terms, the prescription will not be covered by the pharmacy benefit and the retail pharmacy discount will not apply. For more information, contact Express Scripts at **800-887-6194**.

Filing a pharmacy benefit claim

When you fill a prescription at an eligible network pharmacy, including a mail-order pharmacy, you do not need to file a claim. However, if you are unable to use your card at a network pharmacy or if you disagree with the amount you paid, you may file a claim with Express Scripts. Your claim must be submitted in writing within 18 months of the date you had the prescription filled (or you attempted to have it filled). If the prescription is an eligible prescription under the Plan, it will be paid in accordance with Plan terms.

Please call Express Scripts at **800-887-6194** to obtain a claim form, or visit the **WIRE** or **WalmartOne.com**. Your claim will be processed according to the terms described in the **Claims and appeals** chapter.

If your claim is denied, you have a right to appeal the denied claim. If you file an appeal, it will be processed according to the terms described in the **Claims and appeals** chapter.

COORDINATION OF BENEFITS

The pharmacy plan does not coordinate benefits for prescription drug claims. If any portion of a prescription drug claim is reduced, subsidized or paid by another health plan, insurance provider or pharmacy discount program, the Plan will not pay any amount of the pharmacy benefit claim.

Privacy and security

When you purchase prescription drugs through a Walmart or Sam's Club pharmacy or an Express Scripts network pharmacy, you can rest assured that your personal and medical information is kept confidential. All pharmacies that participate in the pharmacy network are covered by and adhere to applicable state and federal regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which protects the privacy of personal health information. Walmart values the trust that our associates place in us. Earning that trust is in accordance with our core value of respect for the individual. For more information, see **Notice of privacy practices – HIPAA information** in the **Legal information** chapter.

Health Savings Account

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Health Savings Account for HSA Plan participants

The Health Savings Account offers HSA Plan participants real savings on qualified health care expenses. Once you open your account, Walmart matches your tax-free contributions dollar-for-dollar, up to set limits. Depending on the level of coverage you choose, Walmart matches up to \$350 for individual coverage and up to \$700 for family coverage. Your account balance earnings are tax-free and, as the money grows from year to year, you can use it to pay for current or future medical expenses on a tax-free basis.

HEALTH SAVINGS ACCOUNT RESOURCES

Find What You Need	Online	Other Resources
Establish an account or change your contribution amount	Log on to the WIRE , WalmartOne.com or Workday	Call People Services at 800-421-1362
Access your Health Savings Account	Log on to MyHealthEquity.com If you are logging in for the first time as a member and have not already established a user ID and password, please click the "Begin Now" button.	Call HealthEquity at 866-296-2860 HealthEquity is the HSA administrator and custodian.
Get a list of qualified medical expenses (I.R.C. § 213(d)) Get information on contribution limits, eligibility and tax reporting responsibilities associated with a Health Savings Account	irs.gov	Call HealthEquity at 866-296-2860 or contact your tax advisor

What you need to know about the Health Savings Account

- You must be enrolled in the HSA Plan in order to open and contribute to a Health Savings Account.
- Walmart will match on a pretax basis each dollar you contribute, up to the matching limit, if you open your Health Savings Account by December 1 of the Plan year.
- The Health Savings Account allows you to pay for IRS-determined qualified medical expenses with tax-free dollars.
- During your enrollment session, you may accept the terms and conditions of the Health Savings Account; the account will not be considered "open," however, until you have successfully passed the customer identification process. If additional documentation is required to complete this process, HealthEquity will contact you directly. In no event will your account be considered open prior to the effective date of your HSA Plan coverage.
- No payroll withholding or employer contributions will be deposited to your Health Savings Account until it is open.
- A welcome kit will be mailed to your home address from HealthEquity within two weeks of your HSA Plan effective date if you have taken the necessary steps to open your account.
- You are not eligible to make Health Savings Account contributions for any month in which you are traveling on Walmart business outside the U.S. and are covered under the GeoBlue policy, which provides health benefit coverage for Walmart associates traveling internationally on business. You are encouraged to consult your tax advisor if you have questions about the amount to reduce your contributions based on your individual circumstances.

Health Savings Account advantages: tax breaks and Walmart contributions

The Health Savings Account offers HSA Plan participants:

- Walmart contributions: Walmart matches your pretax contributions dollar-for-dollar, up to the matching limit.
- The ability to contribute pretax dollars to the account through payroll deductions.
- The ability to pay for qualified medical expenses with tax-free dollars through the account, including easy access to the money in your account using the debit card you will receive. You can also access the funds in your account by logging in to [MyHealthEquity.com](https://www.myhealthequity.com). However, if the funds are used for nonmedical or nonqualified medical expenses, income tax will apply and a 20% penalty may also apply. Note that over-the-counter drugs are considered qualified medical expenses, eligible for tax-free reimbursement under a Health Savings Account, only if they are prescribed by a doctor. (This requirement does not apply to insulin.)

HealthEquity is the HSA administrator/custodian with which Walmart has contracted to receive Health Savings Account contributions from Walmart's payroll. In order to receive the Walmart contribution to your Health Savings Account or make pretax contributions through payroll deduction, you must maintain an open account with HealthEquity and continue medical coverage through the HSA Plan. If you have a Health Savings Account with another custodian, Walmart will not provide the Walmart contribution to your account or allow you to make pretax contributions through payroll deduction for that Health Savings Account, even if Walmart contracted with that custodian in the past.

Interest earnings and capital gains on the balance in your account will not be taxed during the period in which the funds remain in your account. In addition, all Health Savings Account funds withdrawn for qualified medical expenses are tax-free.

You have investment opportunities for your account balance once that balance reaches a certain amount. Investments are not guaranteed or FDIC-insured.

The balance in your Health Savings Account rolls over from year to year, increasing your savings for future medical expenses. You own the balance in your account, and can save it, invest it in funds offered through your custodian or spend it on qualified medical expenses.

NOTE: State tax law may differ from federal tax law in certain states, including Alabama, California and New Jersey.

Please consult your tax advisor or HealthEquity if you have questions about either the federal or state tax implications of a Health Savings Account.

Health Savings Account eligibility

As an HSA Plan participant, you are eligible to open a Health Savings Account as long as you are not enrolled in other health coverage, as described below. Please see the [Opening your Health Savings Account](#) section of this chapter. Even if you are enrolled in the HSA Plan, you are not eligible for the Health Savings Account if you:

- Are covered under any other health plan that is not a qualified high-deductible health plan, including a health care flexible spending account (exceptions include some disease-specific coverage; dental, vision, long-term care and disability coverage; accident policies such as critical illness insurance and accident insurance, and others)
- Are enrolled in Medicare
- Are enrolled in Medicaid
- Are covered under TRICARE®
- Have received medical benefits from the U.S. Department of Veterans Affairs during the preceding three months, other than benefits for preventive care or a service-connected disability, as defined by applicable law (mere eligibility for Veterans Affairs benefits does not disqualify you from contributing to a Health Savings Account), or
- Are claimed as a dependent on another person's tax return.

If you are an HSA Plan participant and also enrolled in critical illness insurance, you're not eligible for the major organ transplant rider under that coverage due to IRS guidance suggesting that such coverage would be viewed as non-high-deductible plan coverage.

Other restrictions may apply. For further information, please call HealthEquity at **866-296-2860**.

During the Plan year, you may be required to confirm account eligibility to continue contributions (for example, if you become Medicare-eligible because of your age, you may be asked to verify that you have not enrolled in Medicare).

The HSA Plan is a qualified high-deductible health plan (HDHP) subject to ERISA and to requirements of federal law that allow you to contribute to a Health Savings Account. However, Walmart intends for the Health Savings Account to be exempt from ERISA by complying with the terms of the Department of Labor Field Assistance Bulletins No. 2004-1 and 2006-02. Accordingly, the Health Savings Account is not established or administered by Walmart or the Associates' Health and Welfare Plan. Instead, the Health Savings Account is established by the associate during the enrollment process and administered by HealthEquity.

If you have non-high-deductible health plan coverage through Walmart or any other employer (e.g., your eligible spouse/partner's employer), including a Flexible Spending Account (FSA) or a Health Reimbursement Account

(HRA), you are generally ineligible to make Health Savings Account contributions (but you can enroll in the HSA Plan). There are exceptions to this rule for “limited purpose” FSAs/HRAs, which can be used only for dental or vision coverage, or for “post-deductible” FSAs/HRAs, which provide coverage only after you satisfy the deductible under an HDHP. For additional information, please contact HealthEquity by phone at **866-296-2860** or online at [MyHealthEquity.com](https://www.MyHealthEquity.com).

You are not eligible to make Health Savings Account contributions for any month in which you are traveling on Walmart business outside the U.S. and are covered under the GeoBlue policy, which provides health benefit coverage for Walmart associates traveling internationally on business. You are encouraged to consult your tax advisor if you have questions about the amount to reduce your contributions based on your individual circumstances.

Opening your Health Savings Account

When you enroll online in the HSA Plan through the [WIRE](https://www.WIRE.com), [WalmartOne.com](https://www.WalmartOne.com) or [Workday](https://www.Workday.com), you will choose the amount you want to contribute to your account through payroll deductions. You may change your contribution amount at any time. See [Setting up or changing your contribution amount](#) later in this chapter.

You'll receive a welcome kit at your home address directly from HealthEquity, the Health Savings Account custodian, generally within the following time frames:

- By the end of December if you enroll during annual enrollment, or
- Within two to three weeks after your Health Savings Account is opened if you enroll at any other time.

Your debit card will be included within the welcome kit. You can activate your debit card online at [MyHealthEquity.com](https://www.MyHealthEquity.com) or by calling HealthEquity at **866-296-2860**.

No payroll withholding or employer contributions will be deposited to your Health Savings Account until it is open. Your account will not be considered “open” until you have successfully passed the customer identification process required to open a Health Savings Account. If additional documentation is required to complete this process, HealthEquity will contact you directly.

In the event that any payroll withholding or employer contribution is made prior to your account being opened, the contribution will be held by your custodian and deposited into your Health Savings Account once your account has been opened. If your account is not opened within a reasonable amount of time, as determined by your custodian, the funds withheld from your check will

be refunded to you through your payroll check (less any applicable payroll taxes) and reported as wages on your Form W-2, and the employer contribution, if any, will be returned to Walmart.

For questions about your account status or fulfillment (welcome kit or debit card), you may call HealthEquity at **866-296-2860** or go online to [MyHealthEquity.com](https://www.MyHealthEquity.com).

Once Walmart receives confirmation from HealthEquity that your account has been opened and you have completed your Health Savings Account deductions selection online, your payroll deduction contributions to the account and Walmart's matching contributions will begin the following pay period. See [When company contributions are made](#) later in this chapter.

If you do not open your Health Savings Account by December 1 of the Plan year, you will forfeit your right to the company's contributions for that year, even if you are covered by the HSA Plan during that year or a portion of that year.

For the purposes of company funding and payroll deductions, you are required to select HealthEquity as your Health Savings Account custodian when you enroll. However, you may move your funds to another Health Savings Account custodian at any time. If you move your Health Savings Account funds to a bank other than HealthEquity and do not maintain a Health Savings Account with HealthEquity, pretax payroll deductions will not be available, you will not receive the company matching contributions and all Health Savings Account fees will be your responsibility.

HEALTH SAVINGS ACCOUNT FEES

The company will pay the monthly maintenance fees if you are enrolled in the HSA Plan and your Health Savings Account custodian is HealthEquity.

The company will not pay overdraft fees, excess contribution fees or lost card fees. If you are enrolled in COBRA, terminate employment with the company, otherwise become ineligible for coverage under the Associates' Medical Plan or are no longer enrolled in the HSA Plan, all associated fees will become your responsibility. These fees will be deducted automatically from your Health Savings Account balance if any of these events occur. You may call HealthEquity at **866-296-2860** to learn more about the fees for various Health Savings Account services. It is your responsibility to check your Health Savings Account balance prior to using funds to pay for services. Current rate and fee schedules are available online at [MyHealthEquity.com](https://www.MyHealthEquity.com). The fee schedule is also included in the welcome kit.

Contributions to your Health Savings Account

Once you have opened your Health Savings Account, as long as your account remains open and you are enrolled in the HSA Plan, Walmart may make contributions to your account as follows:

- Walmart matches your pretax contributions dollar-for-dollar, up to the matching limit described in the chart below.
- You may make pretax contributions to the account through payroll deductions in any amount (of \$5 or more each pay period) up to the legal limit (taking into account Walmart's contributions). For administrative purposes, contributions will generally be based annually on 25 pay periods.
- You can make personal contributions to your account by mailing a check or by electronic funds transfer (EFT) once you have linked a personal bank account on the HealthEquity website. These contributions will be made on an after-tax basis and are not eligible for the Walmart matching contribution. Walmart does not track after-tax contributions to the account and you would therefore need to count such contributions against your annual contribution limit. Check with your tax advisor to determine if you can deduct them from your federal or state tax return.
- In the event your requested Health Savings Account contribution for a specific pay period exceeds the amount of your paycheck after deductions, no contribution or company match will be made to your Health Savings Account for that pay period.
- With respect to your final paycheck, your Health Savings Account salary reductions and corresponding employer match may be reduced because of state law restrictions on salary reduction or because your requested Health Savings Account contribution exceeds the net amount of your payroll check after deductions.

If you experience a status change event and switch from associate-only coverage to family coverage under the HSA Plan during the year, Walmart will increase its matching contribution to correspond with the matching contribution limit for family coverage. If you experience a status change event and switch from family coverage to associate-only coverage during the year, the matching contributions that the company made prior to the change will not be reduced. In the event this results in your having contributions in your account above the annual maximum contribution allowed under IRS guidelines, the excess contributions will need to be withdrawn by your tax-filing deadline to avoid additional taxes.

Associates who are actively enrolled in the HSA Plan are eligible for matching contributions to the specified limit only for contributions made through payroll deductions.

Funds will no longer be contributed once Walmart has received notification that your account has been closed.

ANNUAL CONTRIBUTION LIMITS

By law, the maximum annual contribution that can be made to your account, including both the company's contributions and your contributions (pretax and after-tax), is:


- For 2018, \$3,450 for individual coverage, or
- For 2018, \$6,900 for family coverage.

 **See page 286**

The annual maximum contribution is the total contribution from all sources (payroll contributions by the associate and/or the company and personal contributions) to all accounts.

These amounts are indexed annually by the federal government and are subject to change each year. Please contact your Health Savings Account custodian for questions regarding the contribution limits. If you are age 55 or older, see the section **If you are age 55 or older** later in this chapter for special contribution rules.

YOUR CONTRIBUTIONS AND THE COMPANY'S CONTRIBUTIONS TO THE HEALTH SAVINGS ACCOUNT

Your HSA Plan network annual deductible	Company matching contribution limit: \$1 for \$1 up to	Maximum annual contribution limit (associate and company contributions combined)
\$3,000 (associate-only coverage)	\$350	\$3,450
\$6,000 (family coverage)	\$700	\$6,900
		 See page 286 for 2019 contribution limits

If two associates who are legally married are both eligible to contribute to individual Health Savings Accounts, the contribution limit for 2018 for both accounts combined is based on the maximum amount that can be contributed for a family: \$6,900. Note, however, if either of the associates is age 55 or older in 2018, the total combined contribution is increased by \$1,000 for each associate age 55 or older.

If two associates are in a relationship described under the definition of “eligible dependent,” but this relationship is other than a legal marriage, and they have family coverage, each associate is eligible to contribute to an individual Health Savings Account up to the maximum family contribution limit of \$6,900 (provided that neither associate can be claimed as a tax dependent on any individual’s federal tax return). If either associate is age 55 or older in 2018, the maximum contribution is increased by \$1,000 for each associate.

It’s important to monitor contributions to your Health Savings Account – there will be adverse tax consequences if your contributions exceed the annual limit that has been set by the federal government. Changes in coverage during the year or enrollment after the beginning of the year can affect your contribution limits. If you become aware during the year that combined contributions to your Health Savings Account exceed the annual limit, you can withdraw the excess contribution and the related interest earnings before your income tax return for the year is due (including extensions). For assistance and information, call HealthEquity at **866-296-2860**.

EARNING INTEREST ON YOUR HEALTH SAVINGS ACCOUNT

The balance in your Health Savings Account earns interest. For interest rate information on your account, contact HealthEquity at **866-296-2860** or go online to MyHealthEquity.com. Your current interest earned along with the interest rate schedule is available on your monthly statements.

WHEN COMPANY CONTRIBUTIONS ARE MADE

The company will match dollar-for-dollar the amount that you contribute through payroll deductions each pay period, up to the matching limit for your coverage, as shown in the chart titled [Your contributions and the company’s contributions to the Health Savings Account](#). The company will deposit this contribution, along with any contribution you make through payroll deduction, into your Health Savings Account shortly after the payroll deduction period ends. Walmart will initiate authorized payroll deductions once your Health Savings Account custodian confirms that your Health Savings Account is open and you complete your payroll deduction selection online.

SETTING UP OR CHANGING YOUR CONTRIBUTION AMOUNT

You may change your contribution amount online at any time during the year on a going-forward basis.

To set up your initial contribution amount or to change your contribution amount at any time, log on to the [WIRE](#), WalmartOne.com or [Workday](#) and click on “Online Enrollment.” If you need help setting up your payroll deductions, please contact People Services at **800-421-1362**.

NOTE: Once you make the maximum annual contribution (as stated in the chart on the previous page), your payroll contributions will automatically cease. It will be your responsibility to make a new contribution decision at the next annual enrollment for the following calendar year.

IF YOU ARE AGE 55 OR OLDER

If you are age 55 or older, you can make additional contributions to your Health Savings Account. These are called catch-up contributions and can be made by payroll deductions just like your normal contribution. For 2018, the catch-up contribution limit is \$1,000. Please call HealthEquity at **866-296-2860** for information on catch-up contributions.

If you also cover your spouse under the HSA Plan and your spouse is age 55 or older, he or she may also be eligible to open a second Health Savings Account and contribute catch-up contributions. The contribution limit for 2018 for both accounts combined is based on the maximum amount that can be contributed for a family: \$6,900. If either you or your spouse is age 55 or older in 2018, the total combined contribution is increased by \$1,000 for each participant age 55 or older. The company will not contribute funds or pay any fees associated with the Health Savings Account for your spouse.

If you cover an eligible partner under the HSA Plan and that individual is other than a spouse, you and your partner are each eligible to contribute to individual Health Savings Accounts up to the maximum family contribution limit of \$6,900 (provided that neither party can be claimed as a tax dependent on any individual’s federal tax return). If either associate or partner is age 55 or older in 2018, the maximum contribution is increased by \$1,000 for each participant age 55 or older. The company will not contribute funds or pay any fees associated with the Health Savings Account for your partner.

Please call HealthEquity at **866-296-2860** for information on how to open a Health Savings Account for your eligible spouse/partner.

Paying qualified medical expenses through your Health Savings Account

While the funds in your Health Savings Account belong to you, any money not used for qualified medical expenses will be subject to federal income tax as well as a 20% penalty if you are under the age of 65. You will be required to report the distribution and any applicable penalty on your federal tax return and possibly your state tax return. Qualified medical expenses must be incurred by you, your spouse or your children who qualify as tax dependents. Expenses incurred by any other individual (e.g., your partner) are not considered qualified medical expenses, unless your partner qualifies as your tax dependent. Qualified medical expenses generally include medical, dental and vision expenses, chiropractic care and acupuncture. Note that amounts paid for over-the-counter drugs are considered qualified expenses only if the drugs are prescribed by a doctor. (This requirement does not apply to insulin.) Please visit WalmartOne.com or MyHealthEquity.com to view examples of items generally considered to be medical expenses under Internal Revenue Code section 213(d). If you have questions about qualified medical expenses, please contact HealthEquity.

FILING YOUR INCOME TAX RETURN

Each January, you will receive tax forms to report distributions, contributions and the market value of your Health Savings Account for the previous calendar year. IRS Form 1099-SA reports the distributions from your Health Savings Account in the previous calendar year. IRS Form 5498-SA reports the contributions to your Health Savings Account either “in” or “for” the previous calendar year and the fair market value of your account as of December 31. Both forms are also viewable online. You should save all of your medical expense receipts for income tax purposes. Under IRS guidelines, you must file an IRS Form 8889 with your federal tax return if you (or someone on your behalf, including your employer) make contributions to a Health Savings Account during the year. IRS Form 8889 must also be filed if you have a Health Savings Account balance or use Health Savings Account funds during the year, even if you do not make contributions to the Health Savings Account in that year. Please consult your tax advisor if you have questions regarding the tax forms mentioned above.

Investing your Health Savings Account

Once your account has reached a minimum balance of \$1,000, any amount over that balance can be invested in the selected mutual funds. Over 20 investment funds are available. You can review the funds and learn more online at MyHealthEquity.com under “Investments.”

If you leave the company or are no longer enrolled in the HSA Plan

The funds in your Health Savings Account belong to you as the account holder, even if you enroll in COBRA, change plans (and are no longer enrolled in the HSA Plan), change jobs or leave the company. In these events, all fees associated with the account will become your responsibility.

Closing your Health Savings Account

All funds in your Health Savings Account belong to you, and you may use these funds for qualified medical expenses on a tax-free basis. If you choose to no longer maintain the account, it is your responsibility to close your account (for example, if you are no longer enrolled in the HSA Plan). Call HealthEquity at **866-296-2860** for information on how to close your account.

The dental plan

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The dental plan

The dental plan provides coverage for a wide range of dental services. The dental plan also offers you the choice to use a Delta Dental network dentist and pay less for care. Your teeth are an important part of your overall health. You pay no deductible for preventive and orthodontic services, and when you use network dentists, you'll save money on dental care costs while protecting one of your most valuable personal and professional assets — your smile.

DENTAL PLAN RESOURCES

Find What You Need	Online	Other Resources
Get a listing of Delta Dental PPO and Delta Dental Premier dentists	Go to the WIRE , WalmartOne.com or deltadental.com	Call Delta Dental at 800-462-5410 or People Services at 800-421-1362
Get answers to questions about your dental claims and to contact Delta Dental Customer Service	Go to deltadental.com and select "Subscriber" to create your account	Call Delta Dental at 800-462-5410
Get a claim form if you use a nonparticipating dentist	Go to the WIRE , WalmartOne.com or deltadental.com	

What you need to know about the dental plan

- Dental plan coverage is available to all hourly and management associates and their eligible dependents (except for the spouses/partners of part-time associates, temporary associates and part-time truck drivers).
- Dental plan coverage must remain in effect for two full calendar years.
- Orthodontia assistance is covered after a 12-month waiting period.
- Once you meet the annual deductible, the Plan pays benefits of up to \$2,500 per covered person per calendar year and a lifetime maximum orthodontia benefit of \$1,500 per covered person. The annual deductible does not apply for preventive or orthodontic services.
- Claims may be reviewed by dental consultants to help ensure that the treatment provided meets the guidelines of the dental plan.
- If you have medical coverage with the Associates' Medical Plan, both the dental and medical information are on your plan ID card. Your plan ID card will be mailed to your home address. If you are enrolled in an HMO or if you have dental-only coverage, you will receive a Delta Dental ID card. Your Delta Dental ID card will be mailed to your home address.

Your dental plan

Walmart offers the dental plan to help eligible associates pay for routine dental care. The dental plan is administered through Delta Dental.

Please note that once you enroll in the dental plan, your coverage must remain in effect for two full calendar years. For example, if you enroll on July 1, 2018, your coverage must remain in effect until December 31, 2020. You can add or remove an eligible dependent during annual enrollment or due to a status change event (see the [Eligibility and enrollment](#) chapter). However, you must maintain a minimum of associate-only coverage for two full calendar years.

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

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

For information on dependent eligibility and when dependents can be enrolled, see the [Eligibility and enrollment](#) chapter.

The dental plan benefit is self-insured. This means there is no insurance company that collects premiums and

pays benefits. Instead, participating associates make contributions to cover the cost of their benefits. Claims are processed by Delta Dental of Arkansas.

How the dental plan works

The dental plan covers four types of dental services:

- **Preventive and diagnostic care:** You do not have to meet the annual deductible (\$75 per person/\$225 maximum deductible per family) before benefits for preventive and diagnostic care begin. However, charges you incur for preventive and diagnostic care will not apply toward your annual deductible.
- **Basic care** includes fillings, non-surgical periodontics and root canal therapy and is covered after you meet the annual deductible.
- **Coverage for major care**, which includes surgical periodontics, crowns and dentures, begins after you have met the annual deductible.
- **Orthodontia assistance** coverage begins after you have participated in the dental plan for 12 months; you do not have to meet the annual deductible before receiving benefits for orthodontia care. However, charges you incur for orthodontia care will not apply toward your annual deductible.

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

COVERAGE UNDER THE DENTAL PLAN

Including dental plan benefits that apply to your annual deductible or lifetime maximum

Annual deductible Waived for preventive and diagnostic care and orthodontia care	\$75 per person/\$225 maximum per family		
Maximum benefits Does not apply to orthodontia care	\$2,500 per covered person per calendar year		
	Delta Dental PPO dentists	Delta Dental Premier dentists	Non-network dentists
Preventive and diagnostic care Charges (if any) do not count toward annual deductible	100% covered; no annual deductible applies *In areas served by an insufficient number of PPO dentists, as determined by facility location, services will be covered at 100%. Go to the WIRE or WalmartOne.com for details.	80% covered;* no annual deductible applies	80% covered; no annual deductible
Basic care Including fillings, non-surgical periodontics and root canal therapy	80% of maximum plan allowance after annual deductible is met (70% of maximum plan allowance for composite resin fillings in posterior teeth)		
Major care Including surgical periodontics, crowns and dentures	50% of maximum plan allowance after annual deductible is met		
Orthodontia assistance (12-month wait) Charges do not count toward annual deductible	80% of maximum plan allowance up to \$1,500 lifetime maximum orthodontia benefit per person; no annual deductible applies		

After you have met the annual deductible (if applicable for the service you received) and completed any applicable waiting periods, the Plan pays a percentage of the maximum plan allowance (MPA) for covered expenses.

MAXIMUM PLAN ALLOWANCE

The maximum plan allowance applies to both covered in-network and covered out-of-network dental services. The MPA is the maximum amount the Plan will cover or pay for dental services covered by the Plan.

For covered in-network services, the MPA is that portion of a provider's charges covered by the Plan as determined by the provider's contract with Delta Dental of Arkansas (which includes contracts with an independent licensee company of the Delta Dental Plans Association). Network providers contracted with Delta Dental agree to accept an amount negotiated by Delta Dental of Arkansas for covered services as payment in full, subject to the annual deductible and coinsurance amounts applicable to your coverage.

For covered out-of-network services, the MPA is limited to the allowance set by Delta Dental of Arkansas in its discretion and utilizing such methods or benchmarks Delta Dental may choose to employ, which may include the pricing or allowance offered by the Delta Dental plan in the state where the services were provided. If you see a dental provider who is not contracted with Delta Dental, the Plan will pay the lesser of the MPA or the provider's actual billed charges for a covered procedure. If the provider's billed charges exceed the Plan's MPA, you are responsible for paying your provider the difference. For additional information, call Delta Dental at 800-462-5410.

KNOW WHAT YOU'LL OWE:

GET A PRETREATMENT ESTIMATE

You can find out how much the dental plan will pay for a procedure before the dental work is done by having your dentist submit a proposed treatment plan to Delta Dental. It is recommended that a proposed treatment plan be submitted for treatment totaling \$800.00 or more, particularly when the treatment includes services classified as major care. Delta Dental will provide a pretreatment estimate of the amount that will be covered under the Plan and may suggest an alternate treatment plan if a part of your dentist's initial treatment plan is ineligible for coverage. Proposed treatment plans should be mailed to:

Delta Dental of Arkansas

P.O. Box 15965

Little Rock, Arkansas 72231-5965

Note that Delta Dental's pretreatment estimate is not a guarantee of payment. You still must file a claim under the procedures set out in the [Claims and appeals](#) chapter.

SAVE MONEY BY USING NETWORK DENTISTS

As a dental plan participant, you can use any dentist and receive benefits for covered expenses under the Plan. However, you will save money and time when you use Delta Dental dentists. Providers contracted with Delta Dental's Premier and PPO networks have agreed to accept the dental plan's maximum plan allowance as payment in full for a covered procedure, so you will pay no more than the coinsurance percentage specified under the dental plan (after any applicable annual deductible has been met). In addition, Delta Dental's network providers also provide Delta Dental participants with discounted prices. When you see a Delta Dental PPO provider, you may be able to save more because PPO providers have agreed to accept reduced fees for covered procedures when treating Delta Dental participants. You may save time because network dentists will often file your claims for you.

The Delta Dental PPO network is an extensive nationwide network of dentists, but is not as widely available as the Delta Dental Premier network. Refer to the chart entitled [Coverage under the dental plan](#) earlier in this chapter for details on how coverage terms for preventive and diagnostic care may differ based on the availability of PPO dentists in your area. To find a Delta Dental PPO or Delta Dental Premier dentist near you, see [Dental plan resources](#) at the beginning of this chapter.

IT PAYS TO USE NETWORK DENTISTS

	Delta Dental Premier dentists and PPO dentists	Non-network dentist
Dentist often files claim forms for you	Yes	No
Dentist accepts the maximum plan allowance as payment in full, subject to annual deductible and coinsurance amounts	Yes	No
Dentist offers discounted prices for Delta Dental participants	Yes	No

Filing a dental claim

If you use a Delta Dental network dentist, your dentist will often file the claim for you. If you use a non-network dentist, you may need to file a claim. The dentist may be paid directly from the dental plan if the dentist is a Delta Dental network dentist. If you use a non-network dentist, the payment will be made to you.

You or your dental provider must file a claim within 18 months from date of service or your claim will be denied. Please mail your claim to:

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, Arkansas 72231-5965

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

Claims will be determined under the time frames and requirements set out in the [Claims and appeals](#) chapter. You have the right to appeal a claim denial.

FILING A DENTAL PRESCRIPTION CLAIM

If you do not have medical coverage with the Plan, you will need to file a claim for any dental prescription by completing a claim form with Delta Dental, and your dental prescription will be subject to the terms and limits described earlier in this section. A copy of the claim form can be found on the [WIRE](#) and [WalmartOne.com](#). If you have medical coverage with the Plan, your dental prescriptions would be covered as any medical prescription.

IF YOU OR A FAMILY MEMBER HAS COVERAGE UNDER MORE THAN ONE DENTAL PLAN

If you have coverage under more than one dental plan — for example, you have coverage under the Plan and your spouse's/partner's employer-sponsored dental plan, the coordination of benefits provisions will apply. The dental plan has the right to coordinate with "other plans" under which you are covered so the total dental benefits payable will not exceed the level of benefits otherwise payable under the dental plan. "Other plans" are fully described in [If you have coverage under more than one medical plan](#) in [The medical plan](#) chapter. Dental benefits will not exceed annual or lifetime maximums.

What is covered under the dental plan

The dental plan covers the services listed in this section. There are some limitations. If you have any questions about what is and what is not covered under the dental plan, please call Delta Dental at **800-462-5410**.

PREVENTIVE AND DIAGNOSTIC CARE

Preventive and diagnostic care are covered without having to meet the annual deductible.

Bitewing or periapical X-rays: Periapical X-rays as needed and four bitewings in a calendar year.

Cleaning (dental prophylaxis): One prophylaxis, including cleaning, scaling and polishing of the teeth, is covered twice during a calendar year. Two additional cleanings are allowed during a pregnancy and up to three months following delivery.

Fluoride treatment: Covered once in any consecutive 12-month period for participants under age 19.

Full-mouth debridement: Limited to once per lifetime.

Full-mouth survey or panoramic X-rays: Limited to one procedure in any consecutive 60-month period. A full-mouth series is any combination of 14 or more periapical and/or bitewing X-rays taken on the same date.

Oral evaluations: Benefits are payable as follows:

- Routine oral evaluation: Two evaluations covered during a calendar year.
- Comprehensive detailed oral evaluation or periodontal evaluation: Initial comprehensive oral evaluation will be payable subject to the routine oral evaluation time limitations. Subsequent oral evaluations submitted by the same provider within three years will be processed as routine oral evaluations.

Emergency evaluations performed by dentists are not subject to the calendar year restriction.

Preventive resin restoration: Covered for first and second permanent molars with unrestored occlusal surface for participants under age 19. Limited to one treatment per tooth every five years.

Sealant repair: Covered for first and second permanent molars with unrestored occlusal surface for participants under age 19. Not covered during the first 24 months of the initial placement of the sealant. Limited to one treatment per tooth every 24 months. A sealant or a sealant repair is not covered when the tooth has previously received a preventive resin restoration.

Sealants: Covered for first and second permanent molars with unrestored occlusal surface for participants under age 19. Limited to one treatment per tooth per lifetime.

Space maintainers: Covered for participants under age 19.

BASIC CARE

After you meet the annual deductible, the Plan pays 80% of the maximum plan allowance for basic care.

Amalgam and composite resin fillings: Benefits are payable once per tooth surface in any consecutive 24-month period. Benefits for composite resin fillings for posterior teeth will be 70% of the maximum plan allowance up to the maximum benefit.

Endodontics: Includes pulp therapy and root canal therapy. See [Root canal therapy](#) in [Limited benefits](#) later in this chapter.

Extractions: Nonsurgical extractions.

Non-surgical periodontics: Provided once in any consecutive 36-month period.

Occlusal guard: Benefits are payable once every five years. Repair and/or relining of occlusal guard provided once in any consecutive 24-month period.

Occlusal orthotic device (TMJ appliance): Benefits are payable once every five years.

Periodontal maintenance: Periodontal maintenance is covered only if done 30 days or more after the completion of active periodontal treatment. Thereafter, periodontal maintenance is allowed once every 180 days.

Prescription drugs and medicines: Written for dental purposes and dispensed by a licensed pharmacist.

MAJOR CARE

After you meet the annual deductible, the Plan pays 50% of the maximum plan allowance for major care.

Anesthesia/general anesthetics and IV sedation: Provided only in the following circumstances:

- The patient suffers from a medical condition that prevents him or her from holding still (including but not limited to dystonia, Parkinson's disease, autism)
- The patient is under age six, or
- In connection with certain covered oral surgical procedures.

Complete and partial removable dentures: The Plan will cover a denture that replaces another denture or fixed bridge, or a fixed bridge that replaces another fixed bridge. When alternate treatment plans are available, the Plan will cover the professionally accepted, standard course of treatment. For example, a bridge will be allowed only when a partial denture will not suffice. Complete and partial or removable dentures are not payable for patients under the age of 16. A denture that replaces another denture or fixed bridge, or a fixed bridge that replaces another fixed bridge, will be covered only if the existing denture, partial denture or fixed bridge is at least five years old and cannot be repaired. See also [Prosthetics](#) in [Limited benefits](#) later in this chapter.

Implants: Surgical placement of an implant body is covered once in every seven-consecutive-year period.

- The abutment to support a crown is covered once in every seven-consecutive-year period.
- An implant or abutment-supported retainer is covered once in every seven-consecutive-year period.
- An implant maintenance procedure is covered once in any 12-consecutive-month period.
- Implant removal is covered once in a lifetime per tooth. Implants are not payable for patients under the age of 16.

Crowns, cast restorations, inlays, onlays and veneers:

Covered only when the tooth cannot be restored by amalgam or composite resin filling.

- Replacement will not be covered unless the existing crown, cast restoration, inlay, onlay or veneer is more than seven years old and cannot be repaired.

NOTE: Accidents as a result of biting or chewing are not an exception to the seven-year wait for crown replacements.

- For participants under age 14, benefits for crowns on vital teeth are limited to resin or stainless steel crowns, unless there is a history of root canal therapy or recession of the pulp.
- Treatment is determined according to the alternate treatment plan limitation. See [Alternative treatment plans](#) in [Limited benefits](#) later in this chapter.

Occlusal adjustment (limited): Covered only if done 180 days or more after completion of initial restorative, prosthodontic and implant procedures that include the occlusal surface.

Oral surgery: Surgical extractions and extractions of wisdom teeth, including preoperative and postoperative care, except for those services covered under the Associates' Medical Plan. Oral sedation and/or nitrous oxide (analgesia) are not covered.

Outpatient or inpatient hospital costs and additional fees charged by the dentist for hospital treatment: See [Hospital charges](#) in [What is not covered under the dental plan](#) later in this chapter.

Partial fixed bridgework: See [Alternative treatment plans](#) and [Prosthetics](#) in [Limited benefits](#) later in this chapter.

Surgical periodontics: Treatment of the gums — osseous surgery/soft tissue graft, provided in the same area once in any consecutive 36-month period.

ORTHODONTIA ASSISTANCE

After you have been a participant in the dental plan for 12 months, you are eligible for orthodontia assistance for yourself (the associate). Each of your covered dependents must also participate in the dental plan for 12 months before becoming eligible for orthodontia assistance. (The 12-month wait is waived for localized associates and their covered dependents.)

If the dentist submits a statement at the beginning of a period of orthodontic treatment showing a single charge for the entire treatment, benefits will be paid in the following manner:

- The dentist will receive an initial payment of up to \$150
- A prorated portion of the remainder will be paid every three months based on the estimated period for treatment and on continued eligibility, and
- The amount and number of payments are subject to change if the charge or treatment period changes.

Active orthodontic treatment is deemed started on the date the active appliances are first placed. Active orthodontic treatment is deemed completed on the earlier of:

- The date on which treatment is voluntarily discontinued, or
- The date on which the active bands or appliance(s) are removed.

There are certain orthodontia assistance benefits that are not covered. See [What is not covered under the dental plan](#) later in this chapter.

Limited benefits

 **See page 287**

Alternative treatment plans: When alternative treatment plans are available, the Plan will cover the professionally accepted, standard course of treatment.

Prosthetics: The Plan covers the replacement or addition of teeth to dentures, partials or fixed bridgework when needed, while covered under the Plan.


- The replacement of a complete or partial denture will be covered only if the existing denture or partial is at least five years old and cannot be repaired.
- The replacement of a fixed bridge will be covered only if the existing bridge is at least five years old and cannot be repaired.

Root canal therapy: Includes bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. Payable once per tooth.

- Therapeutic pulpotomy is payable for deciduous teeth only.
- Retreatment of a previous root canal is allowed once in a consecutive 24-month period.

Surgical/nonsurgical periodontics: Provided once in any consecutive 36-month period.

Transfer of treatment: If you transfer from the care of one dentist to another during the course of treatment, or if more than one dentist renders services for one dental procedure, the Plan will pay no more than the amount it would have paid if only one dentist had rendered services.

 **See page 287** for further information about limited benefits under the dental plan.

What is not covered under the dental plan

Accidental injury to sound, natural teeth: Expenses for treatment of accidental injury to sound, natural teeth may be covered under the medical plan. This exclusion does not apply to accidental injuries as a result of biting or chewing; these charges may be covered under the dental plan.

Beyond the scope of licensure or unlicensed: Services rendered by a dentist beyond the scope of his or her license, or any services provided by an unlicensed dentist.

Bridgework: Repair or recementing of bridgework during the first six-month post-delivery period, and such services received more often than once every five years.

Cosmetic purposes: Services performed for cosmetic purposes or to correct congenital, hereditary or developmental malformations. This exclusion does not apply to orthodontic services for the correction of malposed teeth.

Dentures: Repair or relining of dentures during the first six-month post-delivery period, and such services received more often than once every five years.

Elective non-emergency dental services outside the U.S.

Experimental or investigational: Charges for treatment or services, including hospital care, that are experimental, investigational or inappropriate, under protocols established by Delta Dental.

Governmental agency: Services provided or paid for by any governmental agency or under any governmental program or law, except charges for legally entitled benefits under applicable federal laws.

Hospital charges: Services performed in a hospital or outpatient hospital setting, including but not limited to provider and facility charges.

Oral sedation: Oral sedation and/or nitrous oxide (analgesia).

Orthodontia: If bands were removed prior to eligibility, unless five years have elapsed before the placement of new bands. Repair or replacement of an orthodontic appliance is not a benefit.

Orthodontia care: Services in connection with treatment for the correction of malposed teeth during the first 12 consecutive months that a participant is covered under the dental plan.

Periodontal splinting: Charges for complete occlusal adjustments or stabilizing the teeth through the use of periodontal splinting.

Permanent restorations: Charges for bases, liners and anesthetics used in conjunction with permanent restorations (fillings).

Retainers: Separate charges for retainers (appliances that are intended to retain orthodontic relationship) or habit appliances to address harmful behaviors such as thumb-sucking or tongue-thrusting.

Services undertaken prior to effective date or during the waiting period for major care or orthodontia services: Charges for courses of treatment, including prosthetics and orthodontics, which are begun prior to the effective date of coverage or before you are eligible to receive benefits for major care or orthodontia services.

Surgical corrections: Charges for services related to the surgical correction of:

- Temporomandibular joint dysfunction (TMJ)
- Orofacial deformities, and
- Specified oral surgery procedures covered by the Associates' Medical Plan.

Tooth structure: Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.


OTHER CHARGES NOT COVERED

- Any procedure performed for a temporary purpose
- Charges in excess of the maximum plan allowance
- Extraoral grafts
- Hypnosis or acupuncture
- Oral hygiene instruction and dietary instruction
- Plaque control programs
- Repair or replacement of an orthodontic appliance
- Services covered by the Associates' Medical Plan
- Services for which there is no charge
- Teledentistry
- Any other services not specifically listed as covered
- Charges covered by workers' compensation or employers' liability laws
- Services provided by a member of the participant's family, or
- Charges incurred as a result of war.

If you go on a leave of absence

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums either before the leave begins or during the leave. For information about making payments while on a leave of absence, see the [Eligibility and enrollment](#) chapter.

BREAK IN COVERAGE

 **Please see page 289** for information replacing the following two paragraphs.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status within one year from cancellation, you will be enrolled for the same coverage (or, if this coverage is not available, the coverage that is most similar to your prior coverage). Your coverage will be effective the first day of the pay period that you return to active work as defined by the Plan. For more information, contact People Services at **800-421-1362**.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status after one year from cancellation,

you will be considered newly eligible; you may enroll for coverage within the applicable time period and under the conditions described in the [Eligibility and enrollment](#) chapter.

When dental coverage ends

Your coverage and your eligible dependents' coverage ends on your last day of employment or when you are no longer eligible under the terms of the Plan. All benefits cease on the date coverage ends, except for completion of operative procedures in progress at the time coverage ends. Operative procedures are defined as, and limited to, individual crowns, dentures, bridges and implants (and the associated implant superstructure), and are considered "in progress" only if all procedures for commencement of lab work have been completed and all operative procedures are completed within 45 days of termination.

See the [Eligibility and enrollment](#) chapter for a complete list of events that may cause coverage to end. See the [COBRA](#) chapter for information regarding COBRA continuation coverage.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be re-enrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan). If your break is 30 days or less, the annual deductible and waiting period for orthodontia assistance will not reset. If your break is greater than 30 days, your waiting period for orthodontia assistance will reset. If your break is greater than 30 days but less than 13 weeks, and you have already maintained coverage under the Plan for a minimum of two years, you will have 60 days after resuming work to drop or otherwise change the coverage in which you were automatically re-enrolled.

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

If you drop coverage and re-enroll

If you drop coverage and re-enroll within 30 days, you will automatically be re-enrolled for the same coverage you had (or the most similar plans offered under the Plan). In this case, the annual deductible and waiting period for orthodontia assistance will not reset.

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

The vision plan

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The vision plan

The vision plan is designed to address your needs for proper eye care by helping you pay for routine eye exams, lenses, frames and contact lenses. You can receive the same benefits whether you see a provider from a Walmart Vision Center, Sam's Club Optical or the VSP network.

VISION PLAN RESOURCES

Find What You Need	Online	Other Resources
Locate a Walmart Vision Center or Sam's Club Optical provider	Go to the WIRE or WalmartOne.com	
For detailed information about vision plan coverage or to locate a VSP network provider	Go to vsp.com and enter your member number	Call VSP at 866-240-8390
Get the cost for vision plan coverage	Go to the WIRE or WalmartOne.com	Call People Services at 800-421-1362

What you need to know about the vision plan

- All hourly and management associates and their eligible dependents (except for the spouses/partners of part-time associates, temporary associates and part-time truck drivers) can enroll in the vision plan when they are eligible.
- Coverage under the vision plan is separate from coverage under the medical plan, which generally does not cover charges for routine eye care. Eligible associates interested in vision coverage for services not covered by the medical plan must enroll separately in the vision plan.
- In order for benefits to be paid, you must use a Walmart Vision Center or Sam's Club Optical provider or a provider in VSP's network. No benefits are available if you see a non-network provider.
- You may see any Walmart Vision Center, Sam's Club Optical or VSP network provider for care.
- You may purchase contact lenses online at [WalmartContacts.com](#) or [SamsClubContacts.com](#). VSP will coordinate the amount of your purchase eligible for benefit coverage. Go to [vsp.com](#) or call VSP at **866-240-8390** for details about your contact lens benefit.
- Associates who have access to an HMO plan that offers vision coverage will need to compare the HMO plan's coverage and the benefits offered by the vision plan and decide which option best meets their needs.
- If you have medical plan coverage with the Associates' Health and Welfare Plan, the VSP telephone number will appear on your plan ID card, which will be mailed to your home address. If you are enrolled in an HMO or if you enroll for vision coverage only or dental and vision coverage only, you will receive a VSP ID card, which will be mailed to your home address.

Your vision plan

Walmart offers the vision plan to help eligible associates pay for eligible routine eye care. The vision plan is administered through VSP. You may access care under the vision plan through a Walmart Vision Center or Sam's Club Optical facility, or through a provider in VSP's nationwide network.

How the vision plan works

The vision plan covers a routine eye exam once every calendar year, lenses once every calendar year, frames once every calendar year or contact lenses once every calendar year. The vision plan will pay benefits for prescription contact lenses or prescription eyeglasses. If you choose contact lenses, you will not be eligible for lenses or frames again until the next calendar year. Benefits are paid as shown in the chart below. Walmart providers and VSP network providers have agreed to provide their services to covered associates and their covered dependents for a prearranged fee; all you pay is the applicable copay and the

cost of any non-covered or elective items. VSP pays the rest directly to the provider. No benefits are available if you see non-network providers.

Additional charges. Charges for any of the following items will be the associate's responsibility. Call VSP for more information.

- Blended lenses
- Oversize lenses
- Photochromic or tinted lenses other than Pink 1 or 2 allowance
- Coated or laminated lenses
- No-line multifocal lenses
- High-index lenses
- Anti-reflective coating
- Color coating
- Mirror coating
- Optional cosmetic processes
- Cosmetic lenses, and
- Frames or contacts that cost more than your allowance.

VISION PLAN BENEFITS

	Walmart Vision Center	Sam's Club Optical	VSP network providers
Routine exam copay Once every calendar year	\$4 <i>Limitations apply for low-vision testing or supplemental testing for individuals whose vision problems are not correctable with regular lenses.</i>		
Materials copay	\$4 <i>Applies with purchase of frames, lenses or both. Copay is charged only once when frames and lenses are purchased together.</i>		
Progressive lens copay	\$55		
Lenses Once every calendar year <ul style="list-style-type: none"> • Single vision • Lined bifocal • Lined trifocal • Progressive multifocal 	100% covered <i>Standard lenses are covered after applicable copay. Check with your optical team for lenses offered under benefit.</i>		
Frames Once every calendar year	\$130 allowance <i>Charges above the frame allowance are the responsibility of the associate.</i>		
Contact lenses Once every calendar year In lieu of glasses	\$130 contact lens allowance <i>Fitting and evaluation fee up to \$60 may apply. Any charges above the contact lens allowance are the responsibility of the associate.</i>		

NOTE: State and/or local sales taxes may apply and will reduce the vision benefit. No benefits are available if you see non-network providers.

How to use the plan

Follow these steps to use a Walmart Vision Center or Sam's Club Optical provider or a VSP network provider for your vision care.

STEP 1	To find a Walmart Vision Center or Sam's Club Optical provider, go to the WIRE or WalmartOne.com ; to find a provider in the VSP network, call 866-240-8390 or go to vsp.com and enter your member number.
STEP 2	When you call the provider to make an appointment, identify yourself as a VSP member and give the office your first name, last name and date of birth, plus the patient's name (if different). The provider's office will contact VSP to verify your eligibility.
STEP 3	At your visit, pay your copay and/or any other required amount directly to the Walmart Vision Center or Sam's Club Optical or VSP network provider. The provider's office will make its own arrangements for reimbursement and handle any other administrative tasks required.

What is not covered

Regardless of whether you use a Walmart Vision Center, Sam's Club Optical or VSP network provider, there are some expenses the vision plan will not pay for, including:

- Charges for eye exams, lenses or frames that:
 - you are not legally obligated to pay for or for which no charge would be made in the absence of vision coverage
 - exceed plan maximums
 - are not necessary according to accepted standards of ophthalmic practice, or not ordered or prescribed by the attending physician or optometrist
 - do not meet accepted standards of ophthalmic practice, including charges for experimental or investigational services or supplies
 - are received as a result of eye disease, defect or injury due to an act of declared or undeclared war
 - are for any condition, disease, ailment or injury arising out of and in the course of employment compensable under a workers' compensation or employers' liability law and were ordered before the patient became eligible for coverage or after coverage ends
 - are received free from any governmental agency by compliance with laws or regulations enacted by any federal, state, municipal or other governmental body, and
 - are payable under any health care program supported in whole or in part by federal funds or any state or political subdivision.

- Medical or surgical treatment or supplies covered under your medical plan or, if available, HMO
- Professional services or eyewear connected with orthoptics, vision training, subnormal vision aids, aniseikonic lenses and tonography, and other services/materials not covered by the Plan
- Replacement of broken lenses or frames after one year from purchase
- Replacement of lost lenses or frames unless the patient is otherwise eligible under the frequency provisions, as detailed in the [Vision plan benefits](#) chart on the previous page
- Service contract fees
- Plano lenses (nonprescription lenses less than .50 diopter)
- Services from any non-network providers — i.e., any provider that is not affiliated with a Walmart Vision Center or Sam's Club Optical, or that is not a VSP network provider.

Breakage and loss of eyewear

If you're covered under the Plan and you break or damage your eyewear within the first year of purchase, you can return to your Walmart Vision Center, Sam's Club Optical or VSP network provider for replacement or repair. Some warranties on eyewear may be longer than one year; check with your eyewear provider for specific warranties.

Lost eyewear is not covered under the Plan and is the responsibility of the associate.

Filing a vision claim

When you use the vision plan, claims for services generally do not need to be filed; see [How to use the plan](#) above for a description of payment arrangements. When filing a claim is necessary — for example, if you are newly enrolled in the vision plan when you see a vision provider and your personal information is not yet on file with VSP — you must return to the vision provider after your information is in the system and ask the provider to file the claim on your behalf. Your claim will be processed according to the terms described in the [Claims and appeals](#) chapter.

IF YOU OR A FAMILY MEMBER HAS COVERAGE UNDER MORE THAN ONE VISION PLAN

If you have coverage under more than one vision plan — for example, you have coverage under the Plan and your spouse/partner's employer-sponsored vision plan, the coordination of benefits provisions may apply. The vision plan has the right to coordinate with "other plans" under which you are covered, so the total vision benefits payable will not exceed the level of benefits otherwise payable under the vision plan. Under the vision plan, "other plans"

refers only to other plans administered by VSP. There is no coordination-of-benefits provision with vision coverage providers other than VSP. “Other plans” are fully described in **If you have coverage under more than one medical plan** in **The medical plan** chapter.

If you go on a leave of absence

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums either before the leave begins or during the leave. For information about making payments while on a leave of absence, see the **Eligibility and enrollment** chapter.

BREAK IN COVERAGE

 **Please see page 289** for information replacing the following two paragraphs.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status within one year from cancellation, you will be enrolled for the same coverage (or, if this coverage is not available, the coverage that is most similar to your prior coverage). Your coverage will be effective the first day of the pay period that you return to active work as defined by the Plan. For more information, contact People Services at **800-421-1362**.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status after one year from cancellation, you will be considered newly eligible. You may enroll for coverage within the applicable time period and under the conditions described in the **Eligibility and enrollment** chapter.

If you have received covered vision services prior to your leave, any applicable benefit frequency limitation under the vision plan (i.e., eyeglass frames every calendar year) will continue to apply after your return.

When vision coverage ends

Your coverage and your eligible dependents' coverage ends on your last day of employment or when you are no longer eligible under the terms of the Plan.

See the **Eligibility and enrollment** chapter for a complete list of events that may cause coverage to end. See the **COBRA** chapter for information regarding COBRA continuation coverage.

If you leave the company and are rehired

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

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

If you drop coverage and re-enroll

If you drop coverage and re-enroll within 30 days, you will automatically be re-enrolled for the same coverage you had (or the most similar coverage offered under the Plan).

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

If you have received covered vision services prior to your absence, any applicable benefit frequency limitation under the vision plan (i.e., eyeglass frames once every calendar year) will continue to apply after your return.

COBRA

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COBRA

It's important to maintain the financial protection your health care coverage provides for you and your family. If you leave Walmart or a covered family member is no longer eligible for coverage under the Plan, you or any covered family member may be able to continue medical, dental and vision coverage through the continuation provisions of the Plan and as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA). (Additional health coverage options may be available to you through the Health Insurance Marketplace, including less-expensive options, or you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible, such as a spouse's plan.) The Plan contracts with WageWorks, a Third Party Administrator, to administer COBRA. Please familiarize yourself with this one-time opportunity for coverage continuation by carefully reading the COBRA notification and noting enrollment deadlines.

COBRA RESOURCES

Find What You Need	Online	Other Resources
Contact People Services within 60 calendar days of a divorce, legal separation, termination of a relationship with a partner (as defined in this chapter) or ineligibility of dependent(s)		Call People Services at 800-421-1362 or provide notification in writing to: Walmart People Services 508 SW 8th Street, Bentonville Arkansas 72716-3500
Contact WageWorks, the Third Party Administrator for COBRA, for questions regarding eligibility, enrollment, premiums and notification of a second qualifying event	Go to mybenefits.wageworks.com	Call 800-570-1863

What you need to know about your COBRA rights

- If medical, dental or vision coverage ends for you and/or your eligible dependent(s) under the Plan because of a COBRA qualifying event (as defined under [COBRA qualifying events](#) on the next page), you and/or your eligible dependent(s) may be able to continue medical, dental or vision coverage.
- The Plan extends continuation coverage to you and all eligible dependents. Your eligible dependents are your spouse; your dependent children to age 26 (or older, if incapable of self-support); someone for whom you have legal custody or legal guardianship, provided he or she is living as a member of your household and you provide more than half of his or her support; and your partner (as defined under [COBRA qualifying events](#) on the next page). References to COBRA in this section are to the Plan's continuation coverage, which may be more favorable to participants and dependents than the continuation coverage legally required under COBRA.
- You and/or your eligible dependent(s) must contact People Services by calling **800-421-1362** within 60 calendar days of the following COBRA qualifying events to request COBRA continuation coverage or COBRA eligibility will be lost: divorce, legal separation, termination of the relationship with your partner (as defined under [COBRA qualifying events](#) on the next page) or ineligibility of dependents (for instance, a dependent no longer satisfies the requirements for coverage, such as attainment of age 26).
- If your employment ends or you lose medical, dental or vision coverage due to a reduction in hours that makes you ineligible for coverage, you will automatically receive a COBRA election notice offering you the opportunity to enroll in COBRA coverage. If you die, your spouse, partner or dependent children will receive such notice if they had coverage under the Plan immediately before your death.
- The COBRA election period lasts until 60 days after the date that your Plan coverage terminates or 60 days after the date of your COBRA election notice, if later. To enroll, you must:
 1. Complete and mail your COBRA election notice or go online at mybenefits.wageworks.com, and
 2. Make your premium payment by mail, online at mybenefits.wageworks.com or call **800-570-1863** no later than 45 days from the date on which you make your election.

If you have any questions or need assistance with enrollment, please call **800-570-1863**.

COBRA — Medical, dental and vision continuation after coverage ends

If medical, dental or vision coverage under the Plan ends for you or your eligible dependent(s), you and/or your eligible dependent(s) may be able to continue your coverage under the Plan's continuation coverage provisions, which comply with the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

This coverage is called "COBRA coverage." An event that makes you and/or your eligible dependent(s) eligible for COBRA coverage is called a "qualifying event."

You must have had medical, dental or vision coverage under the Plan on the day prior to your qualifying event date to be eligible for COBRA coverage, unless coverage ended during a leave of absence, as described on this page. You are only able to continue medical, dental or vision coverage if you had such coverage the day prior to your qualifying event. You may choose a lesser tier level and/or select an alternate medical plan, if applicable.

If after you elect COBRA coverage, you change medical plans due to a status change event, your annual deductible(s) and out-of-pocket maximum will reset, and you will be responsible for meeting the new deductible(s) and out-of-pocket maximum in their entirety. The exception to this rule is if you change from one of the HRA plans to another, in which case your annual deductible and out-of-pocket maximum will not reset as a result of your change in medical coverage options.

If you have HMO coverage at the time of your qualifying event and the state in which you reside has more favorable coverage continuation rules than federal COBRA, the HMO will generally follow those state rules. For more information on state continuation rights, contact your HMO provider.

COBRA applies only to medical, dental and vision coverage and does not apply to critical illness insurance, accident insurance, company-paid life insurance, optional associate life insurance, optional dependent life insurance, short-term disability, long-term disability or accidental death and dismemberment (AD&D) benefits. See the [Critical illness insurance](#), [Accident insurance](#), [Company-paid life insurance](#), [Optional associate life insurance](#), [Optional dependent life insurance](#) and [Accidental death and dismemberment](#)

[\(AD&D\) insurance](#) chapters in this book for more information regarding portability and/or conversion rights. The Plan also provides continuation coverage for Resources for Living. See the [Resources for Living](#) chapter for more information.

IF YOU ARE ON LEAVE OF ABSENCE

Generally, if your leave ends and you do not return to work, you and any eligible dependent(s) who were enrolled in medical, dental or vision coverage under the Plan during your leave will be offered COBRA, which will run from the date following your employment termination date.

NOTE: If you and any eligible dependent(s) were enrolled in medical, dental or vision coverage under the Plan on the day before your leave of absence began but you dropped coverage during your leave of absence or your coverage was canceled due to nonpayment of premiums during the leave, you will still be offered COBRA when your employment terminates. If you elect COBRA coverage, it will run from the date following your employment termination date. This means that if you or any eligible dependent elects COBRA at the end of a leave of absence during which coverage was dropped or canceled for nonpayment, the elected COBRA coverage will not be effective retroactive to the date coverage was dropped or canceled, but will be effective on the date following your employment termination date.

COBRA qualifying events

You are eligible for COBRA if your medical, dental or vision coverage ends because:

- Your employment with Walmart ends for any reason, or
- You are no longer eligible for medical coverage because the number of hours you regularly work for Walmart has decreased, making you ineligible for coverage under the Plan.

Your spouse or partner (as such term is defined on the following page) is eligible for COBRA if coverage for the spouse or partner ends for any of the following reasons:

- Your employment with Walmart ends for any reason
- Your spouse or partner is no longer eligible for medical, dental or vision coverage because the number of hours you regularly work for Walmart has decreased, making them ineligible for coverage under the Plan
- You and your spouse divorce or legally separate

- You and your partner no longer meet the definition of having a “partnership” for purposes of the Plan. A partner is defined as any of the following:
 - Your domestic partner, as long as you and your domestic partner:
 - Are in an ongoing, exclusive and committed relationship similar to marriage and have been for at least 12 months and intend to continue indefinitely
 - Are not married to each other or anyone else
 - Meet the age for marriage in your home state and are mentally competent to consent to contract
 - Are not related to each other in a manner that would bar marriage in the state in which you live, and
 - Are not in the relationship solely for the purpose of obtaining benefits coverage.
 - Any other person with whom you are joined in a legal relationship recognized as creating some or all of the rights of marriage by the state or country in which the relationship was created.
- You enroll in Medicare benefits Part D, causing your medical coverage to terminate (you must contact People Services by calling **800-421-1362** within 60 days of enrolling in Medicare Part D), or
- You die.

Your eligible dependent(s) other than a spouse or partner (as such term is defined above) is eligible for COBRA if coverage for the dependent(s) ends for any of the following reasons:

- Your employment with Walmart ends for any reason
- Your eligible dependent(s) is no longer eligible for medical, dental or vision coverage because the number of hours you regularly worked for Walmart has decreased, making them ineligible for coverage under the Plan
- You enroll in Medicare benefits Part D, causing your medical coverage to terminate. (You or your eligible dependent must contact People Services by calling **800-421-1362** within 60 days of enrolling in Medicare Part D)
- Your dependent child(ren) no longer meets eligibility requirements (e.g., the end of the month in which a dependent turns age 26), or
- You die.

NOTIFICATION

In general, Walmart will notify WageWorks, the Plan’s Third Party Administrator for COBRA (hereinafter referred to as “COBRA administrator”) if you or your dependents become eligible for COBRA continuation coverage because of your death, termination of employment or a reduction in hours of employment that makes you ineligible for coverage under the Plan. Walmart will generally make this notification to the COBRA administrator within 30 days after the qualifying event.



Federal law places responsibility upon you or your eligible dependent(s) to notify People Services within 60 calendar days after the later of the date of a divorce, legal separation, termination of your partnership (as defined earlier in this section) or ineligibility of dependent(s), or the date on which you will lose coverage under the Plan as a result of one of these events. If you or your eligible dependent(s) does not notify People Services within 60 days, your dependent(s) will not be eligible for COBRA. You or your eligible dependent(s) must also notify the COBRA administrator of a second qualifying event or Social Security disability in order to extend the period of COBRA coverage. Other forms of notice will not bind the Plan. If notice is not provided of a second qualifying event or extension request within 60 days from the later of the date of the second qualifying event or the date on which you lost (or will lose) coverage as a result of a second qualifying event, COBRA continuation rights will expire on the date that your or your eligible dependent’s initial COBRA coverage period expires.

Under the law, you or your eligible dependent is responsible for notifying People Services of your divorce, legal separation, termination of your relationship with a partner (as such term is defined earlier in this section) or a child’s loss of dependent status. The notification must be made within 60 days after the qualifying event (or the date on which coverage would end because of the qualifying event, if later). You or your eligible dependent can provide notice on behalf of yourself as well as any eligible dependent affected by the qualifying event. Provide notice of the qualifying event to People Services by calling **800-421-1362** or writing to:

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

The notice must include the following information:

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

If you do not contact People Services within the 60-day period, you will lose your right to elect COBRA continuation coverage.

Within 14 days after the COBRA administrator receives notification that a qualifying event has occurred, the COBRA administrator, on behalf of the Plan, will send a COBRA election notice to you and your eligible dependent(s) at your last known address. The election notice will describe your right to continue medical, dental or vision coverage under COBRA. (If you do not receive this notification, please contact People Services.) To receive COBRA continuation coverage, you must elect such coverage through the COBRA administrator within 60 calendar days from the date you lose coverage or the date of the election notice, if later. You can contact the COBRA administrator by logging on to mybenefits.wageworks.com or by calling **800-570-1863**. If you do not elect COBRA continuation coverage within the 60-day period, you will lose your right to elect COBRA coverage.

NOTE: You may be asked to provide documentation of the qualifying event in order to receive COBRA coverage. Notify the COBRA administrator of any change of address if you elect COBRA coverage.

You and your eligible dependent(s) each have separate election rights. You may elect COBRA coverage for all of your family members who lost coverage because of the qualifying event. A parent or legal guardian may elect COBRA coverage on behalf of a minor eligible dependent(s). A child born to or placed for adoption with you while you are on COBRA also has COBRA rights.

COBRA is provided subject to the eligibility requirements for continuation coverage for you and your eligible dependents under the law and the terms of the Plan. To the extent permitted by law, the Plan Administrator will retroactively terminate your COBRA coverage if you are later determined to be ineligible.

COBRA STATUS CHANGE EVENTS

After the COBRA election period, you or your eligible dependent may not change or add to the elected COBRA coverage without a status change event outside annual enrollment or a subsequent qualifying event. For

information about status change events, see [Changing your benefits during the year: status change events](#) in the [Eligibility and enrollment](#) chapter. If a status change event occurs (such as if a child is born), you must notify the COBRA administrator within 60 calendar days of the event. Supporting documentation may be required. As long as you are on COBRA, you will have the right to make changes to your coverage during any annual enrollment period.

Unless otherwise provided in the Plan, if you add a spouse or partner (as such term is defined on the previous page) or other eligible dependent due to a status change event while on COBRA, each person must individually meet any applicable benefit waiting period (for example, for transplant coverage or weight loss surgery) and will be subject to any applicable Plan limitations. If you change medical plans due to a status change event, your annual deductible(s) and out-of-pocket maximum will reset, and you will be responsible for meeting the new deductible(s) and out-of-pocket maximum in their entirety. The exception to this rule is if you change from one of the HRA plans to another, in which case your annual deductible and out-of-pocket maximum will not reset as a result of your change in medical coverage options. If you change from one of the HRA plans to another during the Plan year as the result of a status change event, the amount credited to your HRA will be prorated according to the time remaining in the year. If you change from one of the HRA plans to a non-HRA plan, your HRA balance will be forfeited. See [The medical plan](#) chapter for more information.

If you are covered as a dependent and you experience a qualifying event that affects your status as a dependent and makes you eligible for your own continuation coverage under COBRA, you will receive credit toward your deductibles and out-of-pocket maximum under the Associates' Medical Plan for expenses incurred as a covered dependent, unless you change plan options as described above. You will also receive credit toward any waiting periods.

In the event of a status change, you or your eligible dependent may change benefit coverage to another benefit tier under the Plan only if the change in coverage is consistent with the status change event.

If you move to a new location and this affects your medical coverage (i.e., moving from an HMO area to a non-HMO area), you will have 60 calendar days from the date you notify the COBRA administrator of the address change to select a different plan. If you do not submit your selections within 60 days, you will automatically be enrolled in a predetermined plan.

Paying for COBRA coverage

You and/or your eligible dependent(s) will be responsible for both the associate portion of the premium and the portion that was previously paid by the company, plus a

2% administrative fee (50% administrative fee in cases of the 11-month disability extension). The letter sent to you and your eligible dependent(s) following notice of a qualifying event will include the monthly premium cost for COBRA coverage.

Initial COBRA premium: Your first payment will be due 45 days after you elect COBRA and must cover the cost of COBRA coverage from the qualifying event through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment should equal the premiums for October and November and is due on or before December 30, which is the 45th day after the date of her COBRA election. As described below, ongoing premiums are due the first day of each month, with a 30-day grace period. So Sue's December payment will also be due no later than December 31, the end of the 30-day grace period for the December coverage period.)

If your initial premium payment is not made in the allowed time frame, you will not be eligible for COBRA coverage.

Continuing premiums: Monthly premiums are due on the first day of each month following the due date of the initial premium. If you make your payment on or before the first day of each month, your COBRA coverage under the Plan will continue for that month without any break.

You will be allowed a 30-day grace period from the premium due date before coverage is canceled. However, if you make your payment later than the first day of the month, your coverage will be suspended and any claims incurred, including pharmacy benefits, will not be paid until coverage is paid through the current month. If you do not pay this premium, you will be responsible for claims incurred. If the 30th day falls on a weekend or holiday, you will have until the first business day following to have your payment postmarked or paid.

As a courtesy, the COBRA administrator will send you a COBRA premium payment invoice. Premiums are due regardless of your receipt of a payment invoice. If you are paying by mail, attach your payment to the invoice and mail to:

WageWorks
P.O. Box 660212
Dallas, Texas 75266-0212

To pay online, log on to mybenefits.wageworks.com, or to pay by phone, call 800-570-1863.

If your COBRA coverage is canceled due to nonpayment of premiums, your COBRA coverage will end on the last day for which you paid your full COBRA premium on time, and it will not be reinstated.

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

How long COBRA coverage lasts

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

DURATION OF COBRA COVERAGE

Event	Associate	Dependent(s)
<ul style="list-style-type: none"> Your employment with the company ends for any reason You are no longer eligible for coverage under the Plan due to a reduction in hours 	18 months from the date of the event	18 months from the date of the event
<ul style="list-style-type: none"> Your death Your marital (or partnership) status changes Dependent(s) no longer meets eligibility requirements (e.g., turns age 26) 	Not applicable	36 months from the date of the event
You enroll in Medicare less than 18 months prior to your termination of employment or reduction in hours	18 months from the date of termination of employment or reduction in hours	Up to 36 months from the date the associate enrolled in Medicare
You enroll in Medicare Part D	Not applicable	36 months from the date the associate enrolled in Medicare Part D
Disability extension is obtained	29 months from the date of the original event	29 months from the date of the original event
Second qualifying event – you must notify the COBRA administrator within 60 days of the second qualifying event or the date of loss of coverage, if later	Not applicable	Up to 36 months from the date of the original event

IF YOU ARE ENTITLED TO MEDICARE

If you are eligible for Medicare Parts A and/or B and terminate employment with the company (or lose coverage under the Plan), you should be aware that if you do not enroll in Medicare Parts A and/or B during the Medicare special enrollment period, you may have to wait to enroll in Medicare Parts A and/or B (i.e., until the next Medicare annual enrollment period) and may have to pay a higher Medicare premium when you do enroll. The eight-month special enrollment period runs from the date that you are no longer employed by the company (or lose coverage under the Plan, whichever occurs first), even if you elect COBRA continuation coverage (e.g., following termination of employment). For additional information, please refer to Medicare's *Medicare & You* handbook, published annually. The handbook can be obtained directly from Medicare by calling **800-633-4227** or from the Medicare website at [medicare.gov](https://www.medicare.gov).

Please note that entitlement to Medicare means you are eligible for and enrolled in Medicare. If you become entitled to Medicare less than 18 months before a qualifying event due to termination of employment, or a reduction in hours of employment, your eligible dependents can elect COBRA for a period of not more than 36 months from the date you became eligible for Medicare.

If you are entitled to Medicare prior to your COBRA election date, you or your eligible dependent(s) must notify the COBRA administrator at **800-570-1863** of your Medicare status in order to ensure your maximum coverage period is properly calculated.

IF YOU OR AN ELIGIBLE DEPENDENT IS DISABLED

If you and/or your eligible dependent(s) elects COBRA coverage due to your termination of employment or a reduction in hours of employment that makes you ineligible for coverage under the Plan and one of you is disabled, all of you may be entitled to up to 29 months of COBRA coverage. The 29-month COBRA coverage period begins on the date after your termination of employment or reduction in hours of employment that makes you ineligible for coverage under the Plan. The disability extension applies only if all of the following conditions are met:

- The Social Security Administration determines that you or your eligible dependent(s) is disabled
- The disability exists at any time within the first 60 calendar days of COBRA coverage, and

- You and/or your eligible dependent(s) notifies the COBRA administrator of the Social Security Administration's disability determination by submitting a copy of the Social Security Administration disability determination Notice of Award letter to the COBRA administrator within your initial 18-month COBRA period and within 60 days of the later of:
 - The date of your qualifying event
 - The date of your Social Security Administration disability determination Notice of Award, or
 - The date on which you and/or your eligible dependent(s) loses coverage under the Plan as a result of the qualifying event.

In the absence of an official Notice of Award from Social Security, the Plan may accept other correspondence from the Social Security Administration if that correspondence explicitly includes all information the Plan needs in order to grant the extension and is submitted to the COBRA administrator within the time frames listed above.

If you and/or your eligible dependent(s) is determined to qualify for the disability extension, a new invoice will be mailed to you and/or your eligible dependent(s) before the end of the initial 18-month COBRA coverage period.

The COBRA premium for the 19th through the 29th month of COBRA coverage generally is the amount you were paying before the qualifying event, plus the amount the company was paying, plus a 50% administrative fee, or 150% of the full premium amount.

However, if the disability extension applies, but the disabled qualified beneficiary family member is not enrolled in COBRA coverage, the COBRA premium for the covered family members for the extended period is limited to 102%. You or your eligible dependent(s) must notify the COBRA administrator no later than 30 days after the Social Security Administration determines that you or your eligible dependent(s) is no longer disabled.

IF YOU HAVE A SECOND QUALIFYING EVENT WHILE ON COBRA

While an associate cannot receive an extension of COBRA coverage due to a second qualifying event, your eligible dependent(s) who has COBRA coverage due to your termination of employment, or a reduction in hours of

employment that makes you ineligible for coverage under the Plan, may receive COBRA coverage for up to a total of 36 months if a second qualifying event occurs during the original 18-month continuation coverage period (or 29-month coverage period, in the event of a disability extension).

The following can be second qualifying events:

- Your death
- Your divorce, legal separation or termination of a relationship with a partner (as such term is defined earlier in this chapter)
- Your child is no longer eligible for medical, dental or vision coverage (e.g., a dependent turns age 26), or
- Your enrollment in Medicare Part D.

If a second qualifying event occurs while your eligible dependent(s) has COBRA coverage, their COBRA coverage may last up to 36 months from the date of the first qualifying event (the date of your termination of employment, or reduction in hours of employment that makes you ineligible for coverage under the Plan).



To receive the extension of the COBRA coverage period, you or your eligible dependent(s) must notify the COBRA administrator of the second qualifying event within 60 calendar days of the date of the event or loss of coverage following the event, if later. If the COBRA administrator is not notified of the second qualifying event during the 60-day period, your eligible dependent(s) cannot get the COBRA coverage extension and the coverage will be terminated as of the date your initial COBRA period expired.

When COBRA coverage ends

COBRA coverage usually ends after the 18-month, 29-month or 36-month COBRA coverage period. See How long COBRA coverage lasts in this chapter to find out which COBRA coverage period applies to you. COBRA coverage may be terminated before the end of the 18th, 29th or 36th month if:

- The company no longer provides medical, dental or vision coverage to any of its associates
- Excepting the initial 45-day payment period, if COBRA payment is not made within 30 calendar days of the due date (if the 30th day falls on a weekend or non-postal delivery day, you will have until the next business day in order to have your payment postmarked or paid)
- You or your eligible dependent(s) becomes covered by another group health, dental or vision plan after electing COBRA coverage
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate as of the later of (a) the first day of the month that is more than 30 days after a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled, or (b) the end of the coverage period that applies without regard to the disability extension), or
- You or your eligible dependent(s) submits a fraudulent claim or fraudulent information to the Plan.

FILING AN APPEAL

You have the right to appeal an enrollment or eligibility status decision related to your COBRA coverage. See [Appealing an enrollment or eligibility status decision](#) in the [Claims and appeals](#) chapter for more information.

Resources for Living[®]

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Resources for Living®

Resources for Living (RFL) is a valuable, confidential counseling and wellbeing information service available at no cost to all Walmart associates from your date of hire. You and your family members can call a professional counselor at any time for help with stress management, family relationships, career issues and other daily challenges. RFL also provides information and resource referrals for assistance with childcare, eldercare, education, finances, wellness and more.

RFL RESOURCES

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

What you need to know about Resources for Living

- RFL is a professional and confidential counseling and information service available 24 hours a day, seven days a week, 365 days a year.
- You and your household members can find counseling, information and work-life assistance.
- All Walmart associates are automatically enrolled in RFL as of their date of hire.
- Walmart or the Plan pays the entire cost of RFL benefits for you and your family.

Using Resources for Living (RFL)

Life comes with a lot of demands. Resources for Living (RFL) can help you stress less and live more. You and your household family members can call any time or log into the RFL website to find tools for:

- Stress management
- Budgeting
- Relationships
- Wellness
- Family life and more

RFL can provide telephone, televideo and face-to-face counseling, web-based articles and tools, legal and financial help and a resource team to help you find almost anything — from home repair services to childcare. You and your household members can access services any time by calling RFL at **800-825-3555**, 24 hours a day, seven days a week, 365 days a year.

All U.S. associates and their family members are automatically enrolled in RFL as of their first day of employment with Walmart. All benefits under this program are provided and administered by Resources for Living. You can find personalized counseling, support and information for all aspects of your wellbeing, including:

- **Social/Emotional.** Find tips to help you build closer relationships, manage stress and find what motivates you.
- **Career.** Learn new habits that can help you balance your work and life, manage your time and set goals.
- **Financial.** Gain skills to help you set a budget, pay down debt, save for the future and more.
- **Community.** Get connected to local resources such as childcare, eldercare, school, adult education and more.
- **Physical.** Discover how to keep your mind and body healthy with articles on sleep, nutrition, fitness and more.

RFL counseling services

Whether you need help working through an issue or just someone to talk to, RFL offers you support. You can call and get help with:

- Managing stress
- Building healthy relationships
- Coping with depression, anxiety or substance abuse
- Balancing work and life

You or your household family members can talk to an RFL counselor by telephone, televideo or face-to-face. Just call the RFL toll-free number at **800-825-3555** for support, at no cost to you. If your situation calls for face-to-face behavioral counseling, you can receive up to three sessions at no cost.

RFL legal and financial services

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

- Meet your financial goals
- Explore your options related to legal issues
- Make your money go further
- Recover from identify theft, and more

You can receive a half-hour consultation for legal or financial issues or a one-hour consultation for identity-theft issues, at no cost to you. Please note that this service does not provide assistance in situations involving employment law.

RFL work-life services

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

- Care for your child or an older adult
- Military resources
- Pet care
- Adoption resources

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

CALLING RFL

You and your family can get personalized support all day, every day. Simply call **800-825-3555**. Services are available in English and Spanish (other languages available upon request). This service is available at no cost to you. And calls are confidential, except as required by law.

RFL ON THE WEB

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

User ID: **Walmart**

Password: **Associate**

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

When RFL benefits end

RFL benefits for you and your family end upon your termination of employment for any reason, but your RFL benefit will automatically be continued, at no cost, for you and your family throughout the applicable COBRA period under the Associates' Medical Plan.

Filing a claim for RFL benefits

You do not have to file a claim for RFL benefits. You may access the RFL website or contact RFL by phone at any time. However, if you have a question about your benefits, or disagree with the benefits provided, you may contact People Services at **800-421-1362** or file a claim by writing to the following address:

People Services

508 SW 8th Street

Bentonville, Arkansas 72716-3500

Claims and any appeals will be 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.

Critical illness insurance

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Allstate Benefits regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company, the underwriting company and subsidiary of The Allstate Corporation.

Critical illness insurance

When you and your dependents elect to participate in critical illness insurance, you receive benefits in the form of direct lump-sum payments which can be used to help pay for expenses related to covered critical illnesses and diseases. Covered illnesses and diseases include invasive cancer, carcinoma in situ, heart attack, stroke, coronary artery bypass surgery, end-stage renal failure, Alzheimer's disease and many others. You and your dependents will not need to answer any medical questions to receive coverage up to \$20,000.

CRITICAL ILLNESS INSURANCE RESOURCES

Find What You Need	Online	Other Resources
Get detailed information on critical illness insurance	Go to the WIRE , WalmartOne.com or allstateatwork.com/walmart	Call Allstate Benefits at 800-514-9525

What you need to know about critical illness insurance

- All hourly and management associates and their eligible dependents can enroll in critical illness insurance when they are eligible (spouses/partners of part-time hourly associates, temporary associates and part-time truck drivers are not eligible).
- For additional information about critical illness insurance, view the critical illness brochure available online at [allstateatwork.com/walmart](#), the [WIRE](#) or [WalmartOne.com](#).
- To view your Certificate of Insurance, visit [allstateatwork.com/walmart](#), the [WIRE](#) or [WalmartOne.com](#).
- Not all critical illnesses and diseases are eligible for a payment under this benefit. The list of covered critical illnesses and diseases can be found in this chapter or in your Certificate of Insurance.

Critical illness insurance

Critical illness insurance provides a direct benefit if you or any covered dependents are diagnosed with a covered illness or disease. The policy pays benefits for covered critical illnesses and diseases regardless of any other insurance you may have.

Coverage amounts are available in \$5,000 increments up to a maximum of \$20,000 with no Proof of Good Health required. Coverage must be effective before the date of diagnosis in order for an illness or disease to be covered under the Plan.

Critical illness insurance is underwritten by American Heritage Life Insurance Company, a subsidiary of The Allstate Corporation. For complete information about critical illness insurance, call Allstate Benefits at 800-514-9525 or go to allstateatwork.com/walmart.

Eligibility and application for critical illness insurance

You are eligible to apply for and enroll in critical illness insurance if you are a:

- Full-time hourly associate (including full-time hourly pharmacists, field Logistics associates and field supervisor positions in stores and clubs, full-time hourly Vision Center managers and Metro professional non-exempt associates)
- Full-time truck driver, or
- Management associate (including management trainees and California pharmacists).

When applying for critical illness insurance, you may choose:

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

You are eligible to apply for and enroll in critical illness insurance if you are a:

- Part-time hourly associate
- Temporary associate, or
- Part-time truck driver.

Benefits-eligible part-time associates may choose:

- Associate only, or
- Associate + child(ren).

For complete information about eligibility and when you can apply for critical illness insurance, see the [Eligibility and enrollment](#) chapter.

The cost for coverage under critical illness insurance is based on the coverage amounts you choose, the eligible dependents you choose to cover, your age and whether you (and/or your covered spouse/partner) are eligible for tobacco-free rates.

Critical illness benefits

Benefits are payable if you are diagnosed with one of the conditions listed below.

The following benefits are payable at 100% of your coverage election:

- Invasive cancer
- Alzheimer's disease (requires loss of three activities of daily living [ADLs]; see policy for details)
- Coronary artery bypass surgery
- End-stage renal failure
- Heart attack
- Stroke
- Advanced Parkinson's (requires loss of two ADLs)
- Complete loss of sight or hearing (due to illness)
- Quadriplegia (due to illness)
- Complete loss of two eyes, feet, hands, arms or legs (due to illness)
- Coma (lasting seven days) due to illness, or
- Major organ transplant (see note below).

NOTE: If you undergo a major organ transplant, as specified in the major organ transplant rider found in the Certificate of Insurance, you will receive 100% of your benefit selection. If you are enrolled in the HSA Plan, you are not eligible for the major organ transplant rider included in critical illness insurance.

The following benefits are payable at 50% of your coverage election:

- Benign brain tumor
- Paraplegia (due to illness), or
- Complete loss of one eye, foot, hand, arm or leg (due to illness)

Other payable benefits include:

- Ambulance: \$250 for ground ambulance or \$2,000 for air ambulance
- Post-traumatic stress disorder (PTSD): \$100 for each day a covered person receives counseling for PTSD; payable once per day per covered person and limited to six days per coverage year
- Carcinoma in situ: 25% of coverage amount
- Complete loss of one or more fingers and/or one or more toes (due to illness): 25% of coverage amount
- Transient ischemic attacks (TIAs): 25% of coverage amount

- Aneurysm (ruptured or dissecting): 25% of coverage amount
- Specified diseases: 25% of coverage amount
 - Addison’s disease
 - Amyotrophic lateral sclerosis (Lou Gehrig’s disease)
 - Cerebrospinal meningitis (bacterial)
 - Cerebral palsy
 - Cystic fibrosis
 - Diphtheria
 - Encephalitis
 - Huntington’s chorea
 - Legionnaires’ disease (confirmation by culture or sputum)
 - Malaria
 - Multiple sclerosis
 - Muscular dystrophy
 - Myasthenia gravis
 - Necrotizing fasciitis
 - Osteomyelitis
 - Poliomyelitis
 - Rabies
 - Sickle cell anemia
 - Systemic lupus
 - Systemic sclerosis (scleroderma)
 - Tetanus, or
 - Tuberculosis.
- Skin cancer benefit: \$500
 - Positive diagnosis of skin cancer means a diagnosis by a licensed Doctor of Medicine certified by the American Board of Pathology to practice pathological anatomy, or an osteopathic pathologist. Diagnosis is based on microscopic examination of skin biopsy samples.
 - Skin cancer means basal cell carcinoma and squamous cell carcinoma. For the purposes of this policy, skin cancer does not include malignant melanoma (melanoma is covered under the invasive cancer benefit). It also does not include any conditions which may be considered precancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; nonmalignant melanoma; moles; or similar diseases or lesions.
- Recurrence benefit: 50% of original coverage amount for heart attack, stroke, coronary artery bypass surgery, invasive cancer, carcinoma in situ, rabies, aneurysm, benign brain tumor and coma.
- National Cancer Institute (NCI) evaluation and Walmart Centers of Excellence evaluation: \$500 for evaluation; \$250 for transportation and lodging.
- Lodging benefit: \$60 per day for you or each covered family member receiving treatment for a critical illness on an outpatient basis. This benefit is limited to 60 days per calendar year and is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. Outpatient treatment must be received at a treatment facility more than 100 miles from your or your covered family member’s home.
- Transportation benefit: \$0.50 per mile for personal vehicle, up to \$1,500, or up to \$1,500 round-trip transportation for coach fare on a common carrier. Transportation must be required for treatment of a covered critical illness at a hospital (inpatient or outpatient), radiation therapy center, chemotherapy or oncology clinic, or any other specialized free-standing treatment facility. If the treatment is for a covered child and common carrier travel is necessary, the benefit will be paid for up to two adults to accompany the child. This benefit will not be paid if the covered person lives within 100 miles of the treatment facility. For more information, see your Certificate of Insurance or call Allstate Benefits at **800-514-9525**.

Your Certificate of Insurance will contain complete information on the benefits payable through this coverage. To obtain a copy, visit the [WIRE](#), [WalmartOne.com](#) or [Workday](#). You can also call Allstate Benefits at **800-514-9525** for a copy. You can view a brochure online at [allstateatwork.com/walmart](#).

When your critical illness insurance coverage begins

If you enroll during annual enrollment, your coverage will become effective on January 1 of the next Plan year.

If you enroll outside of annual enrollment, your coverage will become effective on the date of your status change event or the end of your eligibility waiting period, whichever is later. If you should die before your effective date (as defined above), no critical illness insurance benefit will be paid to your beneficiary(ies).

Your critical illness insurance will begin whether or not you are actively at work, as long as you have reported for your first day of work and enrolled for the benefit. See the [Eligibility and enrollment](#) chapter for details.

Filing a claim

Within 60 days of the occurrence or commencement of any covered critical illness, or as soon as reasonably possible, send a notice of claim to:

Allstate Benefits
Attn: Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488

You may also provide notice of claim as follows:

Online: allstatebenefits.com/mybenefits

By phone: 800-514-9525

By fax: 877-423-8804

Be sure to provide the following information for the covered person:

- Name
- Social Security number, and
- Date the covered illness occurred or commenced.

You may request a claim form from Allstate Benefits or visit the [WIRE](https://WIRE.WalmartOne.com), WalmartOne.com, [Workday](https://Workday.allstateatwork.com/walmart) or allstateatwork.com/walmart to obtain an online copy. If you do not receive a claim form within 15 days of your request, you may send a notice of the claim to Allstate Benefits by providing Allstate Benefits with a statement of the nature and extent of the loss.

Claims will be determined under the time frames and requirements set out in the [Claims and appeals](#) chapter. You or your beneficiary has the right to appeal a claim denial. See the [Claims and appeals](#) chapter for details.

Naming a beneficiary

If a covered person dies, the covered person's beneficiary(ies) will receive the benefits due at the time of the covered person's death.

You must name a beneficiary(ies) to receive your critical illness insurance benefit if you die. You may do this by going to the [WIRE](#), WalmartOne.com or [Workday](https://Workday.allstateatwork.com/walmart).

You can name anyone you wish. If the beneficiary(ies) you have listed with Walmart differs from those named in your will, the list that Walmart has prevails.

The following information is needed when naming your beneficiary(ies):

- Beneficiary(ies) name
- Beneficiary(ies) current address
- Beneficiary(ies) phone number
- Beneficiary(ies) relationship to you
- Beneficiary(ies) Social Security number
- Beneficiary(ies) date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end, and will be shared equally by any remaining beneficiaries unless your beneficiary form states otherwise.

You can name a minor as a beneficiary; however, Allstate Benefits may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult with an attorney before naming a minor as a beneficiary.

It's important to keep your beneficiary information current. Proceeds will go to whomever is listed on your beneficiary form on file with Walmart, regardless of your current relationship with that person, unless state law requires otherwise.

You (the associate) are automatically assigned as the primary beneficiary of your dependent's critical illness coverage. If you and your dependent(s) die at the same time, benefits will be paid to your dependent's estate or at Allstate Benefits' option to a surviving relative of the dependent.

CHANGING YOUR BENEFICIARY

Your beneficiary(ies) can be changed at any time on the [WIRE](#), WalmartOne.com or [Workday](https://Workday.allstateatwork.com/walmart). Any change in beneficiary must be completed and submitted to Walmart before the covered person's death.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to your surviving family member(s) in the following order:

1. Your spouse/partner; if not surviving, then
2. Your children, in equal shares; if not surviving, then
3. Your parents, in equal shares; if not surviving, then
4. Your siblings, in equal shares; if not surviving, then
5. Your estate.

When benefits are not paid


This policy does not pay benefits for any critical illness due to or resulting from (directly or indirectly):

- Any act of war, whether or not declared, or participation in a riot, insurrection or rebellion
- Intentionally self-inflicted injuries
- Engaging in an illegal occupation or committing or attempting to commit a felony
- Attempted suicide, while sane or insane
- Being under the influence of narcotics or any other controlled chemical substance, unless administered upon the advice of a physician
- Participation in any form of aeronautics, except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports, or
- Alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.

If you go on a leave of absence

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums either before the leave begins or during the leave. For information about making payments while on a leave of absence, see the [Eligibility and enrollment](#) chapter.

BREAK IN COVERAGE

 **Please see page 289** for information replacing the following two paragraphs.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status within one year from cancellation, you will be enrolled for the same coverage (or, if this coverage is not available, the coverage that is most similar to your prior coverage). Your coverage will be effective the first day of the pay period that you return to active work as defined by the Plan. For more information, contact People Services at **800-421-1362**.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status after one year from cancellation, you will be considered newly eligible; you may enroll for coverage within the applicable time period and under the conditions described in the [Eligibility and enrollment](#) chapter.

When coverage ends

Your critical illness insurance coverage ends on the earliest of the following:

- At termination of your employment
- Upon failure to pay your premiums
- On the date of death of you or your dependent
- On the date you or a dependent spouse/partner or child loses eligibility
- On the last day of an approved leave of absence unless you return to work), or
- When the benefit is no longer offered by the company.

Your critical illness insurance coverage for your spouse/partner ends:

- On the last day of the pay period when your job status changes to part-time, temporary or part-time truck driver
- Upon a valid decree of divorce
- Upon termination of domestic partnership
- Upon termination of legal relationship with a person other than a spouse or domestic partner, or
- Upon your death.

CONTINUATION OF COVERAGE AT TERMINATION

If your coverage under critical illness insurance terminates as described earlier in this section, you may continue to receive critical illness insurance directly from Allstate Benefits through portability coverage. To receive portability coverage, you must notify Allstate Benefits that you wish to receive portability coverage and send the first premium for such coverage within 60 days of the date your coverage under critical illness insurance terminated.

The premiums for portability coverage are due in advance of each month's coverage, on the first day of the calendar month. The premiums will be at the same rate that is in effect under critical illness insurance for active associates with the same coverage.

For more information, please contact Allstate Benefits at **800-514-9525**.

WHEN YOUR DEPENDENT BECOMES INELIGIBLE

Any eligible dependent who was covered under critical illness insurance at the time such coverage terminated may also receive portability coverage, under the terms described in the [Continuation of coverage at termination](#) section above.

For more information, please contact Allstate Benefits at **800-514-9525**.

If you leave the company and are rehired

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

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

If you drop coverage and re-enroll

If you drop coverage and re-enroll within 30 days, you will automatically be re-enrolled for the same coverage you had prior to dropping coverage (or the most similar coverage offered under the Plan).

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

Accident insurance

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Allstate Benefits regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company, the underwriting company and subsidiary of The Allstate Corporation.

Accident insurance

An accident can cause unexpected expenses along with injury. If you enroll in accident insurance and are involved in a covered accident while you're off the job, this benefit helps you pay for services necessary as a result of the accident, such as immediate care treatment, hospitalization, physical therapy, transportation and lodging. Benefits are paid directly to you unless you elect to have them paid directly to the provider.

ACCIDENT INSURANCE RESOURCES

Find What You Need	Online	Other Resources
Get detailed information on accident insurance	Go to the WIRE , WalmartOne.com or allstateatwork.com/walmart	Call Allstate Benefits at 800-514-9525

What you need to know about accident insurance

- All hourly and management associates and their eligible dependents can enroll in accident insurance when they are eligible (spouses/partners of part-time hourly associates, temporary associates and part-time truck drivers are not eligible). Proof of Good Health is not required for any level of coverage.
- For additional information about accident insurance, view the accident insurance video or brochure available online at [allstateatwork.com/walmart](#), the [WIRE](#) or [WalmartOne.com](#).
- To view your Certificate of Insurance, visit [allstateatwork.com/walmart](#).

Accident insurance

Accident insurance provides benefits to you if you or any covered dependents receive a covered treatment related to an off-the-job accident. The benefits under this policy are not reduced by any other benefits you may receive.

Accident insurance is underwritten by American Heritage Life Insurance Company, a subsidiary of The Allstate Corporation. For complete information about accident insurance, call Allstate Benefits at **800-514-9525** or go to allstateatwork.com/walmart.

Eligibility and application for accident insurance

You are eligible to apply for and enroll in accident insurance if you are a:

- Full-time hourly associate (including full-time hourly pharmacists, field Logistics associates and field supervisor positions in stores and clubs, full-time hourly Vision Center managers and Metro professional non-exempt associates)
- Full-time truck driver, or
- Management associate (including management trainees and California pharmacists).

When applying for accident insurance, you may choose to cover:

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

You are eligible to apply for and enroll in accident insurance if you are a:

- Part-time hourly associate
- Temporary associate, or
- Part-time truck driver.

Benefits-eligible part-time hourly associates may choose to cover:

- Associate only, or
- Associate + child(ren).

For complete information about eligibility and when you can enroll in accident insurance, see the [Eligibility and enrollment](#) chapter.

The cost for coverage under accident insurance is based on the eligible dependents you choose to cover.

Naming a beneficiary

If a covered person dies, the covered person's beneficiary(ies) will receive the benefits due at the time of the covered person's death.

You must name a beneficiary(ies) to receive your accident insurance benefit if you die. You may do this by going to the [WIRE](#), WalmartOne.com or [Workday](#).

You can name anyone you wish. If the beneficiary(ies) you have listed with Walmart differs from those named in your will, the list that Walmart has prevails.

The following information is needed when naming your beneficiary(ies):

- Beneficiary(ies) name
- Beneficiary(ies) current address
- Beneficiary(ies) phone number
- Beneficiary(ies) relationship to you
- Beneficiary(ies) Social Security number
- Beneficiary(ies) date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end, and will be shared equally by any remaining beneficiaries unless your beneficiary form states otherwise.

You can name a minor as a beneficiary; however, Allstate Benefits may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult with an attorney before naming a minor as a beneficiary.

It's important to keep your beneficiary information up to date. Proceeds will go to whoever is listed on your beneficiary form on file with Walmart, regardless of your current relationship with that person, unless state law requires otherwise.

You (the associate) are automatically assigned as the primary beneficiary of your dependent's accident coverage. If you and your dependent(s) die at the same time, benefits will be paid to your dependent's estate or at Allstate Benefits' option to a surviving relative of the dependent.

CHANGING YOUR BENEFICIARY

Your beneficiary(ies) can be changed at any time on the [WIRE](#), WalmartOne.com or [Workday](#). Any change in beneficiary must be completed and submitted to Walmart before the covered person's death.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to your surviving family member(s) in the following order:

1. Your spouse/partner; if not surviving, then
2. Children, in equal shares; if not surviving, then
3. Parents, in equal shares; if not surviving, then
4. Siblings, in equal shares; if not surviving, then
5. Your estate.

When your accident insurance coverage begins

If you enroll during annual enrollment, your coverage will become effective on January 1 of the next Plan year.

If you enroll outside of annual enrollment, your coverage will become effective on the date of your status change event or the end of your eligibility waiting period, whichever is later. If you should die before your effective date (as defined above) and before Allstate Benefits approves your coverage, no accident insurance benefit will be paid to your beneficiary(ies).

Your accident insurance will begin whether or not you are actively at work, as long as you have reported for your first day of work and enrolled for the benefit. See the [Eligibility and enrollment](#) chapter for details.

Filing a claim

Within 60 days of the occurrence or commencement of any covered accident, or as soon as reasonably possible, send a notice of claim to:

Allstate Benefits
Attn. Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488

You may also provide notice of claim as follows:

Online: allstatebenefits.com/mybenefits

By phone: **800-514-9525**

By fax: **877-423-8804**

Provide the following information for the covered person:

- Name
- Social Security number, and
- Date the covered accident occurred.

You may request a claim form from Allstate Benefits or visit the [WIRE](#), WalmartOne.com or allstateatwork.com/walmart to obtain an online copy. If you do not receive a claim form within 15 days of your request, you may send a notice of the claim to Allstate Benefits by providing Allstate Benefits with a statement of the nature and extent of the loss.

Claims will be determined under the time frames and requirements set out in the [Claims and appeals](#) chapter. You or your beneficiary has the right to appeal a claim denial.

Accident insurance benefits

Accident insurance provides benefits if you or any covered dependent seeks medical treatment or is hospitalized as a result of a covered accident that happens off the job.

For a complete list of benefits and the amounts payable, visit the [WIRE](#), WalmartOne.com or allstateatwork.com/walmart for more details.

Benefits for services that are eligible for payment as a result of a covered off-the-job accident include:

- Immediate care treatment benefit
- Initial hospitalization benefit
- Hospital confinement
- Specific benefit for injuries such as dislocation, burns, skin grafts, eye injury, lacerations, fractures, concussions (brain), emergency dental services, coma (at least seven days), surgical procedures
- Major diagnostic exams benefit
- Physical therapy benefit
- Rehabilitation
- Appliances
- Ambulance
- Blood, plasma and platelets
- Transportation and lodging benefit
- Intensive care unit (ICU)
- Confinement and step-down intensive care unit
- Follow-up treatment
- Prosthesis, or
- Family lodging.

Your Certificate of Insurance will contain complete information on the benefits payable through this coverage. To obtain a copy, visit the [WIRE](#) or WalmartOne.com. You can also call Allstate Benefits at **800-514-9525** for a copy. You can view a brochure and video online at allstateatwork.com/walmart.

When benefits are not paid


Benefits will not be paid for an accident that is caused by or occurs as a result of:

- An injury that occurred as the result of an on-the-job accident
- Injury incurred prior to the covered person's effective date of coverage, subject to the incontestability provision
- Any act of war, whether or not declared, or participation in a riot, insurrection or rebellion
- Suicide, or any attempt at suicide, whether sane or insane
- Any injury sustained while the covered person is under the influence of alcohol or any narcotic, unless administered upon the advice of a physician
- Dental or plastic surgery for cosmetic purposes, except when such surgery is required to treat an injury or correct a disorder of normal bodily function that was caused by an injury
- Participation in any form of aeronautics, except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports
- Committing or attempting to commit an assault or felony
- Driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway, or
- Any injury incurred while a covered person is an active member of the military, naval or air forces of any country or combination of countries. Upon notice and proof of service in such forces, Allstate Benefits will return the prorated portion of the premium paid for any period of such service.

If you go on a leave of absence

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums either before the leave begins or during the leave. For information about making payments while on a leave of absence, see the [Eligibility and enrollment](#) chapter.

BREAK IN COVERAGE

 **Please see page 289** for information replacing the following two paragraphs.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status within one year from cancellation, you will be enrolled for the same coverage (or, if this coverage is not available, the coverage that is most similar to your prior coverage). Your coverage will be effective the first day of the pay period that you return to active work as defined by the Plan. For more information, contact People Services at **800-421-1362**.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work after one year from cancellation, you will be considered newly eligible; you may enroll for coverage within the applicable time period and under the conditions described in the [Eligibility and enrollment](#) chapter.

When coverage ends

Accident insurance coverage for you and/or your dependents will end on the earliest of the following:

- At termination of your employment
- Upon failure to pay your premiums
- On the date of death of you or your dependent
- On the date you or a dependent spouse/partner or dependent child loses eligibility
- On the last day of an approved leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company.

In addition to the terms listed above, accident insurance coverage for your spouse/partner will end (if earlier):

- On the last day of the pay period when your job status changes to part-time, temporary or part-time truck driver
- Upon a valid decree of divorce
- Upon termination of domestic partnership, or
- Upon termination of legal relationship with a person other than a spouse or domestic partner.

CONTINUATION OF COVERAGE AT TERMINATION

If your coverage under accident insurance terminates as described earlier in this section, you may continue to receive accident insurance directly from Allstate Benefits through portability coverage. To receive portability coverage, you must notify Allstate Benefits that you wish to receive portability coverage and send the first premium for such coverage within 60 days of the date your coverage under accident insurance terminated.

The premiums for portability coverage are due in advance of each month's coverage, on the first day of the calendar month. The premiums will be at the same rate that is in effect under accident insurance for active associates with the same coverage.

For more information, please contact Allstate Benefits at **800-514-9525**.

WHEN YOUR DEPENDENT BECOMES INELIGIBLE

Any eligible dependent who was covered under accident insurance at the time such coverage terminated may also receive portability coverage, under the terms described on the previous page.

For more information, please contact Allstate Benefits at 800-514-9525.

If you leave the company and are rehired

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

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

If you drop coverage and re-enroll

If you drop coverage and re-enroll within 30 days, you will automatically be re-enrolled for the same coverage you had prior to dropping coverage (or the most similar coverage offered under the Plan).

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

Company-paid life insurance

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Company-paid life insurance

Whether you are single or married, your loved ones will have expenses as a result of your death. That's why Walmart automatically provides you with life insurance at no cost to you. Your company-paid life insurance benefit can help pay for your funeral, any credit card balances or other debts and expenses you may leave behind.

COMPANY-PAID LIFE INSURANCE RESOURCES

Find What You Need	Online	Other Resources
Change your beneficiary designation	Go to the WIRE , WalmartOne.com or Workday	Beneficiary changes cannot be made over the phone
<ul style="list-style-type: none"> • Get more details about company-paid life insurance • Request an accelerated benefit • Get details about continuing your insurance 		Call Prudential at 877-740-2116
File a claim		Call Prudential at 877-740-2116

What you need to know about company-paid life insurance

- Wal-Mart Stores, Inc. provides all full-time associates (including full-time hourly pharmacists, field Logistics associates, full-time truck drivers, field supervisor positions in stores and clubs, management trainees, California pharmacists, full-time hourly Vision Center managers and Metro professional non-exempt associates) and management associates with company-paid life insurance – there is no cost to you.
- No enrollment is necessary. Coverage will become effective after any applicable waiting period. See the [Eligibility and enrollment](#) chapter for details.
- Your coverage amount is equal to your pay, including overtime and bonuses, during the previous 26 pay periods of active status (52 pay periods if paid weekly) prior to your death, rounded to the nearest \$1,000, up to a maximum of \$50,000. This company-paid insurance is provided through The Prudential Insurance Company of America (Prudential).
- An early payout due to terminal illness is available.
- In addition, if your death occurs outside of a 100-mile radius of your home, there is a benefit for expenses that are incurred to return your body to either a preferred location within the United States, or to your residence at the time of death. The benefit includes expenses for embalming, cremation, a coffin and transportation of your remains. The benefit is the lesser of the cost to return your remains or \$10,000.
- This policy has no cash value.

Naming a beneficiary under your company-paid life insurance

In order to ensure your company-paid life insurance benefit is paid according to your wishes, you must name a beneficiary(ies). You may do this by going to the [WIRE](#), [WalmartOne.com](#) or [Workday](#). Any change in beneficiary must be completed and submitted to Walmart before the covered person's death.

You can name anyone you wish. If the beneficiary(ies) you have listed with Walmart differs from those named in your will, the list that Walmart has prevails. If you have not designated a beneficiary(ies) under the company-paid life insurance benefit, payment will be made to your surviving family member(s) as described under [If you do not name a beneficiary](#) later in this chapter.

The following information is needed when naming your beneficiary(ies):

- Beneficiary(ies) name
- Beneficiary(ies) current address
- Beneficiary(ies) phone number
- Beneficiary(ies) relationship to you
- Beneficiary(ies) Social Security number
- Beneficiary(ies) date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end, and will be shared equally by any remaining beneficiaries unless your beneficiary form states otherwise.

You can name a minor as a beneficiary; however, Prudential may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult with an attorney or an estate planner before naming a minor as a beneficiary.

If you name a minor as a beneficiary, funeral expenses cannot be paid from the minor's beneficiary proceeds.



It's important to update your beneficiary information annually. Keep in mind, proceeds will go to whomever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person. You can change your beneficiary(ies) at any time on the [WIRE](#), [WalmartOne.com](#) or [Workday](#).

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named, payment will be made to your surviving family member(s) in the following order:

1. Widow or widower or partner of the deceased; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares; if not surviving, then
5. Executor or administrator of your estate.

When your company-paid life insurance coverage begins

You must be actively at work in order for your coverage to become effective. You will be considered actively at work on a day that is one of your scheduled work days if you are performing in the usual way all of the regular duties of your job. See the [Eligibility and enrollment](#) chapter for details.

Early payout due to terminal illness

If you are terminally ill, you may elect to receive up to 50% of the amount your beneficiary(ies) would have received upon your death, while you are still living. Payment may be made in a lump sum or 12 equal monthly installments. Upon your death, your beneficiary(ies) will receive the remaining 50% (plus any amount of the early payout not yet received at the time of your death). This benefit is referred to as the "accelerated benefit."

If you terminate from the company after you have received (or begun to receive) the accelerated benefit, you will need to convert the policy in order for your beneficiary(ies) to receive the remaining balance upon your death. If you do not convert the policy upon termination of your employment, there will be no benefit payout for your beneficiary(ies). See the [Continuing your company-paid life insurance after you leave Walmart](#) section in this chapter for details on conversion.

You are terminally ill if:

- There is no reasonable prospect of recovery
- Death is expected within 12 months, and
- A doctor can certify the illness or injury as terminal.

There may be some circumstances when the accelerated benefit will not be paid. Contact Prudential at **877-740-2116** for details.

Tax laws are complex. Please consult with a tax professional to assess the impact of this benefit.

Filing a claim

Within 12 months of the covered associate's death, the deceased associate's beneficiary(ies) must contact Prudential at **877-740-2116** and provide the following information regarding the deceased associate:

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

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

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

The claim will not be finalized until the death certificate is received. Acceptance of the death certificate is not a guarantee of payment.

Claims will be determined under the time frames and requirements set out in the [Claims and appeals](#) chapter. Your beneficiary(ies) has the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For more details, contact Prudential at **877-740-2116**.

When benefits are not paid

Benefits will not be paid to any beneficiary(ies) who engaged in an illegal act that resulted in the death of the associate. Instead, the benefit would go to another eligible designated beneficiary or to a beneficiary in the default list, as specified under [If you do not name a beneficiary](#) earlier in this chapter.

When coverage ends

Your company-paid life insurance coverage ends:

- At termination of your employment
- On the last day of the pay period when your job status changes to part-time
- On the date of your death
- On the date that you lose eligibility
- On the last day of an approved leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company.

This policy has no cash value.

EstateGuidance®

EstateGuidance offers you the convenience of online will preparation from your personal computer at no cost to you. Wills ensure that your assets will be distributed in accordance with your wishes and allow you to name a guardian to take care of your minor children. To complete the online will questionnaire, log on to willguidance.com, password: **Walmart**.

NOTE: Your will does not override the beneficiary designation on a life insurance policy or retirement account (such as a 401(k) plan). For this reason, it is important that you review your beneficiary designations, particularly after you have created a will, to make sure your designations are consistent and fully in line with your wishes. If the beneficiary(ies) you have listed with Walmart differs from those named in your will, the list that Walmart has prevails.

Continuing your company-paid life insurance after you leave Walmart

In most circumstances, you will have two options to continue your company-paid life insurance if your group life coverage ends. The first option, called **portability**, allows you to continue all or a portion of your coverage through a group term policy with Prudential. The second option, called **conversion**, allows you to convert all or a portion of your coverage to a Prudential individual policy.

You must apply for portability or conversion within 31 days of the date your company-paid coverage ends. If you die within 31 days of a qualifying loss of coverage and before electing portability or conversion of your life insurance coverage, Prudential will pay a death benefit to your beneficiary. The benefit will be paid based on the amount of coverage in effect prior to the qualifying loss of coverage, even if you did not apply for portability or conversion of your coverage.

Portability enables you to maintain similar term life insurance with Prudential after your employment ends, if certain conditions are met. Proof of Good Health is required to port your coverage. If you do not pass or submit Proof of Good Health, you will be eligible to convert your company-paid life insurance to an individual policy, as described on the next page.

You will be able to apply for term life coverage under the portability feature if you meet all of these conditions:

1. Your company-paid life coverage ends for any reason other than:
 - a. your failure to pay premiums while you were an active associate
 - b. you leave the company due to a disability, or
 - c. Walmart changes group life insurance carriers and you are, or become, eligible within the next 31 days.
2. You are actively at work on the day your company-paid insurance ends.
3. You are less than age 80.
4. Your amount of insurance is at least \$20,000 on the day your company-paid insurance ends.

If you meet these conditions, you will have 31 days from your termination date to contact Prudential and enroll.

Conversion is a required Plan provision that allows you to convert your life insurance coverage to an individual policy. Rates are based on an individual's age and amount converted. You have 31 days from the termination date of coverage to request to convert your coverage to an individual policy. If your death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted.

For residents of Minnesota, you may elect to continue coverage at your expense if your employment is terminated, either voluntarily or involuntarily, or if you are laid off, as long as the group policy is still in force with the employer. Coverage may be continued until you obtain coverage under another group policy or you return to work from layoff; however, the maximum period that coverage may be continued is 18 months.

To request information on portability or conversion, call Prudential at **877-740-2116**.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be re-enrolled for coverage.

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

Optional associate life insurance

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Optional associate life insurance

You protect your family every day — your paycheck keeps a roof over their heads and food on the table, you use seat belts and child safety seats, and you plan for your family’s college and retirement expenses. What would happen to your family if you died? Would they be forced to deal with a desperate financial situation along with emotional devastation? Optional associate life insurance protects your family financially during a difficult time.

OPTIONAL ASSOCIATE LIFE INSURANCE RESOURCES

Find What You Need	Online	Other Resources
Change your beneficiary designation	Go to the WIRE , WalmartOne.com or Workday	Beneficiary changes cannot be made over the phone
<ul style="list-style-type: none"> • Get more details about life insurance • Request an accelerated benefit • Get details about continuing your insurance 		Call Prudential at 877-740-2116
File a claim		Call Prudential at 877-740-2116

What you need to know about optional associate life insurance

- All hourly and management associates can enroll in optional associate life insurance when they are eligible, as described in the [Eligibility and enrollment](#) chapter.
- Depending on the coverage amount you choose and when you enroll, you may be required to provide Proof of Good Health.
- You can enroll in, change or drop optional associate life insurance at any time, but if you enroll at any time other than your initial enrollment period, you will have to provide Proof of Good Health.
- An early payout due to terminal illness is available.
- This policy is term life insurance. It has no cash value.

Enrolling in optional associate life insurance

Your coverage choices for optional associate life insurance depend on your job classification, as follows:

If you are an hourly associate or part-time truck driver, your coverage choices for optional associate life insurance are:

- \$25,000
- \$50,000
- \$75,000
- \$100,000
- \$150,000
- \$200,000

If you are a management associate, your coverage choices for optional associate life insurance are:

- \$25,000
- \$50,000
- \$75,000
- \$100,000
- \$150,000
- \$200,000
- \$300,000
- \$500,000
- \$750,000
- \$1,000,000

NOTE: To be eligible for this benefit as a management associate, you must be classified in the company's payroll system as a management associate, management trainee, California pharmacist, full-time Vision Center manager, Metro professional non-exempt associate or full-time truck driver.

For all associates enrolling in optional associate life insurance, Proof of Good Health may be required when you enroll, depending on the coverage amount you choose and when you enroll.

This policy has no cash value, and premiums from optional associate life coverage do not subsidize coverage under company-paid life insurance.



It's important to update your beneficiary information annually. Keep in mind, proceeds will go to whomever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person. You can change your beneficiary(ies) at any time on the [WIRE](#), [WalmartOne.com](#) or [Workday](#).

If you die, your beneficiary(ies) may receive a lump sum payment for the coverage amount you select. Optional associate life insurance is insured by The Prudential Insurance Company of America (Prudential).

The cost of optional associate life insurance is based on the coverage amount you select, your age and whether you are eligible for tobacco-free rates.

Hourly associates, part-time truck drivers and management associates (including the job classifications listed in the **NOTE** to the left) can enroll in optional associate life insurance at any time once they are eligible. Proof of Good Health is required if you enroll after your initial enrollment period. You can change or drop coverage at any time. However, if you want to increase your coverage or re-enroll after dropping coverage, you will be required to provide Proof of Good Health.

PROVIDING PROOF OF GOOD HEALTH

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

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

Proof of Good Health includes completing a questionnaire regarding your medical history and possibly having a medical exam. The Proof of Good Health questionnaire is made available when you enroll.

Naming a beneficiary

In order to ensure that your life insurance benefit is paid according to your wishes, you must name a beneficiary(ies) to receive your optional associate life insurance benefit if you die. You may do this by going to the [WIRE](#), [WalmartOne.com](#) or [Workday](#). Any change in beneficiary must be completed and submitted to Walmart before the covered person's death.

You can name anyone you wish. If the beneficiary(ies) you have listed with Walmart differs from those named in your will, the list that Walmart has prevails. If you have not designated a beneficiary(ies) under the optional associate life insurance benefit, payment will be made to your surviving family member(s) as described under **If you do not name a beneficiary** later in this chapter.

The following information is needed when naming your beneficiary(ies):

- Beneficiary(ies) name
- Beneficiary(ies) current address
- Beneficiary(ies) phone number

- Beneficiary(ies) relationship to you
- Beneficiary(ies) Social Security number
- Beneficiary(ies) date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end and will be shared equally by any remaining beneficiary(ies), unless your beneficiary form states otherwise.

You can name a minor as a beneficiary; however, Prudential may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult an attorney or an estate planner before naming a minor as a beneficiary.

If you name a minor as a beneficiary, funeral expenses cannot be paid from the minor's beneficiary proceeds.

It's important to update your beneficiary information annually. Keep in mind, proceeds will go to whomever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person. You can change your beneficiary(ies) at any time on the [WIRE](#), [WalmartOne.com](#) or [Workday](#).

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named, payment will be made to your surviving family member(s) in the following order:

1. Widow or widower or partner of the deceased; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares; if not surviving, then
5. Executor or administrator of your estate.

When your optional associate life insurance coverage begins

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

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

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

You must be actively at work in order for your coverage to become effective. You will be considered actively at work

on a day that is one of your scheduled work days if you are performing in the usual way all of the regular duties of your job. See the [Eligibility and enrollment](#) chapter for details.

Early payout due to terminal illness

If you are terminally ill, you may receive up to 50% of the coverage amount you have chosen while you are still living. Payment may be made in a lump sum or 12 equal monthly installments. Upon your death, your beneficiary(ies) will receive the remaining 50% (plus any amount of the early payout not yet received at the time of your death). This benefit is referred to as the "accelerated benefit."

If you terminate from the company after you have received (or begun to receive) the accelerated benefit, you will need to convert the policy to an individual policy in order for your beneficiary(ies) to receive the remaining balance upon your death. If you do not convert the policy upon termination of your employment, there will be no benefit payout for your beneficiary(ies). See the [Continuing your optional associate life insurance after you leave Walmart](#) section later in this chapter for details on conversion.

You are terminally ill if:

- There is no reasonable prospect of recovery
- Death is expected within 12 months, and
- A doctor can certify the illness or injury as terminal.

There may be some circumstances when the accelerated benefit will not be paid. Contact Prudential at **877-740-2116** for details.

Tax laws are complex. Please consult a tax professional to assess the impact of this benefit.

Filing a claim

Within 12 months of the covered associate's death, contact Prudential at **877-740-2116** and provide the following information regarding the deceased associate:

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

A copy of the death certificate is required as proof of death. Mail the death certificate to:

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

The claim will not be finalized until the death certificate is received. Acceptance of the death certificate is not a guarantee of payment.

Claims will be determined under the time frames and requirements set out in the [Claims and appeals](#) chapter. Your beneficiary(ies) has the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For more details, contact Prudential at **877-740-2116**.

When benefits are not paid

Benefits will not be paid to any beneficiary(ies) who engaged in an illegal act that resulted in the death of the associate. Instead, the benefit would go to another eligible designated beneficiary or a beneficiary in the default list, as specified under [If you do not name a beneficiary](#) earlier in this chapter.

No benefits will be paid to your beneficiary(ies) if you die as a result of a self-inflicted injury or suicide while sane or insane during the first two years of coverage. If you increase your coverage and you die as a result of a self-inflicted injury or suicide within two years of the date you increase your coverage, your beneficiary(ies) will receive the prior coverage amount.


If your beneficiary(ies) files a claim within the first two years of your approval date, Prudential has the right to re-examine your Proof of Good Health questionnaire. If material facts about you were stated inaccurately, the actual facts will be used to determine what amount of coverage should have been in effect, if any, and:

- The claim may be denied, and
- Premiums paid may be refunded.

If you go on a leave of absence

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums either before the leave begins or during the leave. For information about making payments while on a leave of absence, see the [Eligibility and enrollment](#) chapter.

BREAK IN COVERAGE

 **Please see page 289** for information replacing the following two paragraphs.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status within one year from cancellation, you will be enrolled for the same coverage (or, if this coverage is not available, the coverage that is most similar to your prior coverage). Your coverage will be effective the first day of the pay period that you return to active work as defined by the Plan. For more information, contact People Services at **800-421-1362**.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status after one year from cancellation, you will be considered newly eligible; you may enroll for coverage within the applicable time period and under the conditions described in the [Eligibility and enrollment](#) chapter.

When coverage ends

Your optional associate life insurance coverage ends:

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

This policy has no cash value.

Continuing your optional associate life insurance after you leave Walmart

In most circumstances, you will have two options to continue your optional associate life insurance if your group life coverage ends. The first option, called **portability**, allows you to continue all or a portion of your current coverage through a group term policy with Prudential. The second option, called **conversion**, allows you to convert all or a portion of your coverage to a Prudential individual policy.

You must apply for portability or conversion within 31 days of the date your coverage ends. If you die within 31 days of a qualifying loss of coverage and before electing portability or conversion of your life insurance coverage, Prudential will pay a death benefit to your beneficiary. The benefit will be paid based on the amount of coverage in effect prior to the qualifying loss of coverage, even if you did not apply for portability or conversion of your coverage.

Portability enables you to maintain similar term life insurance with Prudential after your employment ends if certain conditions are met. Proof of Good Health is not required to port your coverage. You can, however, receive preferred rates similar to the rates you paid while an active

associate if you submit and pass Proof of Good Health. If you do not pass or submit Proof of Good Health, your rates will be based on Prudential's standard portability rates.

You will be able to apply for term life coverage under the portability feature if you meet all of these conditions:

1. Your optional associate life coverage ends for any reason other than:
 - a. your failure to pay premiums while you were an active associate
 - b. you leave the company due to a disability, or
 - c. Walmart changes group life insurance carriers and you are or become eligible within the next 31 days.
2. You meet the active work requirement on the day your insurance ends.
3. You are less than age 80.
4. Your amount of insurance is at least \$20,000 on the day your insurance ends.

If you meet these conditions, you will have 31 days from your termination date to contact Prudential and enroll.

Conversion is a required Plan provision that allows you to convert your life insurance coverage to an individual policy. Rates are based on an individual's age and amount converted. You have 31 days from the termination date of coverage to request to convert your coverage to an individual policy. If your death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted.

For residents of Minnesota, you may elect to continue coverage at your expense if your employment is terminated, either voluntarily or involuntarily, or if you are laid off, as long as the group policy is still in force with the employer. Coverage may be continued until you obtain coverage under another group policy or you return to work from layoff; however, the maximum period that coverage may be continued is 18 months.

To request information on portability or conversion, call Prudential at **877-740-2116**.

If you leave the company and are rehired

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

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

If you drop or decrease your coverage and re-enroll

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

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

Optional dependent life insurance

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Optional dependent life insurance

The loss of your spouse/partner could mean the loss of an income or a need for childcare. The loss of a child could mean medical bills and funeral expenses. While you and your family are dealing with the emotional burden that the loss of a family member brings, you can receive help for the financial consequences through optional dependent life insurance. Think about the expenses you would have if your spouse/partner or child died. Optional dependent life insurance could ease your financial situation, helping your family get through a difficult time.

OPTIONAL DEPENDENT LIFE INSURANCE RESOURCES

Find What You Need	Online	Other Resources
Get more details about life insurance	Go to the WIRE or WalmartOne.com	Call Prudential at 877-740-2116
File a claim		Call Prudential at 877-740-2116


What you need to know about optional dependent life insurance

- All full-time hourly and management associates can enroll their spouses/partners and/or children in optional dependent life insurance when they are eligible, as described in the [Eligibility and enrollment](#) chapter.
- All part-time hourly associates and part-time truck drivers can enroll their children in optional dependent life insurance when they are eligible, but cannot enroll their spouses/partners.
- Proof of Good Health for your spouse/partner is required if you enroll for a coverage amount above \$5,000 during your initial enrollment period, or for any coverage amount if you enroll at any other time.

Enrolling in optional dependent life insurance

All hourly and management associates can enroll in optional dependent life insurance. When you enroll in optional dependent life insurance, if your covered spouse/partner and/or legal dependent dies, you may receive a lump sum payment for the coverage amount you select. Optional dependent life insurance is insured by The Prudential Insurance Company of America (Prudential).

Your coverage choices for optional dependent life insurance are as follows.

 **See page 287** for new options for spouse/partner and child coverage.

- Spouse/partner (except for part-time hourly associates, temporary associates and part-time truck drivers):
 - \$5,000
 - \$15,000
 - \$25,000
 - \$50,000
 - \$75,000
 - \$100,000
- Child:
 - \$2,000 per child
 - \$5,000 per child
 - \$10,000 per child

Depending on the coverage amount you choose and when you enroll, your spouse/partner may be required to provide Proof of Good Health.

You (the associate) are automatically assigned as the primary beneficiary of your dependent's life insurance coverage. If you and your covered dependent(s) die at the same time, benefits will be paid to your dependent's estate or, at Prudential's option, to a surviving relative of the dependent.

The cost of optional dependent life insurance for your spouse/partner is based on the coverage amount you select, your (the associate's) age and whether your spouse/partner is eligible for the tobacco-free rates. The cost of coverage for your child(ren) is based on the coverage amount you select.

This policy has no cash value, and premiums from optional dependent life coverage do not subsidize coverage under company-paid life insurance.

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

PROOF OF GOOD HEALTH

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

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

Proof of Good Health includes completing a questionnaire regarding your spouse/partner's medical history and possibly requiring your spouse/partner to have a medical exam. The Proof of Good Health questionnaire is made available when you enroll your spouse/partner. Proof of Good Health is not required for children.

When your optional dependent life insurance coverage begins

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

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

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

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

You must be actively at work in order for your dependent coverage to be effective. You will be considered actively at work on a day that is one of your scheduled work days if you are performing in the usual way all of the regular duties of your job. See the [Eligibility and enrollment](#) chapter for details.

Additional benefits

Benefits also are payable under certain circumstances, as stated below. Effective Oct. 13, 2018, the additional benefits payable under the circumstances described here increase from \$2,000 to \$5,000.

See page 287

- If a dependent child is born alive and dies within 60 days of birth and was eligible but not enrolled in optional dependent life insurance prior to the loss — with a live birth certificate and a death certificate — Prudential will pay a \$2,000 benefit only.
- If a dependent child is stillborn, Prudential will pay a \$2,000 benefit to associates who have met the eligibility waiting period for dependent life insurance. See the [Eligibility and enrollment](#) chapter for details. A stillborn child is defined as an eligible associate's natural-born child whose death occurs before expulsion, extraction or delivery and whose fetal weight is 350 grams or more; or, if fetal weight is unknown, whose duration in utero was 20 or more complete weeks of gestation. If both the mother and father of the stillborn child work at Walmart, each associate is eligible to submit a claim for this benefit separately, for a total of \$4,000.

Filing a claim

Within 12 months of the covered dependent's death, contact Prudential at **877-740-2116** and provide the following information regarding the deceased:

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

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

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

The claim will not be finalized until the death certificate is received. Acceptance of the death certificate is not a guarantee of payment.

Claims will be determined under the time frames and requirements set out in the [Claims and appeals](#) chapter. You have the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For more details, contact Prudential at **877-740-2116**.

When benefits are not paid

Benefits will not be paid to you if you engage in an illegal act that results in the death of the insured. Instead, the benefit may go to the insured's estate.

No benefits will be paid to you if your spouse/partner or dependent child dies as a result of a self-inflicted injury or suicide while sane or insane during the first two years of coverage. If you increase your dependent's coverage and your spouse/partner or dependent child dies as a result of a self-inflicted injury or suicide within two years of the increase in coverage, you will receive the prior coverage amount.


If you file a claim for your spouse/partner within the first two years of your approval date, Prudential has the right to re-examine your spouse/partner's Proof of Good Health questionnaire. If material facts about your spouse/partner were stated inaccurately, the actual facts will be used to determine what amount of coverage should have been in effect, if any, and:

- The claim may be denied, and
- Premiums paid may be refunded.

If you go on a leave of absence

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums either before the leave begins or during the leave. For information about making payments while on a leave of absence, see the [Eligibility and enrollment](#) chapter.

BREAK IN COVERAGE

 **Please see page 289** for information replacing the following two paragraphs.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status within one year from cancellation, you will be enrolled for the same coverage (or, if this coverage is not available, the coverage that is most similar to your prior coverage). Your coverage will be effective the first day of the pay period that you return to active work as defined by the Plan. For more information, contact People Services at **800-421-1362**.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status after one year from cancellation, you will be considered newly eligible; you may enroll for coverage within the applicable time period and under the conditions described in the [Eligibility and enrollment](#) chapter.

When coverage ends

Your optional dependent life insurance coverage ends:

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

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

This policy has no cash value.

Continuing your optional dependent life insurance after you leave Walmart

In most circumstances, you will have two options to continue your optional dependent life insurance if your group life coverage ends. The first option, called **portability**, allows you and your dependents to continue all or a portion of your current coverage through a group term policy with Prudential. The second option, called **conversion**, allows you to convert all or a portion of your coverage to a Prudential individual policy.

Portability enables you to maintain similar term life insurance with Prudential after your employment ends if certain conditions are met.

Proof of Good Health is not required to “port” your coverage. You can, however, receive preferred rates similar to the rates you paid while an active associate if you and your dependents submit and pass Proof of Good Health. If you do not pass or submit Proof of Good Health, your rates will be based on Prudential’s standard portability rates.

You will be able to apply for term life coverage under the portability feature if you meet all of these conditions:

1. The optional dependent life coverage on the dependent ends because your optional associate life coverage ends for any reason other than:
 - a. your failure to pay, when due, any contribution required for it
 - b. the end of your employment on account of your retirement due to disability, or
 - c. the end of the optional associate life coverage for all associates when such coverage is replaced by group life insurance from any carrier for which you are or become eligible within the next 31 days.
2. You apply and become covered for term life coverage under the portability plan.
3. With respect to a dependent spouse/partner, that spouse/partner is less than age 80.
4. With respect to a dependent child, that child is less than age 26.
5. The dependent is covered for optional dependent life coverage on the day your optional associate life coverage ends.
6. The dependent is not confined for medical care or treatment, at home or elsewhere, on the day your optional associate life coverage ends.

Conversion is a required Plan provision that allows you to convert your life insurance coverage to an individual policy. Rates are based on an individual’s age and amount converted.

For residents of Minnesota, you may elect to continue coverage at your expense if your employment is terminated, either voluntarily or involuntarily, or if you are laid off, as long as the group policy is still in force with the employer. Coverage may be continued until you obtain coverage under another group policy or you return to work from layoff; however, the maximum period that coverage may be continued is 18 months.

To request information on portability or conversion, call Prudential at **877-740-2116**.

If you leave the company and are rehired

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

If you return to work after 13 weeks, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period. Proof of Good Health is required for spouse/partner coverage plans above \$5,000.

See the [Eligibility and enrollment](#) chapter for details.

If you drop or decrease your coverage and re-enroll

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

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

Accidental death and dismemberment (AD&D) insurance

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Accidental death and dismemberment (AD&D) insurance

Accidents are unpredictable and unavoidable. But you don't have to be unprepared for the financial consequences of a serious injury or death. Accidental death and dismemberment insurance is available to you and your family, and Proof of Good Health is not required. If you choose coverage and experience a covered loss, accidental death and dismemberment benefits can help pay the cost of medical care, childcare and education expenses.

AD&D INSURANCE RESOURCES

Find What You Need	Online	Other Resources
Change your beneficiary designation	Go to the WIRE , WalmartOne.com or Workday	Beneficiary changes cannot be made over the phone
Get more details about AD&D insurance		Call Prudential at 877-740-2116
File a claim		Call Prudential at 877-740-2116

What you need to know about AD&D insurance

- All hourly and management associates can enroll in AD&D when they are eligible, as described in the [Eligibility and enrollment](#) chapter.
- Proof of Good Health is not required for AD&D insurance, regardless of the coverage amount you choose.
- AD&D insurance pays a lump sum benefit for loss of life, limb, sight, speech, hearing or paralysis due to an accident.

Enrolling in AD&D insurance

All hourly and management associates can enroll in accidental death and dismemberment (AD&D) insurance. AD&D insurance pays a lump sum benefit to you or your beneficiary(ies) if you or your covered dependent(s) has a loss of life, limb, sight, speech or hearing, or becomes paralyzed, due to an accident.

You have two AD&D coverage decisions. You choose whom you want to cover and your coverage amount.

You choose to cover:

- Associate only
- Associate + dependent(s)

NOTE: If you are a part-time hourly associate, temporary associate or part-time truck driver and you choose associate + dependent(s) coverage, you can cover your dependent children but not your spouse/partner.

The coverage amount for your dependent(s) will be a percentage of the coverage amount you choose for yourself (see **AD&D coverage amount** later in this chapter). The amounts available for you to choose as your associate coverage amount are:

- \$25,000
- \$50,000
- \$75,000
- \$100,000
- \$150,000
- \$200,000

Management associates may also choose the following coverage amounts:

- \$300,000
- \$500,000
- \$750,000
- \$1,000,000

The amount of your benefit depends on the type of loss you experience. See **When AD&D benefits are paid** later in this chapter for more detail.

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

The cost of AD&D insurance is based on the coverage amount you select and whether you choose associate-only or associate + dependent(s) coverage.

Naming a beneficiary

In order to ensure that your AD&D benefit is paid according to your wishes, you must name a beneficiary(ies). You may complete your beneficiary form by going to the **WIRE**,

WalmartOne.com or **Workday**. You (the associate) will receive any benefits payable for your covered dependents.

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

The following information is needed when you are naming your beneficiary(ies):

- Beneficiary(ies) name
- Beneficiary(ies) current address
- Beneficiary(ies) phone number
- Beneficiary(ies) relationship to you
- Beneficiary(ies) Social Security number
- Beneficiary(ies) date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally.

You can name a minor as a beneficiary. However, Prudential may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult with an attorney before naming a minor as a beneficiary. If you name a minor as a beneficiary, funeral expenses cannot be paid from the minor's beneficiary proceeds.

It is important to keep your beneficiary information up to date. Proceeds will go to whomever is listed on your beneficiary form on file with Walmart, regardless of your current relationship with that person.

CHANGING YOUR BENEFICIARY

Your beneficiary(ies) can be changed at any time on the **WIRE**, **WalmartOne.com** or **Workday**. Any change in beneficiary must be completed and submitted to Walmart before the covered person's death.

IF YOU DO NOT NAME A BENEFICIARY

If there is no beneficiary designated or no surviving beneficiary at the time of your death, Prudential will determine the beneficiary to be one or more of the following surviving you:

1. Widow or widower or partner of the deceased; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares, if not surviving, then
5. Your estate.

When your AD&D coverage begins

If you enroll during annual enrollment, your coverage will become effective on January 1 of the next Plan year.

If you enroll outside of annual enrollment, your coverage will become effective on the date of the status change event or the end of your eligibility waiting period, whichever is later.

Your AD&D coverage will begin whether or not you are actively at work, as long as you have reported for your first day of work and enrolled for the benefit. See the [Eligibility and enrollment](#) chapter for details.

AD&D coverage amount

When you enroll in AD&D insurance, the coverage amount you select is the amount that applies to you, the associate. If you enroll in associate + dependent(s) coverage, the coverage amount for your dependent(s) is a percentage of your associate coverage amount. The coverage amount for your dependent(s) depends on the type of dependents you are covering. See the [Full benefit amount](#) chart below for information on the coverage amount for your family members.

When AD&D benefits are paid

If you or your dependent (if you choose associate + dependent(s) coverage) sustains an accidental injury that is the direct and sole cause of a covered loss, proof of the accidental injury and covered loss must be sent to Prudential.

Prudential will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

Direct and sole cause: The covered loss occurs within 12 months of the date of the accidental injury and was a direct result of the accidental injury, independent of other causes.

Paralysis: Loss of use, without severance, of a limb. A doctor must determine that the loss is complete and not reversible. (“Severance” means complete separation and dismemberment of the limb from the body.)

COVERED LOSSES PAID AT FULL BENEFIT

The following covered losses resulting from an accident are payable at the full benefit:

- Loss of life: It will be presumed that you have suffered a loss of life if your body is not found within one year of disappearance, stranding, sinking or wrecking of any vehicle in which you were an occupant.
- Loss of both hands above the wrists; both feet above the ankles; total and permanent loss of sight in both eyes; loss of speech and hearing in both ears that lasts for six consecutive months following the accident.
- Loss of one hand and one foot: Severance at or above the wrist or ankle joint.
- Loss of one arm or one leg: Severance at or above the elbow or above the knee.
- Loss of one hand or foot and sight in one eye: Severance at or above the wrist or ankle joint, with total and permanent loss of sight in one eye.
- Quadriplegia: Total paralysis of both upper and lower limbs.
- Paraplegia: Total paralysis of both lower limbs.
- Hemiplegia: Total paralysis of upper and lower limbs on one side of the body.

FULL BENEFIT AMOUNT

Associate coverage amount	If a spouse/partner is the only dependent covered	If both a spouse/partner and children are covered dependents		If children are the only dependents
Associate – 100%	Spouse/partner – 50%	Spouse/partner – 40%	Children – 10%	Children – 25%
\$25,000	\$12,500	\$10,000	\$2,500	\$6,250
\$50,000	\$25,000	\$20,000	\$5,000	\$12,500
\$75,000	\$37,500	\$30,000	\$7,500	\$18,750
\$100,000	\$50,000	\$40,000	\$10,000	\$25,000
\$150,000	\$75,000	\$60,000	\$15,000	\$37,500
\$200,000	\$100,000	\$80,000	\$20,000	\$50,000

Management associates only:

\$300,000	\$150,000	\$120,000	\$30,000	\$75,000
\$500,000	\$250,000	\$200,000	\$50,000	\$125,000
\$750,000	\$375,000	\$300,000	\$75,000	\$187,500
\$1,000,000	\$500,000	\$400,000	\$100,000	\$250,000

50% OF FULL BENEFIT

The following covered losses resulting from an accident are payable at 50% of full benefit:

- Brain damage: Brain damage means permanent and irreversible physical damage to the brain, causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of more than five consecutive days within 30 days of the accident and continue for 12 consecutive months.
- Loss of hand or foot: Severance at or above the wrist or ankle.
- Loss of sight in one eye: Permanent loss of sight in one eye.
- Loss of speech or hearing in both ears: Total and permanent loss of speech or hearing (i.e., continuing for at least six consecutive months following the accident).

25% OF FULL BENEFIT

The following covered losses resulting from an accident are payable at 25% of full benefit:

- Loss of hearing in one ear: Total and permanent loss of hearing (i.e., continuing for at least six consecutive months following the accident).
- Loss of thumb and index finger of the same hand: Severance at or above the point at which they are attached to the hand.
- Uniplegia: Total paralysis of one limb.

COMA BENEFIT

If you or your covered dependent(s) is comatose or becomes comatose within 365 days as the result of an accident, a coma benefit equal to 1% of the insured's coverage amount will be paid for 11 consecutive months to you, your spouse/partner, your children or a legal guardian. The benefit is payable after 31 consecutive days of being comatose. If you or your covered dependent(s) remains comatose beyond 11 months, the full sum of the coverage, less any AD&D benefit already paid, will be made to you or your designated beneficiary.

"Coma" means a profound state of unconsciousness from which the comatose person cannot be aroused, even by powerful stimulation, as determined by the person's doctor. Such state must begin within 365 days of the accidental injury and continue for 31 consecutive days.

Additional AD&D benefits

Additional benefits may be payable by the Plan:

- Seat belt benefit: If you and/or your covered dependents suffer a loss of life as a result of a covered accident that occurs while wearing a seat belt, an additional benefit may be payable.

- Safe motorcycle rider benefit: If you and/or your covered dependents suffer a loss of life as a result of a covered accident that occurs while wearing a helmet, an additional benefit may be payable.
- Education and childcare benefit: If you (the associate) suffer a loss of life, a childcare benefit, child education benefit and/or spouse/partner education benefit may be payable.
- Home alteration and vehicle modification benefit: If you and/or your covered dependents suffer a covered loss that requires home alteration or vehicle modification, an additional benefit may be payable.
- COBRA monthly medical premium benefit: If you (the associate) suffer a covered accidental bodily injury, which results in a termination after a leave of absence, an additional benefit may be payable to assist with the continuation of your medical benefits under the Associates' Medical Plan.
- Monthly rehabilitation benefit: If you and/or your covered dependents suffer a covered accidental bodily injury that requires medically necessary rehabilitation, an additional benefit may be payable.

When benefits are not paid

AD&D benefits will not be paid for any loss that occurs prior to your enrollment in the Plan, nor any loss caused or contributed to by the following:

- Suicide or attempted suicide, while sane or insane
- Intentionally self-inflicted injuries, or any attempt to inflict such injuries
- Sickness, whether the loss results directly or indirectly from the sickness
- Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment
- Any bacterial or viral infection. But this does not include:
 - Pyogenic infection resulting from an accidental cut or wound, or
 - Bacterial infection resulting from accidental ingestion of a contaminated substance.
- Taking part in any insurrection
- War, or any act of war. "War" means declared or undeclared war, and includes resistance to armed aggression
- An accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces (this does not include Reserve or National Guard active duty for training)
- Travel or flight in any vehicle used for aerial navigation (includes getting in, out, on or off any such vehicle) if the person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers
- Commission of or attempt to commit an assault or a felony

- While operating a land, water or air vehicle, being legally intoxicated, or
- Being under the influence of or taking any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, and all amendments, unless prescribed by and administered in accordance with the advice of the insured's doctor.

Filing a claim

Within 90 days of the loss, call Prudential at **877-740-2116** and provide the following:

- Name
- Associate's Social Security number
- Date of death or injury, and
- Cause of death or injury (if known).

Prudential will send a claim packet to your address on file. The required information must be completed and returned with the claim forms and an original or certified copy of the death certificate, when applicable, to:

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


Benefits are paid in a lump sum. If you or a covered dependent sustains more than one covered loss due to an accidental injury, the amount paid, on behalf of any such injured person, will not exceed the full amount of the benefit.

Claims will be determined under the time frames and requirements set out in the [Claims and appeals](#) chapter. You or your beneficiary has the right to appeal a claim denial.

If you go on a leave of absence

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums either before the leave begins or during the leave. For information about making payments while on a leave of absence, see the [Eligibility and enrollment](#) chapter.

BREAK IN SERVICE

 **Please see page 289** for information replacing the following two paragraphs.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status within one year of cancellation, you will be enrolled for the same coverage you had prior to your leave of absence. Your coverage will be effective the first day of the pay period that you return to active work as defined by the Plan. For more information, contact People Services at **800-421-1362**.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to active work status after one year of cancellation, you will be considered newly eligible; you may enroll for coverage within the applicable time period and under the conditions described in the [Eligibility and enrollment](#) chapter.

When coverage ends

Your AD&D coverage ends:

- At termination of your employment
- Upon failure to pay your premiums
- On the date of your death
- On the date you or a dependent spouse/partner or child loses eligibility
- On the last day of an approved leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company. AD&D coverage cannot be converted to individual coverage after coverage ends.

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

If you leave the company and are rehired

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

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

See the [Eligibility and enrollment](#) chapter for details.

If you drop or decrease your coverage and re-enroll

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

If you re-enroll more than 30 days after dropping or decreasing coverage, you may enroll for coverage under the time periods and conditions described in the [Eligibility and enrollment](#) chapter.

Business travel accident insurance

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policies issued by the applicable insurers under this chapter regarding the calculation of benefits and limitations under the policies, the terms of the policies will govern. You may obtain a copy of these policies by contacting the Plan.

Business travel accident insurance

While you are traveling on authorized company business, Walmart's business travel accident insurance protects you financially if you have an accident that results in death or certain types of injury. This coverage costs you nothing and is effective on your first day of work.

BUSINESS TRAVEL ACCIDENT INSURANCE RESOURCES

Find What You Need	Online	Other Resources
Change your beneficiary designation	Go to the WIRE , WalmartOne.com or Workday	Beneficiary changes cannot be made over the phone
Get more details about business travel accident insurance		Call Prudential at 877-740-2116
File a business travel accident insurance claim		Call Prudential at 877-740-2116
Get more details about international business travel medical insurance through GeoBlue	Go to geo-blue.com	Call GeoBlue at 888-412-6403

What you need to know about business travel accident insurance

- Wal-Mart Stores, Inc. provides all associates with business travel accident insurance — at no cost to you. The company pays for this coverage in full.
- No enrollment is necessary. Coverage will become effective on your first day of active work. See the [Eligibility and enrollment](#) chapter for details.
- Business travel accident insurance pays a lump-sum benefit for loss of life, limb, sight, speech or hearing or paralysis, due to an accident you are involved in while traveling on authorized company business.
- Your coverage amount is three times your Base Annual Earnings — maximum of \$1 million and minimum of \$200,000 (unless otherwise specified). This company-paid insurance is provided through The Prudential Insurance Company of America (Prudential).
- International business travel medical insurance is available for eligible business travelers through GeoBlue.

Your business travel accident insurance

If you experience a covered injury resulting in loss or death while traveling on authorized company business, a lump-sum benefit is payable to you or your beneficiary(ies) of up to three times your Base Annual Earnings, with a maximum of \$1 million and minimum of \$200,000 (unless otherwise specified).

Base Annual Earnings* is defined as follows:

- **For hourly associates:** Annualized hourly rate as shown in the Walmart payroll system as of date of loss or death.
- **For management associates and officers:** Base salary as shown in the Walmart payroll system as of date of loss or death.
- **For truck drivers:** Annualized average day's pay as of date of loss or death, as determined by Logistics Finance.

* Base Annual Earnings shall exclude any bonus you may receive.

Naming a beneficiary

In order to ensure that your business travel accident insurance benefit is paid according to your wishes, you must name a beneficiary(ies). You (the associate) will receive any benefits payable for the injuries listed in **When business travel accident insurance benefits are paid** later in this chapter.

You can name anyone you wish. If the beneficiary(ies) you have listed with Walmart differs from those named in your will, the list that Walmart has prevails.

The following information is needed when naming your beneficiary(ies):

- Beneficiary(ies) name
- Beneficiary(ies) current address
- Beneficiary(ies) phone number
- Beneficiary(ies) relationship to you
- Beneficiary(ies) Social Security number
- Beneficiary(ies) date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.



It's important to update your beneficiary information annually. Keep in mind, proceeds will go to whomever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person. You can change your beneficiary(ies) at any time on the **WIRE**, **WalmartOne.com** or **Workday**. Any change in beneficiary must be completed and submitted to Walmart before the covered person's death.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end, and it will be shared equally by any remaining beneficiary(ies), unless your beneficiary form states otherwise.

You can name a minor as a beneficiary. However, Prudential may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult an attorney or an estate planner before naming a minor as a beneficiary. If you or an estate planner names a minor as a beneficiary, funeral expenses cannot be paid from the minor's beneficiary proceeds.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named, payment will be made to your surviving family member(s) in the following order:

1. Widow or widower or partner of the deceased; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares; if not surviving, then
5. Executor or administrator of your estate.

Filing a claim for business travel accident benefits

Within 12 months of the covered associate's injury or death or within 90 days of the onset of a coma, contact Prudential at **877-740-2116** and provide the following regarding the associate:

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

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

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

The claim will not be finalized until the death certificate is received, where applicable. Acceptance of the death certificate is not a guarantee of payment.

Benefits can be paid in a lump sum or, upon written request, in monthly installments. Only one benefit, the highest, will be paid if you suffer more than one loss resulting from a single accident.

When business travel accident insurance benefits are paid

If you are involved in an accident while traveling on authorized company business and the injuries result in death or a loss listed below, the Plan will pay the benefit outlined in this section.

“Paralysis” means loss of use, without severance, of a limb. A doctor must determine that the loss is complete and not reversible. (“Severance” means complete separation and dismemberment of the limb from the body.)

Exposure to the elements: It will be presumed that you (the associate) have suffered a loss of life if your body has not been found within one year of the disappearance, stranding, sinking or wrecking of any vehicle in which you were an occupant.

If one or more associates suffer a common loss as a result of the same accident, the maximum the business travel accident insurance policy will pay for all loss is \$10 million per accident. This includes any means of transportation owned and operated by the company.

FULL BENEFIT – THREE TIMES YOUR BASE ANNUAL EARNINGS – MAXIMUM OF \$1 MILLION AND MINIMUM OF \$200,000 (UNLESS OTHERWISE SPECIFIED)

- Loss of life
- Quadriplegia: Total paralysis of both upper and lower limbs
- Paraplegia: Total paralysis of both lower limbs
- Hemiplegia: Total paralysis of upper and lower limbs on one side of the body
- Both hands, both feet or sight in both eyes: Severance through or above the wrists or ankle joints, or total and irrecoverable loss of sight
- One hand and one foot: Severance through or above the wrist or ankle joint
- Speech and hearing in both ears: Complete inability to communicate audibly in any degree, with irrecoverable loss of hearing that cannot be corrected by any hearing aid or device, or
- Hand or foot and sight in one eye: Severance through or above the wrist or ankle joint, with total and irrecoverable loss of sight in one eye.

50% OF FULL BENEFIT

- Hand or foot: Permanent severance through or above the wrist but below the elbow, or permanent severance at or above the ankle but below the knee
- Brain damage: Brain damage means permanent and irreversible physical damage to the brain, causing the complete inability to perform all of the substantial and material functions and activities of everyday life. Such damage must manifest itself within 30 days of the accidental injury, require hospitalization of at least five days and persist for 12 consecutive months
- Sight in one eye: Total and irrecoverable loss of sight in one eye, or
- Speech or hearing in both ears: Complete inability to communicate audibly in any degree, or irrecoverable loss of hearing that cannot be corrected by any hearing aid or device.

25% OF FULL BENEFIT

- Thumb and index finger of the same hand: Severance of each through or above the joint closest to the wrist, or
- Uniplegia: Total paralysis of one limb.

Additional business travel accident insurance benefits

Business travel accident insurance provides these additional benefits:

- Seat belt benefit
- Airbag benefit
- Coma benefit
- Funeral expenses benefit
- Medical evacuation benefit
- Family relocation and accompaniment, and
- Specific activity hazard: traveling to, from or while attending Walmart’s Annual Shareholders Meeting.

Felonious assault benefit: If you (the associate) suffer a covered loss from a felonious assault because of your employment with Walmart while you are working or on an authorized business trip, a benefit of up to \$10,000 may be payable. A covered loss is either death, dismemberment or paralysis, as described under [When business travel accident insurance benefits are paid](#).

When business travel accident insurance benefits are not paid

Business travel accident insurance benefits will not be paid for the following:

- Intentionally self-inflicted injuries while sane or insane
- Suicide or attempted suicide
- Sickness, whether the loss results directly or indirectly from the sickness
- Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the sickness
- Any bacterial or viral infection, except a pyogenic infection resulting from an accidental cut or wound or a bacterial infection resulting from accidental ingestion of a contaminated substance
- Losses resulting from war or act of war (declared or undeclared), including resistance to armed aggression or an accident while on full duty with the armed services for more than 30 days (this does not include Reserve or National Guard active duty for training)
- Losses resulting from riding in an unlicensed aircraft
- Losses resulting from flying as a crew member of an airplane, except one owned and operated by the company
- Injuries that arise during an attempt to commit an assault or the commission of a felony
- Losses resulting from being legally intoxicated while operating a land, water or air vehicle, or
- Losses resulting from being under the influence of or taking any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, and all amendments, unless prescribed by and administered in accordance with the advice of the insured's doctor.

When coverage ends

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

If you leave the company and are rehired

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

International business travel medical insurance

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

GeoBlue provides travel assistance services to you and your eligible dependents if you require emergency medical treatment while traveling on company-authorized business. For eligible associates, Walmart pays for this coverage in full — there is no cost to you and no enrollment is necessary. Coverage is valid for a trip lasting up to 180 days. Coverage is not available for personal travel even when you add personal travel to a business trip.

You are not eligible to make Health Savings Account contributions for any month in which you are traveling on Walmart business outside the U.S. and are covered under the GeoBlue policy. You are encouraged to consult with your tax advisor if you have questions about the amount to reduce your contributions based on your individual circumstances.

GEOBLUE SERVICES

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

GeoBlue has a network of doctors, physicians and medical facilities in over 180 countries and can also make appointments on your behalf and arrange for direct billing. Associates are advised to contact GeoBlue Customer Service at **888-412-6403** before obtaining medical treatment to ensure that the treatment is covered.

GeoBlue provides the following services:

- Reimbursement for eligible medical expenses
- Assistance in location of physician, medical facilities and making medical appointments
- Direct billing and payment guarantees
- Coordination for emergency medical evacuation to the nearest appropriate medical facility for the associate and an accompanying family member(s), and
- Repatriation of remains.

If you incur eligible medical expenses, submit them to GeoBlue for reimbursement. They should not be charged to the corporate credit card or submitted for reimbursement through the travel and expense system.

Associates are advised to register on geo-blue.com before their business travel, using group access code **QHG9999WALM**. By registering, you gain access to services and benefits including the following:

- Ability to print out your insurance ID card in case yours is lost
- Locate a doctor or facility
- Check your symptoms
- Translate medical terms and medications, and
- Understand health and security risks.

Downloading the GeoBlue app: Once you've registered, download the GeoBlue app and log in with the email address and password you created when you registered on the website. The GeoBlue app provides you with the most convenient access to your ID card and GeoBlue's self-service tools including mapping to your nearest approved medical facility/provider, making appointments, etc.

GeoBlue member ID cards: Cards will carry the Blue Cross Blue Shield logo and will be available in your travel department. Additional or replacement cards can be downloaded via geo-blue.com.

Claims: Claim forms are generally not required for GeoBlue services. However, if you have a question about your benefits or disagree with the benefits provided, you may contact GeoBlue or file a claim by writing the following address:

GeoBlue
One Radnor Corporate Center, Suite 100
Radnor, Pennsylvania 19087

Any claims and appeals will be determined under the time frames and requirements set out in the procedures for filing a claim for medical benefits outlined in the [Claims and appeals](#) chapter. Contact GeoBlue at any time by calling **888-412-6403**. Outside the U.S. call collect: **610-254-5830**.

Short-term disability for hourly associates

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Short-term disability for hourly associates

Pregnancy, a scheduled surgery or an unexpected illness or injury could keep you off the job and off the payroll for an extended period of time. The Walmart short-term disability plan for hourly associates can protect part of your paycheck if you become disabled for more than seven calendar days. When you can't work, the Walmart short-term disability plan works for you.

SHORT-TERM DISABILITY FOR HOURLY ASSOCIATES RESOURCES

Find What You Need	Online	Other Resources
Get more details about short-term disability or file a claim (for all states except California and Rhode Island)	Go to WalmartOne.com	Call Sedgwick/Lincoln (formerly Liberty) at 800-492-5678
If you work in California	Go to edd.ca.gov	Call the state of California at 800-480-3287
If you work in Rhode Island	Go to www.dlt.ri.gov/tdi	Call the state disability carrier at 401-462-8420

What you need to know about short-term disability for hourly associates

- Walmart offers a short-term disability basic plan and a short-term disability enhanced plan to all full-time hourly associates (including full-time hourly pharmacists, field Logistics associates, field supervisor positions in stores and clubs and full-time hourly Vision Center managers), except for associates who work in California, Hawaii, New Jersey and Rhode Island, who are eligible for state-mandated disability coverage.
- Eligible full-time hourly associates will automatically be enrolled in the short-term disability basic plan after their eligibility waiting period, except for associates who work in California, Hawaii, New Jersey and Rhode Island. No associate contributions are required for the short-term disability basic plan.
- All full-time hourly associates who are eligible for the short-term disability basic plan will also have the option to enroll in the short-term disability enhanced plan, except for associates who work in California, Hawaii, New Jersey, New York and Rhode Island. Associates who work in New York will have the option to enroll in the New York short-term disability enhanced plan, which is separately funded and administered.
- While you are disabled and receiving short-term disability benefits, the short-term disability basic plan replaces 50% of your income up to a maximum of \$200 per week. The short-term disability enhanced plan replaces 60% of your income with no weekly maximum. The New York short-term disability enhanced plan replaces 60% of your income up to a maximum of \$6,000 per week.
- If you enroll in the short-term disability enhanced plan during your initial enrollment period, your coverage begins on your effective date, as described in this chapter. If you enroll in the short-term disability enhanced plan at any time other than during your initial enrollment period, your short-term disability enhanced plan coverage will not begin until you complete a 12-month waiting period.
- There is a 90-day deadline from the date your disability begins to file a claim for short-term disability benefits, except in the states of California, Hawaii, New Jersey, New York and Rhode Island. Associates who work in these states should refer to the [Filing a claim for short-term disability](#) section for more information.

Enrollment in short-term disability and when coverage is effective

All full-time hourly associates (with the exceptions listed below) will be automatically enrolled for coverage in the short-term disability basic plan after their eligibility waiting period. At that time, all associates automatically enrolled in the short-term disability basic plan will also have the opportunity to enroll in the short-term disability enhanced plan.

Associates who work in the following states are not eligible for, and will not be enrolled in, either the short-term disability basic plan or the short-term disability enhanced plan: California, Hawaii, New Jersey and Rhode Island. These states have state-mandated disability plans.

Associates who work in New York have a state-mandated disability plan; however, they will also be automatically enrolled for coverage in the short-term disability basic plan after their eligibility waiting period, in order to supplement their state-mandated benefit. Associates who work in New York will also have the opportunity to enroll in the New York short-term disability enhanced plan. The short-term disability basic benefit for associates in New York and the New York short-term disability enhanced plans are fully insured and administered by Liberty Life Assurance Company of Boston (Liberty), a Liberty Mutual company.

Note that as of Jan. 1, 2019, all references to “Liberty Life Assurance Company of Boston (Liberty)” are changed to “Lincoln Financial Group (Lincoln).”

 **See page 289**

HOW SHORT-TERM DISABILITY IS FUNDED AND ADMINISTERED

In all states except California, Hawaii, New Jersey, New York and Rhode Island, short-term disability coverage is administered by Sedgwick Claims Management Services, Inc. (Sedgwick). Coverage in California and Rhode Island is provided and administered by the state. Coverage in New York is provided as stated above. Coverage in Hawaii and New Jersey is provided in accordance with the state program and insured by Lincoln (formerly Liberty).

Except as noted above with respect to certain states, short-term disability coverage is self-insured. This means there is no insurance company that collects premiums and pays benefits. No associate contributions are required for the short-term disability basic plan. The company may fund benefits under the short-term disability basic plan by using the company’s general assets, by using any asset of the Plan or Trust, or through a combination of these sources. For the short-term disability enhanced plan, participating associates make contributions intended to cover the costs of the benefits.

For information on coverage, call the phone number listed in [Short-term disability resources](#) at the beginning of this chapter.

The short-term disability basic plan provides up to 50% of your average weekly wage for up to 25 weeks of an approved disability, after a waiting period of seven calendar days if you become totally disabled as defined by the Plan. The maximum weekly benefit under the short-term disability basic plan is \$200. For more information about your average weekly wage, see [Your short-term disability benefit](#) later in this chapter.

For all participants other than those working in New York: if you become totally disabled as defined by the Plan, the short-term disability enhanced plan provides up to 60% of your average weekly wage for up to 25 weeks after a waiting period of seven calendar days, with no weekly maximum benefit. The New York short-term disability enhanced plan provides up to 60% of your average weekly wage for up to 25 weeks after a waiting period of seven calendar days if you become totally disabled as defined by the Plan, and has a \$6,000 maximum weekly benefit.



Short-term disability benefits are different in the following states: California, Hawaii, New Jersey, New York and Rhode Island. For information about benefits in any of these states, call the applicable number listed in [Short-term disability resources](#) at the beginning of this chapter.

ENROLLMENT FOR SHORT-TERM DISABILITY BENEFITS

You are automatically enrolled in the short-term disability basic plan after your 12-month eligibility waiting period. You must be actively at work for your coverage to become effective. You will be considered actively at work on a day that is one of your scheduled work days if you are performing in the usual way all of the duties of your job. See the [Eligibility and enrollment](#) chapter for details.

The date your short-term disability enhanced plan coverage begins depends on when you enroll for coverage:

- If you enroll during your initial enrollment period, your coverage begins on your effective date. See the [Eligibility and enrollment](#) chapter for information on your initial enrollment period and your effective date.
- If you enroll at any time after your initial enrollment period as a late enrollee, you are required to finish a 12-month waiting period before your coverage is effective. You will not pay short-term disability enhanced plan premiums during your 12-month waiting period.
 - If your late enrollment is due to a status change event, your 12-month waiting period will begin as of the date of the event.
 - If your late enrollment is during an annual enrollment, your 12-month waiting period will begin as of the date you enroll.

You may drop your short-term disability enhanced plan coverage at any time; the change will be effective the day after you drop coverage. If you drop your short-term disability enhanced plan coverage and later decide to re-enroll, you will be treated as a late enrollee with a 12-month waiting period, as described on the previous page.

COST OF COVERAGE

The short-term disability basic plan is provided at no cost to you. Your cost for the short-term disability enhanced plan is based on your biweekly earnings and your age. Premiums are deducted from all wages, including bonuses. You will not be required to pay short-term disability enhanced plan premiums from any short-term disability benefit payments you receive. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving short-term disability benefits, your premiums will be withheld from those payments.

Your short-term disability costs differ in the following states:

- California
- Hawaii
- New Jersey
- New York, and
- Rhode Island.

For details, refer to the contact information in the [Short-term disability resources](#) at the beginning of this chapter.

When you qualify for benefits

In order to qualify for short-term disability benefits through the Plan, you must meet the following requirements:

- You must be actively at work at the time of your total disability (except in certain cases of leave of absence or layoff, as described later in this chapter under [Coverage during a leave of absence or temporary layoff](#)).
- You must submit medical evidence provided by a qualified doctor that you are totally disabled as defined by the Plan (qualified doctors are legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors (M.D.), osteopaths (D.O.), nurse

practitioners, physician's assistants, psychologists or other medical practitioners whose services are eligible for reimbursement by the Associates' Health and Welfare Plan).

- You must receive approval by Sedgwick or Lincoln (formerly Liberty) of your claim.

These conditions apply whether you are covered under the short-term disability basic plan, enhanced plan or New York short-term disability enhanced plan. Sedgwick or Lincoln (formerly Liberty) may require written proof of your disability or additional information before making a decision on your claim. A statement by your physician(s) that you are unable to work does not in and of itself qualify you for short-term disability benefits. Also note that approval of a Medical Leave of Absence does not constitute approval for short-term disability benefits.

Qualification requirements in California, Hawaii, New Jersey, New York and Rhode Island may be different. If you are an associate working in one of these states, contact the applicable number listed in [Short-term disability resources](#) at the beginning of this chapter for information on qualification requirements.

As defined by the Plan, "totally disabled" or "total disability" means that you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy. Benefits will be payable during a loss of license only while you are disabled and pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. The determination of whether you are disabled will be made by Sedgwick (or Lincoln [formerly Liberty], as applicable) on the basis of objective medical evidence. Objective medical evidence consists of facts and findings, including, but not limited to, X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician. In addition, you must be under the continuous care of a qualified doctor and following the course of treatment prescribed. Loss of license in and of itself is not sufficient for meeting the definition of disability.

If Sedgwick or Lincoln (formerly Liberty) requests that you be examined by an independent physician or other medical professional, you must attend the exam in order to be considered for benefits.

If your total disability is the result of more than one cause, you will be paid as if they were one. The maximum benefit for any one period of disability is limited to 25 weeks, after the initial seven-day waiting period.



NOTE: If your disability is caused by a mental illness or substance abuse, you are strongly encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, or clinical social worker who holds a Master of Social Work (M.S.W.), specializes in mental health and substance abuse and is licensed pursuant to state law.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that is:

- Not under the care of and being treated by a qualified doctor
- Caused by taking part in an insurrection, rebellion or a riot or civil disorder
- Resulting from your commission of or attempt to commit a crime (e.g., assault, battery, felony or any illegal occupation or activity)
- One for which workers' compensation benefits are paid, or may be paid, if properly claimed, or
- Sustained as a result of doing any work for pay or profit.

Filing a claim for short-term disability

In California and Rhode Island, you must submit your short-term disability claim directly to the state, as described below.

Claims for short-term disability benefits in Hawaii, New Jersey and New York must be submitted to Sedgwick within 30 days of the date your disability begins. Sedgwick will notify Lincoln (formerly Liberty) of your disability claim.

For all other states, you must submit your short-term disability claim to Sedgwick within 90 days of the date your disability begins in order to assure consideration for benefits. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

If you experience a disabling illness or injury, or are scheduled to begin maternity leave, follow these steps:

STEP 1: Notify Sedgwick to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury or pregnancy. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated. Report your disability online by going to WalmartOne.com/LOA > [viaOne express](#), or call **800-492-5678** (you may also file in advance of your last day worked for scheduled surgery or pregnancy claims). Processing of your claim cannot begin until you have stopped working.

STEP 2: Tell your doctor's office that they will be contacted and asked to complete an attending physician's statement and provide medical information, including the following:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, and
- Doctor visit notes.

You will need to sign a form authorizing your doctor to release this information. (If filing your claim online, an electronic signature is accepted.)

STEP 3: Follow up with your doctor to ensure that information was forwarded to the disability administrator.

Claims will be determined under the time frames and requirements set out in the [Claims and appeals chapter](#). You have the right to appeal a claim denial. See the [Claims and appeals](#) chapter for details.

You may be required to provide written proof of your disability or additional medical information before your benefit payments begin.

California associates: You must file a claim with the state of California by calling **800-480-3287** within 41 days of the date of your disability.

Rhode Island associates: You must file a claim with the state of Rhode Island by calling **401-462-8420**.

When short-term disability benefits begin

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

You may use up to 40 hours of available paid time off (PTO) to substitute for the benefit waiting period. You must repay the company for PTO taken beyond the benefit waiting period of seven calendar days.

If you are receiving short-term disability at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information. You will not accrue additional PTO while you are receiving short-term disability benefits.

Your short-term disability benefit

The amount of your short-term disability benefit is based on:

- Your average weekly wage, and
- Whether or not you have enrolled in the short-term disability enhanced plan.

AVERAGE WEEKLY WAGE


Length of employment	How average weekly wage is determined
Employed 12 months or more	Total gross pay ÷ 52 weeks For example, the average weekly wage for an associate with a total annual gross pay of \$36,400 is \$700 ($\$36,400 \div 52$)
Employed less than 12 months	Total gross pay ÷ number of weeks worked For example, the average weekly wage for an associate with a total gross pay of \$8,400 for 12 weeks of work is \$700 ($\$8,400 \div 12$)

If a weekly benefit is payable for less than a week, your pay will be 1/7 of the weekly benefit for each day you were disabled.

Total gross pay includes:

- Overtime
- Bonuses
- PTO and other illness protection benefits (not including any previously paid disability benefits), and
- Personal pay for the 26 pay periods prior to your last day worked (or for the number of pay periods worked if less than 26). Note that if you have any pay periods in which you had no earnings, those pay periods will be excluded and the number of pay periods used for the calculation will be decreased.

The maximum weekly benefit under the short-term disability basic plan is \$200. There is no maximum weekly benefit under the short-term disability enhanced plan, except in New York, where the maximum is \$6,000 per week. A hypothetical benefit calculation is shown to the right, using an average weekly wage of \$700.

 For information on the maternity benefit under the short-term disability plan for hourly associates, [see page 287](#).

YOUR SHORT-TERM DISABILITY BENEFIT: AN EXAMPLE

If you have	Your benefit is
Short-term disability basic plan coverage	50% of your average weekly wage to a maximum of \$200/week
	Average weekly wage: \$700 50% of \$700: \$350 Reduced to the maximum weekly benefit: \$200
Short-term disability enhanced plan coverage	60% of your average weekly wage
	Average weekly wage: \$700 60% of \$700: \$420 There is no maximum weekly benefit under the short-term disability enhanced plan, so this figure would not be reduced (in New York, there is a maximum weekly benefit of \$6,000 per week).

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

The taxation of benefits payable to you depends on whether you are enrolled in only short-term disability basic or in both short-term disability basic and short-term disability enhanced. If you are enrolled only in short-term disability basic, because you do not make any contributions to the short-term disability basic plan or pay any tax on the coverage that Walmart provides, any short-term disability benefits payable to you are subject to taxes. If you are enrolled in both short-term disability basic and short-term disability enhanced, because both Walmart and you pay for the cost of the coverage through a combination of Walmart pre-tax and associate after-tax contributions, a portion of your short-term disability benefits will be taxed. Walmart will generally withhold federal, state, local and Social Security taxes from the portion of the benefit that is taxable.

In the states of Hawaii, New Jersey and New York, benefits are partially taxed. Please contact Lincoln (formerly Liberty) for more information.

NOTE: The Plan has the right to recover from you, and you must repay, any amount that is overpaid to you for short-term disability benefits under this Plan. See [The Plan's right to recover overpayment](#) and [Right to salary/wage deduction](#) in the [Claims and appeals](#) chapter. If you do not repay overpaid amounts in a timely manner, the company may treat the portion of such amounts that were not taxed when paid as taxable wages to you (reportable on your Form W-2) or, alternatively, deduct such amounts from your paycheck(s), to the extent permitted by law.

Continuing benefit coverage while disabled

If you wish to continue medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness insurance and accident insurance coverage while you are receiving short-term disability benefits, you must make premium payments each pay period for each of these benefits. If you are participating in the short-term disability plan and have an approved claim, your premiums for the above benefits will be deducted out of your disability benefit checks, which will be issued through the Walmart payroll system. If you fail to pay your premiums for your other benefit plan(s), your benefits may be canceled. See the [Eligibility and enrollment](#) chapter for details.

Your disability coverage will not be canceled if you are receiving disability benefits under the Plan. You will not be required to pay short-term disability enhanced plan or long-term disability plan premiums from any short-term disability benefit payments received. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving short-term disability benefits, your premiums will be withheld from those payments.

When short-term disability benefit payments end

If you are receiving short-term disability benefits from the Plan due to an approved disability, your benefit payments from the Plan will end on the earliest of:

- The date you are no longer totally disabled
- The date you fail to furnish the required proof that you are totally disabled when requested to do so by Sedgwick or by Lincoln (formerly Liberty)
- The date you are no longer under the continuous care and treatment of a qualified doctor
- The date you refuse to be examined, if Sedgwick or Lincoln (formerly Liberty) requires an examination
- The last day of the maximum period for which benefits are payable (end of 25 weeks)
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart, or
- The date of your death.

When your short-term disability benefits end, and for any reason you do not return to work, you must request an extension of your leave. Failure to do so may result in your employment being terminated.

If you return to work within 30 days of the end of your approved disability claim, you will be reinstated to the disability coverage you had prior to your disability. If you do not return to work within 30 days of the end of your disability claim, your coverage will lapse until you return to work and meet the active work requirement.

NOTE: State short-term disability programs may have different end dates.

Returning to work

Sedgwick will contact you prior to your expected return-to-work date and advise you of any steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

Notify Sedgwick when you have physically returned to work. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options, which will include requesting an extension of your leave or voluntarily terminating employment. Failure to request an extension may result in your employment being terminated if you do not voluntarily terminate employment.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less of active full-time work (with or without medical restrictions) and become totally disabled again from the same or a related condition that caused the first period of disability, as determined by Sedgwick or Lincoln (formerly Liberty), known as a “relapse/recurrent claim,” your short-term disability benefits will pick up where they left off before you came back to work. There will be no additional waiting period. The combined benefit duration for both periods of total disability will not exceed 25 weeks.

If you have returned to active full-time work for more than 30 calendar days and then become totally disabled from the same or a related cause, it will be considered a new disability, and you may be able to receive up to 25 weeks of benefits.

A new benefit waiting period of seven calendar days will apply.

If you have returned to active full-time work for any number of calendar days and then become totally disabled from a new and unrelated cause, it will be considered a new disability, and you may qualify for up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

Coverage during a leave of absence or temporary layoff

Once your short-term disability coverage is effective and you are eligible to file a claim for benefits, if you are not actively at work due to an approved non-disability leave of absence or temporary layoff, you will continue to be eligible for short-term disability benefits for 90 days from your last day of work. Your eligibility for short-term disability benefits will end on the 91st day after your approved non-disability leave or temporary layoff begins, but will be reinstated if you return to active work status within one year.

When coverage ends

Your short-term disability basic plan and enhanced plan coverage ends:

- At termination of your employment
- On the last day of the pay period when your job status changes from an eligible job status
- On the date of your death
- On the date you lose eligibility
- On the 91st day of an approved leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company.

In addition, coverage under the short-term disability enhanced plan would end the day after you drop your coverage under that Plan.

If you leave the company and are rehired

If you leave the company and return to full-time work for the company within 13 weeks, you will automatically be re-enrolled for the same coverage plan you had prior to leaving the company (or the most similar coverage offered under the Plan). If you are automatically re-enrolled in short-term disability enhanced plan coverage and choose to drop it after you return, you may do so at any time.

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

If you lose and then regain eligibility

If you lose eligibility and then regain eligibility within 30 days, you will automatically be re-enrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan).

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

Salaried short-term disability plan

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This information does not create an express or implied contract of employment or any other contractual commitment. Walmart may modify this information at its sole discretion without notice, at any time, consistent with applicable law.

Salaried short-term disability plan

Pregnancy, a scheduled surgery or an unexpected illness or injury could keep you off the job and off the payroll for an extended period of time. The Walmart salaried short-term disability plan can protect part of your paycheck if you become disabled for more than seven calendar days. When you can't work, the Walmart salaried short-term disability plan works for you.

SALARIED DRIVER SHORT-TERM DISABILITY RESOURCES

Find What You Need	Online	Other Resources
Get more details about salaried short-term disability or file a claim within 90 days of the date your disability began (provided to salaried associates in all 50 states)	Go to WalmartOne.com	Call Sedgwick at 800-492-5678
Request review of a denied short-term disability claim	Go to WalmartOne.com/LOA > viaOne® express	Call Sedgwick at 800-492-5678

What you need to know about salaried short-term disability

- Walmart provides the salaried short-term disability plan for all salaried associates, management trainees, associates classified as California pharmacists and Metro professional non-exempt associates. There is no cost to the associate.
- No enrollment in the salaried short-term disability plan is necessary. Coverage is effective as of your date of hire.
- If you become disabled for more than seven consecutive calendar days and are eligible to receive short-term disability benefits, the salaried short-term disability plan replaces 100% of your base pay for up to six weeks and 75% of your base pay for up to 19 additional weeks, after an initial waiting period of seven calendar days. (Note that there is no initial waiting period for work-related disabilities that qualify for workers' compensation through Walmart, but the amount of your benefit will be different. See the chart titled [Your salaried short-term disability plan benefit](#) for more information.)
- If your disability is due to pregnancy, the salaried short-term disability plan replaces 100% of your base pay for nine weeks, after an initial waiting period of seven calendar days. Generally no medical evidence is required for this short-term disability maternity benefit.
- The salaried short-term disability plan is not a benefit covered by ERISA and is not part of the Associates' Health and Welfare Plan.
- There is a 90-day deadline from the date your disability begins to file a claim for short-term disability benefits. The claims and appeals procedures described in this chapter apply to the salaried short-term disability benefit rather than the procedures in the [Claims and appeals](#) chapter.

Enrollment in short-term disability and when coverage is effective

You are automatically enrolled for coverage in the salaried short-term disability plan if you are:

- A salaried associate (exempt)
- A management trainee (non-exempt)
- An associate classified as a California pharmacist* (non-exempt), or
- A Metro professional non-exempt associate.

Coverage is effective as of your date of hire. Salaried short-term disability coverage is administered by Sedgwick Claims Management Services, Inc. (Sedgwick).

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

HOW SALARIED SHORT-TERM DISABILITY IS ADMINISTERED

If you become disabled and eligible to receive short-term disability benefits, the salaried short-term disability plan generally pays 100% of your base pay for up to six weeks of an approved disability, after an initial waiting period of seven calendar days of continuous disability. (Disabilities that qualify for workers’ compensation through Walmart are treated differently, as described in the chart titled [Your salaried short-term disability plan benefit](#).) If you remain disabled and eligible for benefits after the first six weeks of disability payments, the salaried short-term disability plan will pay 75% of your base pay for up to 19 additional weeks.

If your disability is due to pregnancy, the salaried short-term disability plan pays a maternity benefit of 100% of your base pay for the first nine weeks, after an initial waiting period of seven calendar days.

In order for your pay to continue during the initial seven-day waiting period, you may use paid time off (PTO). Salaried short-term disability benefits begin on the eighth calendar day after your eligible disability begins.

COST OF COVERAGE

The salaried short-term disability plan is provided by the company at no cost to you.

STATE-SPONSORED SHORT-TERM DISABILITY

Short-term disability benefits provided by individual states will generally have no impact on your eligibility for the salaried short-term disability benefit through Walmart, or the amount of the benefit you receive under Walmart’s plan.

An exception to this policy will apply to all eCommerce salaried and Metro professional non-exempt associates who work in California. For these associates, benefits received under Walmart’s salaried short-term disability plan will be reduced by the amount of the state-sponsored short-term disability benefit.

When you qualify for benefits

In order to qualify for short-term disability benefits through the salaried short-term disability plan, you must meet the following requirements:

- You must submit medical evidence provided by a qualified doctor that you are totally disabled as defined by the salaried short-term disability plan (qualified doctors are legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors (M.D.), osteopaths (D.O.), nurse practitioners, physician’s assistants, psychologists or other medical practitioners recognized by the Associates’ Health and Welfare Plan).
- You must receive approval by Sedgwick of your claim.



NOTE: If your disability is caused by a mental illness or substance abuse, you are strongly encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, or clinical social worker who holds a Master of Social Work (M.S.W.), specializes in mental health and substance abuse and is licensed pursuant to state law.

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

As defined by the salaried short-term disability plan, “totally disabled” or “total disability” means that you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy. Benefits will be payable during a loss of license only while you are disabled or pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. The determination of whether you are disabled

will be made by Sedgwick on the basis of objective medical evidence. Objective medical evidence consists of facts and findings, including but not limited to X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician. In addition, you must be under the continuous care of a qualified doctor and following the course of treatment prescribed. Loss of license in and of itself is not sufficient for meeting the definition of disability.

If Sedgwick requests that you be examined by an independent physician or other medical professional, you must attend the exam in order to be considered for benefits.

If your total disability is the result of more than one cause, you will be paid as if they were one. The maximum benefit for any one period of disability is limited to 25 weeks, after the initial waiting period of seven calendar days.

NOTE: If your disability is due to pregnancy, Sedgwick will not require objective medical evidence (as described on the previous page) as a condition for approving your disability claim for the short-term disability maternity benefit, unless you begin your leave of absence more than two weeks prior to your estimated date of delivery. If you begin your leave of absence more than two weeks prior to your estimated date of delivery, objective medical evidence will be required. The maternity benefit will generally begin on the earlier of two weeks before the estimated date of delivery (as determined by a qualified doctor) or the actual date of delivery.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that is:

- Not under the care of and being treated by a qualified doctor
- Caused by taking part in an insurrection, rebellion or a riot or civil disorder
- Resulting from your commission of or attempt to commit a crime (e.g., assault, battery, felony or any illegal occupation or activity), or
- Sustained as a result of doing any work for pay or profit.

Filing a claim for short-term disability

If you experience a disabling illness or injury, or are planning to begin maternity leave, follow these steps:

STEP 1: Notify Sedgwick to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury or pregnancy. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated. Report your disability online by going to WalmartOne.com/LOA > [viaOne express](#), or call **800-492-5678** (you may also file in advance of your last day worked for scheduled surgery or pregnancy claims).

Processing of your claim cannot begin until you have stopped working. All claims for benefits under Walmart's salaried short-term disability plan must be submitted to Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

STEP 2: Tell your doctor's office that they will be contacted and asked to complete an attending physician's statement and provide medical information, including the following:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, and
- Doctor visit notes.

You will need to sign a form authorizing your doctor to release this information. (If filing your claim online, an electronic signature is accepted.)

STEP 3: Follow up with your doctor to ensure that information was forwarded to the disability administrator.

Provisional pay

If you have notified Sedgwick of your disability, you will have 20 days from the date you initially notified Sedgwick of your disability to provide the required medical documentation. Your pay will continue for up to 20 days from your date of disability, known as "provisional pay." Your pay will be suspended after 20 days from your date of disability if the required medical documentation has not been approved. If you do not meet this 20-day deadline, the suspension of pay will be effective the first day of the pay period in which the 21st day falls. (In cases of pregnancy, verification of your due date is the only medical verification required for the short-term disability maternity benefit, unless you begin your leave of absence more than two weeks prior to your estimated date of delivery.) If your claim is approved, the approval will be effective as of the date of your disability, and the initial 20 days will count toward the duration of your disability benefit and initial waiting period.

If your claim is denied before the 21st day due to your medical circumstances not meeting the salaried short-term disability plan's definition of total disability, your pay will be suspended and Walmart will commence efforts to recover the amount paid to you for the period following your illness or injury.

Provisional pay does not apply to relapse/recurrent claims.

NOTE: If you become disabled, file your claim for benefits promptly. A delay in filing or submitting medical information could result in delayed benefit payment, disruption to your wages or the denial of your claim. If it is determined that any wages have been paid to you in error, the company reserves the right to recover any overpayment.

AFTER YOU HAVE FILED YOUR CLAIM

Once you have filed your claim, Sedgwick will make a decision in no more than 45 days after receipt of your properly filed claim. The time for a 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 Sedgwick'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 Sedgwick deems necessary to decide your claim, the time for decision will be suspended as of the date on which the notification of the extension is sent to you until the date your response is received. If your claim is approved, the decision will contain information sufficient to reasonably inform you of that decision.

If your claim is denied, Sedgwick will send you a written notification of the denial, which will include:

- Specific reasons for the decision
- Specific reference to the policy provisions on which the decision is based
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- A description of the review procedures and time limits applicable to such procedures, and
- If an internal rule, guideline, protocol or other similar criteria was relied upon in making the denial, either
 - The specific rule, guideline, protocol or other similar criteria, or
 - A statement that such a rule, guideline, protocol or other similar criteria was relied upon in making the denial and that a copy will be provided free of charge to you upon request.

APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

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

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

Sedgwick will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if it is determined that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification of the denial that will include:

- The specific reason(s) for the adverse determination
- Reference to the specific plan provisions on which the determination was based
- A statement describing your right to request copies, free of charge, of all documents, records or other information relevant to your claim
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- A statement describing any appeal procedures offered by the Plan.

VOLUNTARY SECOND APPEAL OF A SALARIED SHORT-TERM DISABILITY CLAIM

If your appeal is denied, you may make a voluntary second appeal of your denial orally or in writing to Sedgwick. You must submit your second appeal within 180 days of the receipt of the written notice of denial. You may submit any written comments, documents, records and any other information relating to your claim. The same criteria and response times that applied to your first appeal, as described earlier, are generally applied to this voluntary second appeal.

All salaried short-term disability appeals should be sent to:

**Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748**

When short-term disability benefits begin

If you are approved for short-term disability benefits, the benefit will begin after a waiting period of seven calendar days, on the eighth calendar day after your total disability begins. (Note that there is no waiting period for work-related disabilities that qualify for workers' compensation through Walmart.)

In order for your pay to continue during the initial seven-day waiting period, you may use paid time off (PTO). Salaried short-term disability benefits begin on the eighth calendar day after your eligible disability begins. PTO may not be used while receiving short-term disability benefits.

If you are receiving short-term disability at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information.

You will not accrue additional PTO while you are receiving short-term disability benefits.

Your short-term disability benefit

The amount of your short-term disability benefit is based on:

- Your base pay as of your last day worked, and
- The duration of your disability.

Base pay, for purposes of the salaried short-term disability benefit, is defined as follows:

ASSOCIATE TYPE	BASE PAY
Exempt associates	Gross biweekly salary
Non-exempt associates	Hourly rate multiplied by hours scheduled that pay period

If you become disabled and eligible to receive short-term disability benefits, the salaried short-term disability plan pays benefits as described here:

YOUR SALARIED SHORT-TERM DISABILITY PLAN BENEFIT

Duration of your disability	Your benefit is:	
	If your disability does not qualify for workers' compensation through Walmart	If you have a work-related disability that qualifies for workers' compensation through Walmart
Up to 7 weeks	After an initial waiting period of 7 calendar days, 100% of your base pay. Benefits begin on the 8th calendar day. You may use PTO during your first 7 calendar days of continuous disability.	100% of your base pay, with no initial waiting period. Benefits are payable as of the date of your disability.
More than 7 weeks, up to 26 weeks	75% of your base pay. For example, if your base pay is \$1,000, 75% of \$1,000 is a \$750 benefit.	Workers' compensation benefits are payable at the applicable state rate; short-term disability benefits will make up the difference up to 75% of your base pay. For example, if your base pay is \$1,000 and workers' compensation pays 66% for your disability, or \$660, short-term disability will pay an additional \$90, for a total benefit of \$750. (If the state-mandated workers' compensation rate exceeds 75% of your base pay, you will not receive any short-term disability benefit.)

See the [Continuing benefit coverage while disabled](#) section for additional details regarding your premiums.

If a weekly benefit is payable for less than a week, your pay will be based on your base pay divided by your regular work schedule for each day you were disabled.

NOTE: Workers' compensation and short-term disability benefits will be made as separate payments.

MATERNITY BENEFIT

Maternity benefits under the salaried short-term disability plan are as described here:

MATERNITY BENEFIT	
Duration of benefit	Your benefit is:
Up to 9 weeks*	<p>100% of your base pay after an initial waiting period of 7 calendar days.</p> <p>Maternity benefits under the salaried short-term disability plan begin on the 8th calendar day after your eligible disability begins. You may use PTO during your first 7 calendar days of continuous disability.</p>

* You may also be eligible for additional parental and family care pay equal to 100% of your base pay. For more information, refer to the parental and family care pay policy on the [WIRE](#).

NOTE: If you experience medical complications during pregnancy, benefits may be payable under the salaried short-term disability plan after the end of the nine-week duration of maternity benefits. Benefits would be equal to 75% of your base pay from week 11, up to 25 weeks.

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

Benefits payable to you under Walmart's salaried short-term disability plan are company-provided, at no cost to you. Because you do not make any contributions to the salaried short-term disability plan, any benefits payable to you are subject to taxes. Walmart will generally withhold federal, state, local and Social Security taxes from the amount of your benefits.

NOTE: The salaried short-term disability plan has the right to recover from you, and you must repay, any amount that is overpaid to you for short-term disability benefits under this plan. See [The Plan's right to recover overpayment](#) and [Right to salary/wage deduction](#) in the [Claims and appeals](#) chapter.

Continuing benefit coverage while disabled

If you have an approved disability claim and are receiving short-term disability benefits, premiums will be deducted from your disability benefit checks (issued through the Walmart payroll system) for any coverage you have under any of the following Walmart benefits: medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness and accident insurance. See the [Eligibility and enrollment](#) chapter for details.

Your salaried short-term disability coverage will not be canceled if you are receiving disability benefits under the plan, unless your employment terminates. You will not be required to pay long-term disability premiums from any short-term disability benefit payments received. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving short-term disability benefits, your long-term disability premiums will be withheld from those payments.

When short-term disability benefit payments end

If you are receiving short-term disability benefit payments from the salaried short-term disability plan due to an approved disability, your benefit payments from the plan will end on the earliest of:

- The date you are no longer totally disabled
- The date you fail to furnish the required proof that you are totally disabled when requested to do so by Sedgwick
- The date you are no longer under the continuous care and treatment of a qualified doctor
- The date you refuse to be examined, if Sedgwick requires an examination
- The last day of the maximum period for which benefits are payable (end of 25 weeks)
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart
- The date your employment terminates, or
- The date of your death.

When your short-term disability benefits end and for any reason you do not return to work, you must request an extension of your leave; failure to do so may result in your employment being terminated.

Returning to work

Sedgwick will contact you prior to your expected return-to-work date and advise you of any steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

Notify Sedgwick when you have physically returned to work. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options, which will include requesting an extension of your leave or voluntarily terminating employment. Failure to request an extension may result in your employment being terminated if you do not voluntarily terminate employment.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less of active full-time work (with or without medical restrictions) and become totally disabled again from the same or a related condition that caused the first period of disability as determined by Sedgwick, known as a “relapse/recurrent claim,” your short-term disability benefits will pick up where they left off before you came back to work. There will be no additional waiting period. The combined benefit duration will not exceed 25 weeks.

If you have returned to active full-time work for more than 30 calendar days and then become totally disabled from the same or a related cause, it will be considered a new disability, and you may be able to receive up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

If you have returned to active full-time work for any number of calendar days and then become totally disabled from a new and unrelated cause, it will be considered a new disability, and you may qualify for up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

Intermittent leave. If you are able to return to work following a disability claim but the same or a related condition will require you to continue to miss work occasionally, notify Sedgwick and your facility of your situation. Your treatment may be covered under your prior short-term disability claim for up to 12 months from the date you return to work from your short-term disability claim. Salaried short-term disability generally pays 100% of your base pay for the duration of your approved intermittent leave.

Coverage during a leave of absence or temporary layoff

If you are not working due to an approved non-disability leave of absence or temporary layoff, you will continue to be eligible for short-term disability benefits for 90 days from your last day of work. Your eligibility for short-term disability benefits would end on the 91st day after your approved non-disability leave or temporary layoff begins, but would be reinstated if you return to work. See [Benefits continuation if you go on a leave of absence](#) in the [Eligibility and enrollment](#) chapter for more information, including details on paying for benefits while on leave.

When coverage ends

Your short-term disability coverage ends:

- At termination of your employment
- On the last day of the pay period when your job status changes from an eligible job status
- On the date of your death
- On the 91st day of an approved non-disability leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company.

If you leave the company and are rehired

If you leave the company and return to work for the company as a salaried associate, you will automatically be re-enrolled in the salaried short-term disability plan.

Truck driver short-term disability plan

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This information does not create an express or implied contract of employment or any other contractual commitment. Walmart may modify this information at its sole discretion without notice, at any time, consistent with applicable law.

Truck driver short-term disability plan

Pregnancy, a scheduled surgery or an unexpected illness or injury could keep you off the job and off the payroll for an extended period of time. The Walmart truck driver short-term disability plan can protect part of your paycheck if you become disabled for more than seven calendar days. When you can't work, the Walmart truck driver short-term disability plan works for you.

TRUCK DRIVER SHORT-TERM DISABILITY RESOURCES

Find What You Need	Online	Other Resources
Get more details about truck driver short-term disability or file a claim within 90 days of the date your disability began (provided to all full-time truck drivers in all 50 states)	Go to WalmartOne.com	Call Sedgwick at 800-492-5678
Request review of a denied short-term disability claim	Go to WalmartOne.com/LOA > viaOne® express	Call Sedgwick at 800-492-5678

What you need to know about truck driver short-term disability

- Walmart provides the truck driver short-term disability plan for all full-time truck drivers. There is no cost to the driver.
- No enrollment in the truck driver short-term disability plan is necessary. Coverage is effective as of your date of hire.
- If you become disabled for more than seven consecutive calendar days and are eligible to receive short-term disability benefits, the truck driver short-term disability plan replaces 75% of your average day's pay for up to 25 weeks, after an initial waiting period of seven calendar days. Note that different rules may apply to work-related disabilities that qualify for workers' compensation through Walmart. See the chart titled [Your truck driver short-term disability plan benefit](#) for more information.)
- If your disability is due to pregnancy, the truck driver short-term disability plan replaces 75% of your average day's pay for up to nine weeks, after an initial waiting period of seven calendar days. Generally, no medical evidence is required for this short-term disability maternity benefit.
- The truck driver short-term disability plan is not a benefit covered by ERISA and is not part of the Associates' Health and Welfare Plan.
- There is a 90-day deadline from the date your disability begins to file a claim for short-term disability benefits. The claims and appeals procedures described in this chapter apply to the truck driver short-term disability benefit rather than the procedures in the [Claims and appeals](#) chapter.

Enrollment in short-term disability and when coverage is effective

All full-time truck drivers will be automatically enrolled for coverage in the truck driver short-term disability plan. Coverage is effective as of your date of hire. Truck driver short-term disability coverage is administered by Sedgwick Claims Management Services, Inc. (Sedgwick).

HOW TRUCK DRIVER SHORT-TERM DISABILITY IS ADMINISTERED

If you become disabled and eligible to receive short-term disability benefits, the truck driver short-term disability plan generally pays 75% of your average day's pay for up to 25 weeks of an approved disability, after an initial waiting period of seven calendar days of continuous disability. The waiting period begins on your next scheduled work day after your total disability begins. (Disabilities that qualify for workers' compensation through Walmart are treated differently, as described in the chart titled [Your truck driver short-term disability plan benefit.](#))

If your disability is due to pregnancy, the truck driver short-term disability plan pays a maternity benefit of 75% of your average day's pay for the first nine weeks of an approved disability, after an initial waiting period of seven calendar days.

In order for your pay to continue during the initial seven-day waiting period, you may use paid time off (PTO). Truck driver short-term disability benefits begin the day after the initial waiting period ends.

COST OF COVERAGE

The truck driver short-term disability plan is provided by the company at no cost to you.

STATE-SPONSORED SHORT-TERM DISABILITY

Short-term disability benefits provided by individual states will generally have no impact on your eligibility for the truck driver short-term disability benefit plan through Walmart, or the amount of the benefit you receive under Walmart's plan.

When you qualify for benefits

In order to qualify for short-term disability benefits through the truck driver short-term disability plan, you must meet the following requirements:

- You must submit medical evidence provided by a qualified doctor that you are totally disabled as defined by the truck driver short-term disability plan (qualified doctors are legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors

(M.D.), osteopaths (D.O.), nurse practitioners, physician's assistants, psychologists or other medical practitioners recognized by the Associates' Health and Welfare Plan).

- You must receive approval by Sedgwick of your claim.



NOTE: If your disability is caused by a mental illness or substance abuse, you are strongly encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, or clinical social worker who holds a Master of Social Work (M.S.W.), specializes in mental health and substance abuse and is licensed pursuant to state law.

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

As defined by the truck driver short-term disability plan, "totally disabled" or "total disability" means that you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy. Benefits will be payable during a loss of license only while you are disabled or pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. The determination of whether you are disabled will be made by Sedgwick on the basis of objective medical evidence. Objective medical evidence consists of facts and findings, including but not limited to X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician. In addition, you must be under the continuous care of a qualified doctor and following the course of treatment prescribed. Loss of license in and of itself is not sufficient for meeting the definition of disability.

If Sedgwick requests that you be examined by an independent physician or other medical professional, you must attend the exam in order to be considered for benefits.

If your total disability is the result of more than one cause, you will be paid as if they were one. The maximum benefit for any one period of disability is limited to 25 weeks, after the initial waiting period.

NOTE: If your disability is due to pregnancy, Sedgwick will not require objective medical evidence (as described on this page) as a condition for approving your disability claim

for the short-term disability maternity benefit, unless you begin your leave of absence more than two weeks prior to your estimated date of delivery. If you begin your leave of absence more than two weeks prior to your estimated date of delivery, objective medical evidence will be required. The maternity benefit will generally begin on the earlier of two weeks before the estimated date of delivery (as determined by a qualified doctor) or the actual date of delivery.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that is:

- Not under the care of and being treated by a qualified doctor
- Caused by taking part in an insurrection, rebellion or a riot or civil disorder
- Resulting from your commission of or attempt to commit a crime (e.g., assault, battery, felony or any illegal occupation or activity), or
- Sustained as a result of doing any work for pay or profit.

Filing a claim for short-term disability

If you experience a disabling illness or injury, or are planning to begin maternity leave, follow these steps:

STEP 1: Notify Sedgwick to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury or pregnancy. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated. Report your disability online by going to WalmartOne.com/LOA > [viaOne express](#), or call 800-492-5678 (you may also file in advance of your last day worked for scheduled surgery or pregnancy claims). Processing of your claim cannot begin until you have stopped working. All claims for benefits under Walmart's truck driver short-term disability plan must be submitted to Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

STEP 2: Tell your doctor's office that they will be contacted and asked to complete an attending physician's statement and provide medical information, including the following:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, and
- Doctor visit notes.

You will need to sign a form authorizing your doctor to release this information. (If filing your claim online, an electronic signature is accepted.)

STEP 3: Follow up with your doctor to ensure that information was forwarded to the disability administrator.

Provisional pay

If you have notified Sedgwick of your disability, you will have 20 days from the date you initially notified Sedgwick of your disability to provide the required medical documentation. Your pay will continue for up to 20 days from your date of disability, known as "provisional pay." Your pay will be suspended after 20 days from your date of disability if the required medical documentation has not been approved. If you do not meet this 20-day deadline, the suspension of pay will be effective the first day of the pay period in which the 21st day falls. (In cases of pregnancy, verification of your due date is the only medical verification required for the short-term disability maternity benefit, unless you begin your leave of absence more than two weeks prior to your estimated date of delivery.) If your claim is approved, the approval will be effective as of the date of your disability, and the initial 20 days will count toward the duration of your disability benefit and initial waiting period.

If your claim is denied before the 21st day due to your medical circumstances not meeting the truck driver short-term disability plan's definition of total disability, your pay will be suspended and Walmart will commence efforts to recover the amount paid to you for the period following your illness or injury.

Provisional pay does not apply to relapse/recurrent claims.

NOTE: If you become disabled, file your claim for benefits promptly. A delay in filing or submitting medical information could result in delayed benefit payments, disruption to your wages or the denial of your claim. If it is determined that any wages have been paid to you in error, the company reserves the right to recover any overpayment.

AFTER YOU HAVE FILED YOUR CLAIM

Once you have filed your claim, Sedgwick will make a decision no more than 45 days after receipt of your properly filed claim. The time for a 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 Sedgwick'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 Sedgwick deems necessary to decide your claim, the time for decision will be suspended as of the date on which the notification of the extension is sent to you until the date your response is received. If your claim is approved, the decision will contain information sufficient to reasonably inform you of that decision.

If your claim is denied, Sedgwick will send you a written notification of the denial, which will include:

- Specific reasons for the decision
- Specific reference to the policy provisions on which the decision is based
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- A description of the review procedures and time limits applicable to such procedures, and
- If an internal rule, guideline, protocol or other similar criteria was relied upon in making the denial, either
 - The specific rule, guideline, protocol or other similar criteria, or
 - A statement that such a rule, guideline, protocol or other similar criteria was relied upon in making the denial and that a copy will be provided free of charge to you upon request.

APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

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

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

Sedgwick will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if it is determined that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification of the denial that will include:

- The specific reason(s) for the adverse determination
- Reference to the specific plan provisions on which the determination was based

- A statement describing your right to request copies, free of charge, of all documents, records or other information relevant to your claim
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- A statement describing any appeal procedures offered by the Plan.

VOLUNTARY SECOND APPEAL OF A TRUCK DRIVER SHORT-TERM DISABILITY CLAIM

If your appeal is denied, you may make a voluntary second appeal of your denial orally or in writing to Sedgwick. You must submit your second appeal within 180 days of the receipt of the written notice of denial. You may submit any written comments, documents, records and any other information relating to your claim. The same criteria and response times that applied to your first appeal, as described earlier, are generally applied to this voluntary second appeal.

All truck driver short-term disability appeals should be sent to:

Walmart Disability and Leave Service Center at Sedgwick National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

When short-term disability benefits begin

If you are approved for short-term disability benefits, the benefit will begin after a waiting period of seven calendar days. The waiting period begins on your next scheduled work day after your total disability begins. (Note that work-related disabilities that qualify for workers' compensation through Walmart may have different waiting periods under state law.)

In order for your pay to continue during the initial seven-day waiting period, you may use paid time off (PTO). Truck driver short-term disability benefits begin after the initial waiting period. PTO may not be used while receiving short-term disability benefits.

If you are receiving short-term disability at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information.

You will not accrue additional PTO while you are receiving short-term disability benefits.

Your short-term disability benefit

The amount of your short-term disability benefit is based on your average day's pay as of your last day worked. If you become disabled and eligible to receive short-term disability benefits, the truck driver short-term disability plan replaces 75% of your average day's pay as of your last day prior to your disability for up to 25 weeks, after an initial waiting period of seven calendar days. There is no maximum weekly benefit under the truck driver short-term disability plan.

YOUR TRUCK DRIVER SHORT-TERM DISABILITY PLAN BENEFIT

Duration of your disability	Your benefit is:	
	If your disability does not qualify for workers' compensation through Walmart	If you have a work-related disability that qualifies for workers' compensation through Walmart
Up to 26 weeks	<p>After an initial waiting period of 7 calendar days, 75% of your average day's pay. The waiting period begins on your next scheduled workday after your total disability begins.</p> <p>You may use PTO during your first 7 calendar days of continuous disability.</p> <p>For example, if your average day's pay over the week totals \$1,000, 75% of \$1,000 is a \$750 weekly benefit.</p>	<p>75% of your average day's pay. Sedgwick will pay 75% during the state workers' compensation waiting period, then workers' compensation will pay according to the state's compensation rate. Sedgwick will "top off" this pay to 75%. If the state compensation rate is greater than 75%, you will not receive additional benefits from Sedgwick.</p> <p>For example, if your workers' compensation benefit or anticipated benefit is 66%, the short-term disability benefit will provide 9% of your wages.</p> <p>Workers' compensation is not taxed, while short-term disability benefits are taxed.</p> <p>Short-term disability benefits are paid through your payroll check, while workers' compensation is paid through a separate check.</p>

See the [Continuing benefit coverage while disabled](#) section for additional details regarding your premiums.

If a weekly benefit is payable for less than a week, your pay will be based on 75% of your average day's pay multiplied by your program for each day you were disabled.

NOTE: Workers' compensation and short-term disability benefits will be made as separate payments except in the states of Texas and Wyoming, where the entire benefit will be included in the payment you receive from Walmart.

MATERNITY BENEFIT

Maternity benefits under the truck driver short-term disability plan are as described here:

MATERNITY BENEFIT	
Duration of benefit	Your benefit is:
Up to 9 weeks*	75% of your average day's pay after an initial waiting period of 7 calendar days. You may use PTO during your first 7 calendar days of continuous disability.

* You may also be eligible for additional parental and family care pay equal to 75% of your average day's pay. For more information, refer to the parental and family care pay policy on the [WIRE](#).

NOTE: If you experience medical complications during pregnancy, benefits may be payable under the truck driver short-term disability plan after the end of the nine-week duration of maternity benefits. Benefits would be equal to 75% of your average day's pay from week 11, up to 25 weeks.

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

Benefits payable to you under the truck driver short-term disability plan are company-provided, at no cost to you. Because you do not make any contributions to the truck driver short-term disability plan, any benefits payable to you are subject to taxes. Walmart will generally withhold federal, state, local and Social Security taxes from the amount of your benefit payments.

NOTE: The truck driver short-term disability plan has the right to recover from you, and you must repay, any amount that is overpaid to you for short-term disability benefits under this plan. See [The Plan's right to recover overpayment](#) and [Right to salary/wage deduction](#) in the [Claims and appeals](#) chapter.

Continuing benefit coverage while disabled

If you have an approved disability claim and are receiving short-term disability benefits, premiums will be deducted from your disability benefit checks (issued through the Walmart payroll system) for coverage you may have under any of the following Walmart benefits: medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness and accident insurance. See the [Eligibility and enrollment](#) chapter for details.

Your truck driver short-term disability coverage will not be canceled if you are receiving disability benefits under the truck driver short-term disability plan unless your employment terminates. You will not be required to pay long-term disability premiums from any short-term disability benefit payments received. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving short-term disability benefits, your long-term disability premiums will be withheld from those payments.

When short-term disability benefit payments end

If you are receiving short-term disability benefit payments from the truck driver short-term disability plan due to an approved disability, your benefit payments from the plan will end on the earliest of:

- The date you are no longer totally disabled
- The date you fail to furnish the required proof that you are totally disabled when requested to do so by Sedgwick
- The date you are no longer under the continuous care and treatment of a qualified doctor
- The date you refuse to be examined, if Sedgwick requires an examination
- The last day of the maximum period for which benefits are payable (end of 25 weeks)
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart
- The date your employment terminates, or
- The date of your death.

When your short-term disability benefits end and for any reason you do not return to work, you must request an extension of your leave; failure to do so may result in your employment being terminated.

Returning to work

Sedgwick will contact you prior to your expected return-to-work date and advise you of any steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

Notify Sedgwick when you have physically returned to work. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options,

which will include requesting an extension of your leave or voluntarily terminating employment. Failure to request an extension may result in your employment being terminated if you do not voluntarily terminate employment.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less of active full-time work (with or without medical restrictions) and become totally disabled again from the same or a related condition that caused the first period of disability, as determined by Sedgwick, known as a “relapse/recurrent claim,” your short-term disability benefits will pick up where they left off before you came back to work. There will be no additional waiting period. The combined benefit duration will not exceed 25 weeks.

If you have returned to active full-time work for more than 30 calendar days and then become totally disabled from the same or a related cause, it will be considered a new disability, and you may be able to receive up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

If you have returned to active full-time work for any number of calendar days and then become totally disabled from a new and unrelated cause, it will be considered a new disability, and you may qualify for up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

Intermittent leave. If you are able to return to work following a disability claim but the same or a related condition will require you to continue to miss work occasionally, notify Sedgwick and your facility of your situation. Your treatment may be covered under your prior short-term disability claim up to 12 months from the date you return to work from your short-term disability claim. Truck driver short-term disability generally pays 100% of your average day’s pay for the duration of your approved intermittent leave.

Coverage during a leave of absence or temporary layoff

If you are not working due to an approved non-disability leave of absence or temporary layoff, you will continue to be eligible for short-term disability benefits for 90 days from your last day of work. Your eligibility for short-term disability benefits would end on the 91st day after your approved non-disability leave or temporary layoff begins, but would be reinstated if you return to work. See [Benefits continuation if you go on a leave of absence](#) in the [Eligibility and enrollment](#) chapter for more information, including details on paying for benefits while on leave.

When coverage ends

Your short-term disability coverage ends:

- At termination of your employment
- On the last day of the pay period when your job status changes from an eligible job status
- On the date of your death
- On the 91st day of an approved non-disability leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company.

If you leave the company and are rehired

If you leave the company and return to work for the company as a full-time truck driver, you will automatically be re-enrolled in the truck driver short-term disability plan.

Long-term disability

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Lincoln Financial Group, or Lincoln (formerly Liberty Life Assurance Company of Boston, or Liberty), regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Long-term disability


Your paycheck is the foundation of your financial health. Think about how you would survive financially if you became disabled and were unable to work. Your bills would keep coming, even if your paychecks stopped. When you enroll, Walmart's long-term disability plan works with other benefits you receive during a disability to replace part of your paycheck.

LONG-TERM DISABILITY RESOURCES

Find What You Need	Online	Other Resources
Get more details about long-term disability or file a claim	Go to WalmartOne.com	Call Lincoln (formerly Liberty) at 800-492-5678

What you need to know about long-term disability

- Walmart offers a long-term disability (LTD) plan and also an LTD enhanced plan. All full-time hourly associates (including full-time hourly pharmacists, field Logistics associates, field supervisor positions in stores and clubs, full-time hourly Vision Center managers and Metro professional non-exempt associates) and management associates (including management trainees and California pharmacists) are eligible to enroll in either plan (but may not enroll in both the LTD and LTD enhanced plans).
- If you enroll in either plan after your initial eligibility period, your long-term disability coverage will not begin until you complete a 12-month waiting period.
- The long-term disability plans work with any other benefits you receive while disabled to replace 50% of your average monthly wage under the LTD plan or 60% of your average monthly wage under the LTD enhanced plan.
- Long-term disability benefits are paid at the end of each 30-day period of disability (bi-monthly as of Jan. 1, 2019; see page 287), as long as you continue to be disabled as defined by the LTD plan or the LTD enhanced plan.

 **See page 287**

Enrollment in long-term disability and when coverage is effective

You are eligible to enroll in long-term disability coverage if you are:

- A full-time hourly associate, or
- A management associate.

There are two long-term disability plans offered:

- **The LTD plan.** Provides up to 50% of your average monthly wage after your waiting period if you become disabled as defined by the plan.
- **The LTD enhanced plan.** Provides up to 60% of your average monthly wage after your waiting period if you become disabled as defined by the plan.

Both plans are insured by Lincoln (formerly Liberty) and both have a maximum monthly benefit of \$15,000 (\$18,000 for the LTD enhanced plan effective Jan. 1, 2018).

 **See page 287**

For more information about your waiting period, see **When LTD benefits begin** later in this chapter. For more information about your average monthly wage, see **Your LTD benefit** later in this chapter.

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

- If you enroll during your initial enrollment period, your coverage begins on your effective date. See the **Eligibility and enrollment** chapter for information on your initial enrollment period and your effective date.
- If you enroll at any time after your initial enrollment period, you will be considered a late enrollee and will be required to finish a 12-month waiting period before your coverage is effective, as described below. You will not pay LTD plan or LTD enhanced plan premiums during your 12-month waiting period.
 - If your late enrollment is due to a status change event, your 12-month waiting period will begin as of the date of the event.
 - If your late enrollment is during an annual enrollment, your 12-month waiting period will begin as of the date you enroll.

You may drop your LTD plan or LTD enhanced plan coverage at any time; the change will be effective the day after you drop coverage. If you drop long-term disability and later decide to re-enroll, you will be treated as a late enrollee with a 12-month waiting period, as described above.

In order to receive benefits under the LTD plan or the LTD enhanced plan, you must be actively at work at the time of your disability.

THE COST OF LTD COVERAGE

Your cost for LTD coverage is based on your biweekly earnings, your age and whether you select the LTD plan or the LTD enhanced plan. Premiums are deducted from all wages, including bonuses. You will not be required to pay long-term disability premiums from any long-term disability benefit payments you receive. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving long-term disability benefits, your premiums will be withheld from those payments.

When you qualify for LTD benefits

Under the terms of the LTD plan and LTD enhanced plan, “disability” 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 the material and substantial duties of any occupation.

In determining whether you are disabled, Lincoln (formerly Liberty) will not consider employment factors, including but not limited to: interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing or loss of professional or occupational license or certification.

To qualify for LTD benefits:

- You must be unable to return to work after the initial benefit waiting period of disability.
- You must continue to be under the appropriate care of a qualified doctor (qualified doctors include legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses).
- Lincoln (formerly Liberty) must receive and approve certification with accompanying medical documentation of a disability from your qualified doctor before benefits are considered for payment.

With respect to covered persons employed as pilots and copilots of an aircraft: “disability” or “disabled” means that, as a result of an injury or sickness, the covered person is unable to perform the material and substantial duties of his or her own occupation under the applicable Federal Aviation Administration fitness standards.

When benefits are not paid

Benefits will not be paid for any LTD claim due to:

- War, declared or undeclared, or any act of war
- Active participation in a riot
- The committing of or attempting to commit a felony or misdemeanor, or
- Cosmetic surgery, unless such surgery is in connection with an injury or sickness sustained while the individual is a covered person.

No benefit will be payable during any period of incarceration.

PRE-EXISTING CONDITION EXCLUSION

You will not receive LTD benefits for any condition, diagnosed or undiagnosed, for which you had received treatment during the 90-day period prior to your effective date, unless you have not been treated for the same or related pre-existing condition for more than 365 days while insured. Under the terms of the pre-existing condition exclusion, you are receiving “treatment” when you are consulting, receiving care or services provided by or under the direction of a physician, including diagnostic measures; being prescribed drugs and/or medicines, whether you choose to take them or not; and taking drugs and/or medicines.

If you change from the LTD plan (50% benefit) to the LTD enhanced plan (60% benefit), the pre-existing condition exclusion will apply to the additional coverage amount. If you had satisfied the pre-existing condition requirement of the LTD plan (50% benefit) and then suffer a disability before you had satisfied the pre-existing condition exclusion of the LTD enhanced plan (60% benefit), you will only receive benefits under the LTD plan (50% benefit).

When LTD benefits begin

If you are approved by Lincoln (formerly Liberty) for LTD benefits, they will begin after your waiting period: 26 weeks or the end of your short-term disability benefits – whichever is longer.

Paid time off (PTO) may not be used while receiving LTD benefits. If you are receiving LTD benefits at the end of the PTO plan year, please refer to your location’s PTO policy for payout and/or carryover information. You will not accrue additional PTO while you are receiving LTD benefits.

IF YOU RETURN TO WORK DURING YOUR WAITING PERIOD AND BECOME DISABLED AGAIN

If you cease to be disabled and return to work full-time for a total of 60 calendar days or less during a waiting period, the waiting period will not be interrupted (although the days you work will not be counted toward your benefit waiting period). If you return to work for a total of more than 60 calendar days while satisfying your benefit waiting period, you must satisfy an entirely new benefit waiting period if you again become disabled before you are eligible to receive LTD benefits.

Filing an LTD claim

If you are on an approved short-term disability claim and are eligible for LTD benefits, your claim will be automatically transitioned from Sedgwick to Lincoln (formerly Liberty) around the 17th week of disability. You may also call Lincoln at **800-492-5678** if you have questions regarding your eligibility or if you have not been contacted within the time frame noted above. Lincoln will provide you with additional information on how to complete your claim.

Associates receiving workers’ compensation benefits and enrolled in the LTD plan or LTD enhanced plan may be eligible for disability benefits after their waiting period has expired. Call Lincoln (formerly Liberty) at **800-492-5678** to report your LTD claim.

Claims will be determined under the time frames and requirements set out in the [Claims and appeals](#) chapter. You have the right to appeal a claim denial. See the [Claims and appeals](#) chapter for details.

Your LTD benefit

The amount of your LTD benefit is based on:

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

AVERAGE MONTHLY WAGE

Length of employment	How average monthly wage is determined
Employed 12 months or more	<p>Prior annual pre-disability earnings ÷ 12 months</p> <p>For example, the average monthly wage for an associate with prior annual pre-disability earnings of \$36,000 is \$3,000 ($\\$36,000 \div 12$).</p>
Employed less than 12 months	<p>Prior annual pre-disability earnings ÷ number of months worked</p> <p>For example, the average monthly wage for an associate with prior annual pre-disability earnings of \$21,000 for seven months of work is \$3,000 ($\\$21,000 \div 7$).</p>

Annual pre-disability earnings include:

- Overtime
- Bonuses
- Paid time off (not including any previous disability benefits), and
- Personal pay for the 26 pay periods (52 if paid weekly) prior to your last day worked.

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

Your LTD benefit is shown below:

YOUR LTD BENEFIT	
If you enrolled	Your coverage is
In the LTD plan	50% of your average monthly wage minus the amount of other benefits or income you or your family are eligible to receive (for example, Social Security disability benefits*)
In the LTD enhanced plan	60% of your average monthly wage minus the amount of other benefits or income you or your family are eligible to receive (for example, Social Security disability benefits*)

* See [Other benefits or income that reduces LTD benefits](#) for more information.

The maximum monthly benefit under both the LTD plan and the LTD enhanced plan is \$15,000 (\$18,000 for the LTD enhanced plan as of Jan. 1, 2018).

 [See page 287](#)

Your benefit will be no less than \$100 or 10% of your gross benefit, whichever is greater, for any month that you are eligible to receive LTD benefits. The total of your monthly disability payment, plus all earnings, cannot exceed 100% of your average monthly wage prior to your disability.

LTD benefits are paid at the end of each 30-day period of disability (bi-monthly as of Jan. 1, 2019; see page 287), as long as you continue to be disabled as defined by the LTD plans.

Lincoln (formerly Liberty) has the right to recover, and you must repay, any amount that is overpaid to you for LTD benefits under the LTD plan or LTD enhanced plan.

TAXES AND YOUR LTD BENEFIT

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

OTHER BENEFITS OR INCOME THAT REDUCES LTD BENEFITS

Your LTD benefit amount will be reduced, or offset, by other benefits or income you or your family receives or are eligible to receive. Examples include, but are not limited to, income from the following:

- Social Security disability insurance
- Social Security retirement benefits that are granted after the date of total disability
- Workers' compensation
- Employer-related individual policies
- No-fault automobile insurance
- An employer retirement plan that begins after the date of the total disability, or
- Settlement or judgment, less associated costs of a lawsuit that represents or compensates for your loss of earnings.

If any of the benefits that reduce your LTD benefits are subsequently adjusted by cost-of-living increases, your LTD benefit will not be further reduced. Please refer to the policy for a complete list of offsets. You may obtain a copy of the LTD policy by calling Lincoln (formerly Liberty) at **800-492-5678**.

REDUCTION OF LTD BENEFIT EXAMPLE

Annual salary: \$36,000	LTD Plan (50%)	LTD Enhanced Plan (60%)
Average monthly wage	\$3,000	\$3,000
Benefit amount (percentage of average monthly wage, subject to the \$15,000 maximum)	\$1,500	\$1,800
Less estimated Social Security disability benefit	-\$750	-\$750
Less dependent's estimated Social Security benefits	-\$375	-\$375
LTD payment (monthly)	\$375	\$675

APPLYING FOR SOCIAL SECURITY DISABILITY BENEFITS

You may be eligible to receive Social Security disability benefits after you have been disabled for five months. If your disability is expected to last, or has already lasted, 12 consecutive months, the LTD policy terms may require you to apply for Social Security disability benefits. If the Social Security Administration denies you benefits, you will be required to follow the Social Security Administration's appeal process.

Failure to file for Social Security disability benefits could result in your Social Security retirement benefits being reduced when you reach the age of retirement. If you qualify for Social Security disability or retirement benefits while you are receiving benefits under the LTD plan and your Social Security disability claim is approved retroactively, you must reimburse Lincoln (formerly Liberty) for any LTD benefits overpaid during the period covered by the retroactive Social Security approval.

If you are disabled and working

You may be eligible to receive disability benefits if you are partially disabled. Under the Plan, “partial disability” and “partially disabled” mean that, as a result of sickness or injury, you are able to:

- Perform one or more, but not all, of the material and substantial duties of your own or any occupation on a full-time or part-time basis, or
- Perform all of the material and substantial duties of your own occupation on a part-time basis, and
- Earn between 20% and 80% of your indexed pre-disability earnings.

Your “pre-disability monthly earnings” means your regular monthly rate of pay in effect for the 26 regular pay periods (52 if paid weekly) immediately prior to your last day worked, divided by 12. Pre-disability earnings include overtime, bonuses, paid time off, vacation, illness protection and personal pay, but not commissions or any other fringe benefits or extra compensation. If you have worked for less than 12 months with the company, your regular monthly rate of pay will be based upon the total earnings you actually received while working for the company immediately prior to the date you became totally disabled, annualized and divided by 12.

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

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

After the first three months that you are partially disabled and working, the following calculation is used to determine your monthly benefit for a partial disability.

DISABLED AND WORKING BENEFIT CALCULATION

$$\frac{(A - B) \times C}{A} = D$$

A	Your indexed pre-disability monthly earnings
B	Your current monthly earnings
C	The monthly benefit payable if you were qualified as totally disabled
D	The disabled and working benefit payable

Continuing benefit coverage while disabled

If you wish to continue medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness insurance and accident insurance coverage while you are receiving LTD benefits, you must make premium payments each pay period. These amounts will not be deducted from your LTD benefit payments. If you fail to pay your premiums for these benefit plans, your benefits may be canceled. See the [Eligibility and enrollment](#) chapter for details.

Your disability coverage will not be canceled while you are receiving disability benefits under this policy. You will not be required to pay short-term disability enhanced plan or LTD plan premiums from any LTD benefit payments you receive. If, however, you receive any other earnings through the Walmart payroll systems while you are receiving LTD benefits, your premiums will be withheld from those payments.

IF YOU PASS AWAY WHILE RECEIVING LTD BENEFITS

Coverage under the LTD plan and LTD enhanced plan ends upon your death. However, if you pass away while you are receiving LTD benefits, a lump-sum payment of \$5,000 or three times your gross monthly LTD benefit, whichever is greater, will be paid to your surviving spouse/partner. If you are not survived by a spouse/partner, the payment will be made to your surviving children, including stepchildren and legally adopted children, in equal shares. However, if any of these children are minors or incapacitated, payment will be made on their behalf to the court-appointed guardian of the children’s property. If you are not survived by a spouse/partner or children, the payment will be made to your estate.

When LTD benefit payments end

LTD benefit payments will end on the earliest of:

- The date you fail to furnish proof of continued disability and regular attendance of a doctor
- The date you fail to cooperate in the administration of your claim. For example: providing information or documents needed to determine whether benefits are payable and/or determining the benefit amount
- The date you refuse to be examined or evaluated at reasonable intervals
- The date you refuse to receive appropriate available treatment
- The date you refuse a similar job with Walmart, paying comparable wages, where workplace modifications or accommodations are made to allow you to perform the material and substantial duties of your job
- The date you are able to work in your own occupation on a part-time basis but choose not to

- The date your partial disability monthly earnings exceed 80% of your indexed pre-disability earnings
- The date you are no longer totally disabled
- The last day of the maximum period for which benefits are payable (see chart below), or
- The date of your death.

IF THE DISABILITY IS DUE TO MENTAL ILLNESS, ALCOHOLISM OR DRUG ADDICTION

To receive LTD benefits for more than 24 months for the following disabilities, you must be confined in a hospital or other facility licensed to provide medical care:

- Mental illness (excluding demonstrable, structural brain damage)
- Any condition that results from mental illness
- Alcoholism, and
- Non-medical use of narcotics, sedatives, stimulants, hallucinogens or similar substances.

MAXIMUM DURATION OF LTD BENEFITS

Age when you become totally disabled	Benefits duration (months of LTD benefits)
Prior to age 62	Until normal retirement age (as listed to the right)
62	48 months
63	42 months
64	36 months
65	30 months
66	27 months
67	24 months
68	21 months
69 or older	18 months

SOCIAL SECURITY NORMAL RETIREMENT AGE

Year of birth	Normal retirement age
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 through 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

When you are not confined to a hospital or other licensed facility, there will be a 24-month lifetime benefit for these disabilities unless you are fully participating in an extended treatment plan for the condition that caused the disability, in which case the benefit will be payable for up to 36 months.

If you return to work and become disabled again

If you return to work for less than six months of active full-time work and become totally disabled again from the same or a related condition that caused the first period of disability, as determined by Lincoln (formerly Liberty), known as a “relapse/recurrent claim,” the recurrent disability will be part of the same disability.

If you return to work as an active full-time associate for six months or more, any recurrence of a disability will be treated as a new disability. A new waiting period must be completed.

Coverage during a leave of absence or temporary layoff

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

When coverage ends

Your LTD coverage ends:

- At termination of your employment, except that coverage will be continued if you are absent due to disability during the 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
- Upon failure to pay your premiums
- On the date you lose eligibility
- If you do not return to work after the last day of an approved leave of absence
- When the benefit is no longer offered by the company
- The day after you drop coverage, or
- On the date of your death.

If you leave the company and are rehired

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

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

If you lose and then regain eligibility

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

If you lose eligibility and then regain eligibility after 30 days, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the [Eligibility and enrollment](#) chapter.

Truck driver long-term disability

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Lincoln Financial Group, or Lincoln (formerly Liberty Life Assurance Company of Boston, or Liberty), regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Truck driver long-term disability

If a disability keeps you off the road and unable to work, truck driver long-term disability benefits works with other benefits you receive to replace part of your paycheck. The Plan offers two truck driver long-term disability plans that pay benefits for different lengths of time.

TRUCK DRIVER LONG-TERM DISABILITY RESOURCES

Find What You Need	Online	Other Resources
Get more details about truck driver long-term disability or file a claim	Go to WalmartOne.com	Call Lincoln (formerly Liberty) at 800-492-5678

What you need to know about truck driver long-term disability

- Full-time truck drivers may choose from two truck driver long-term disability (LTD) plans: the truck driver LTD plan or the truck driver LTD enhanced plan. Each plan offers a choice of full-duration coverage or five-year coverage.
- The truck driver long-term disability plan works with any other benefits you receive while disabled to replace 50% of your average monthly wage if you select the truck driver LTD plan or 60% of your average monthly wage if you select the truck driver LTD enhanced plan.
- If you enroll in either plan after your initial eligibility period, you will have to submit Evidence of Insurability, and you may be required to undergo a medical exam at your own expense before you can be approved for coverage.
- Truck driver long-term disability benefits are paid at the end of each 30-day period of disability (bi-monthly as of Jan. 1, 2019; see page 287), as long as you continue to be disabled as defined by the truck driver LTD plan or the truck driver LTD enhanced plan.

 **See page 287**

Enrollment in truck driver LTD and when coverage is effective

You are eligible to enroll in truck driver LTD coverage if you are a full-time truck driver. Truck driver LTD offers two coverage plans, each of which can be chosen in either of two options:

- **LTD plan**
 - Five-year coverage
 - Full-duration coverage
- **LTD enhanced plan**
 - Five-year coverage
 - Full-duration coverage

The truck driver LTD plan options pay benefits as described in the following chart.

TRUCK DRIVER LTD		
	LTD PLAN	LTD ENHANCED PLAN
Five-year coverage	Pays 50% of average monthly wage	Pays 60% of average monthly wage
	Both plans pay benefits for 60 months, unless the longer of the following time periods is less than 60 months, in which case the monthly benefit will be payable for the longer period: <ul style="list-style-type: none"> • The amount of time shown in the Maximum duration of truck driver LTD chart (later in this chapter), or • The amount of time between the date you become disabled and your normal retirement age under the Social Security Act, as shown in the Social Security normal retirement age chart (later in this chapter). 	
	LTD PLAN	LTD ENHANCED PLAN
Full-duration coverage	Pays 50% of average monthly wage	Pays 60% of average monthly wage
	Both plan options pay benefits for the longer of: <ul style="list-style-type: none"> • The amount of time shown in the Maximum duration of truck driver LTD chart (later in this chapter), or • The amount of time between the date you become disabled and your normal retirement age under the Social Security Act, as shown in the Social Security normal retirement age chart (later in this chapter). 	

The truck driver LTD plans are insured by Lincoln (formerly Liberty) and have a maximum monthly benefit of \$15,000 (\$18,000 for the LTD enhanced plan effective Jan. 1, 2018).

 **See page 287**

Your benefit will be no less than \$100 or 10% of your gross benefit, whichever is greater, for any month that you are eligible to receive LTD benefits.

The date your coverage is effective depends on when you enroll for coverage:

- If you enroll during your initial enrollment period, your coverage will be effective on your date of hire.
- If you enroll at any time after your initial enrollment period as a late enrollee, your coverage will be effective the first day of the pay period after People Services receives approval from Lincoln (formerly Liberty). You will be required to provide Evidence of Insurability (you must complete a medical history questionnaire and may be required to undergo a medical exam at your own expense) and may be denied coverage.
- If you enroll in the five-year coverage plan and subsequently decide to enroll in the full-duration coverage plan, you will be treated as a late enrollee and required to provide Evidence of Insurability before you can be approved for coverage. Your coverage will be effective the first day of the pay period after People Services receives approval from Lincoln (formerly Liberty).

You may drop your truck driver LTD plan or truck driver LTD enhanced plan coverage at any time; the change will be effective the day after you drop coverage. If you drop long-term disability and later decide to re-enroll in either plan, you will be treated as a late enrollee, as described above.

THE COST OF TRUCK DRIVER LTD COVERAGE

Your cost for truck driver long-term disability coverage is based on your biweekly earnings and the type of truck driver LTD coverage you select. Premiums are deducted from all wages, including bonuses. You will not be required to pay truck driver LTD premiums from any truck driver LTD benefit payments received. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving truck driver LTD benefits, your premiums will be withheld from those payments.

When you qualify for truck driver LTD benefits

Under the terms of the truck driver LTD plans, “disability” means that, due to an injury or sickness during the benefit waiting period and for the next 24 months of disability, you are unable to perform the material and substantial duties of your own occupation, or you lose medical certification in accordance with the Federal Motor Carrier Safety Regulations. After 24 months of benefit payments, “disability” means that you are unable to perform the material and substantial duties of any occupation.

In determining whether you are disabled, Lincoln (formerly Liberty) will not consider employment factors, including but not limited to: interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing or loss

of professional or occupational license or certification for reasons other than a covered injury or sickness.

To qualify for truck driver LTD benefits:

- You must be unable to return to work after the initial benefit waiting period of disability.
- You must continue to be under the appropriate care of a qualified doctor (qualified doctors include legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses).
- Lincoln (formerly Liberty) must receive and approve certification with accompanying medical documentation of a disability from your qualified doctor before benefits are considered for payment.

If you file a claim within the first two years of your approval date, Lincoln (formerly Liberty) has the right to re-examine your Evidence of Insurability questionnaire. If material facts about you were stated inaccurately, the true circumstances will be used to determine if and for what amount your coverage should have been in effect, and your premium may be adjusted.

When benefits are not paid

Benefits will not be paid for any truck driver LTD claim due to:

- War, declared or undeclared, or any act of war
- Active participation in a riot
- The committing of or attempting to commit a felony or misdemeanor, or
- Cosmetic surgery, unless such surgery is in connection with an injury or sickness sustained while the individual is a covered person.

No benefit will be payable during any period of incarceration.

PRE-EXISTING CONDITION EXCLUSION

You will not receive truck driver LTD benefits for any condition, diagnosed or undiagnosed, for which you had received treatment during the 90-day period prior to your effective date unless you have not been treated for the same or related pre-existing condition for more than 365 continuous days while insured. Under the terms of the pre-existing condition exclusion, you are receiving “treatment” when you are consulting, receiving care or services provided by or under the direction of a physician, including diagnostic measures; being prescribed drugs and/or medicines, whether you choose to take them or not; and taking drugs and/or medicines.

If you change from the five-year duration coverage to the full-duration coverage under either of the truck driver LTD plans, the pre-existing condition exclusion will apply to the additional duration. If you had satisfied the pre-existing condition requirement of the five-year duration coverage plan and then suffer a disability before you had satisfied the pre-existing condition exclusion of the full-duration coverage plan, you will only receive benefits under the five-year duration coverage plan.

When truck driver LTD benefits begin

If you are approved by Lincoln (formerly Liberty) for truck driver LTD benefits, they will begin after your waiting period: 26 weeks or the end of your short-term disability benefits – whichever is longer.

Paid time off (PTO) may not be used while receiving LTD benefits. If you are receiving LTD benefits at the end of the PTO plan year, please refer to your location’s PTO policy for payout and/or carryover information. You will not accrue additional PTO while you are receiving LTD benefits.

IF YOU RETURN TO WORK DURING YOUR WAITING PERIOD AND BECOME DISABLED AGAIN

If you cease to be disabled and return to work for a total of 60 calendar days or less during a waiting period, the waiting period will not be interrupted (although any days that you work will not be counted toward meeting your waiting period). If you return to work for a total of more than 60 calendar days while satisfying your benefit waiting period, you must satisfy an entirely new benefit waiting period if you again become disabled before you are eligible to receive LTD benefits.

Filing a truck driver LTD claim

If you are on an approved short-term disability claim and are eligible for LTD benefits, your claim will be automatically transitioned from Sedgwick to Lincoln (formerly Liberty) around the 17th week of disability. You may also call Lincoln at **800-492-5678** as soon as you know you will need to use your truck driver LTD benefit. Lincoln will provide you with additional information on how to complete your claim.

Associates receiving workers’ compensation benefits and enrolled for truck driver LTD insurance may be eligible for disability benefits after their waiting period has expired. Call Lincoln (formerly Liberty) at **800-492-5678** to report your truck driver LTD claim by approximately the 45th day of being on workers’ compensation disability benefits.

Claims will be determined under the time frames and requirements set out in the [Claims and appeals](#) chapter. You have the right to appeal a claim denial. See the [Claims and appeals](#) chapter for details.

Your truck driver LTD benefit

The amount of your truck driver LTD is based on:

- Your average monthly wage, and
- Which truck driver LTD plan you're enrolled in.

AVERAGE MONTHLY WAGE

Length of employment	How average monthly wage is determined
Employed 12 months or more	Your activity pay, mileage rate and bonuses, paid in the 26 pay periods prior to your last day worked ÷ 12 months
Employed less than 12 months	Your activity pay, mileage rate and bonuses ÷ the number of months worked

Your truck driver long-term disability benefit is shown below:

YOUR TRUCK DRIVER LONG-TERM DISABILITY BENEFIT

If you enrolled	Your coverage is
In the truck driver five-year coverage LTD plan or the truck driver full-duration coverage LTD plan	50% of your average monthly wage minus the amount of other benefits or income you or your family are eligible to receive (for example, Social Security disability benefits*)
In the truck driver five-year coverage LTD enhanced plan or the truck driver full-duration coverage LTD enhanced plan	60% of your average monthly wage minus the amount of other benefits or income you or your family are eligible to receive (for example, Social Security disability benefits*)

* See **Other benefits or income that reduces truck driver long-term disability benefits** for more information.

The maximum monthly benefit under any of the four truck driver long-term disability plan options is \$15,000 (\$18,000 for the LTD enhanced plan as of Jan. 1, 2018).

See page 287

Your benefit will be no less than \$100 or 10% of your gross benefit, whichever is greater, for any month that you are eligible to receive truck driver long-term disability benefits. The total of your monthly disability payment, plus all earnings, cannot exceed your average monthly wage prior to your disability.

Truck driver long-term disability benefits are paid at the end of each 30-day period of disability (bi-monthly as of Jan. 1, 2019; see page 287), as long as you continue to be disabled as defined by the truck driver LTD plans.

Lincoln (formerly Liberty) has the right to recover from you any amount that is overpaid to you for truck driver long-term disability benefits under the truck driver LTD plan or the truck driver LTD enhanced plan.

TAXES AND YOUR LTD BENEFIT

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

OTHER BENEFITS OR INCOME THAT REDUCES TRUCK DRIVER LTD BENEFITS

Your truck driver LTD benefit amount will be reduced, or offset, by other benefits or income you or your family receive or are eligible to receive. Examples include, but are not limited to, income from the following:

- Social Security disability insurance
- Social Security retirement benefits that are granted after the date of total disability
- Workers' compensation
- Employer-related individual policies
- No-fault automobile insurance
- An employer retirement plan that begins after the date of the total disability, or
- Settlement or judgment, less associated costs of a lawsuit, that represents or compensates for your loss of earnings.

If any of the benefits that reduce your LTD benefits are subsequently adjusted by cost-of-living increases, your LTD benefit will not be further reduced. Please refer to the policy for a complete list of offsets. You may obtain a copy of the truck driver LTD policy by calling Lincoln (formerly Liberty) at **800-492-5678**.

REDUCTION OF TRUCK DRIVER LTD BENEFIT EXAMPLE

	LTD plan (50%)	LTD enhanced plan (60%)
Average monthly wage	\$3,000	\$3,000
Benefit amount (percentage of average monthly wage, subject to the \$15,000 maximum)	\$1,500	\$1,800
Less estimated Social Security disability benefit	- \$750	- \$750
Less dependent's estimated Social Security benefits	- \$375	- \$375
LTD payment (monthly)	\$375	\$675

APPLYING FOR SOCIAL SECURITY DISABILITY BENEFITS

You may be eligible to receive Social Security disability benefits after you have been disabled for five months. If your disability is expected to last, or has already lasted, 12 consecutive months, the truck driver LTD policy terms may require you to apply for Social Security disability benefits. If the Social Security Administration denies you benefits, you will be required to follow the Social Security Administration's appeal process.

Failure to file for Social Security disability benefits could result in your Social Security retirement benefits being reduced when you reach the age of retirement. If you qualify for Social Security disability or retirement benefits while you are receiving benefits under any of the truck driver LTD plan options and your Social Security disability claim is approved retroactively, you must reimburse Lincoln (formerly Liberty) for any LTD benefits overpaid during the period covered by the retroactive Social Security approval.

If you are disabled and working

You may be eligible to receive disability benefits if you are partially disabled. Under the truck driver LTD plans, "partial disability" and "partially disabled" mean that, as a result of sickness or injury, you are able to:

- Perform one or more, but not all, of the material and substantial duties of your own or any occupation on a full-time or part-time basis, or
- Perform all of the material and substantial duties of your own occupation on a part-time basis, and
- Earn between 20% and 80% of your indexed pre-disability earnings.

Your "pre-disability monthly earnings" means your activity pay, mileage rate and bonus in effect for the 52 weeks immediately prior to your last day worked, divided by 12.

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

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

After the first three months that you are partially disabled and working, the following calculation is used to determine your monthly benefit for a partial disability.

DISABLED AND WORKING BENEFIT CALCULATION

$$\frac{(A - B) \times C}{A} = D$$

A	Your indexed pre-disability monthly earnings
B	Your current monthly earnings
C	The monthly benefit payable if you were qualified as totally disabled
D	The disabled and working benefit payable

Continuing benefit coverage while disabled

If you wish to continue medical, dental, AD&D, optional associate and dependent life insurance, critical illness insurance and accident insurance coverage while you are receiving truck driver LTD benefits, you must make benefits premium payments each pay period. These amounts will not be deducted from your truck driver LTD benefit payments. If you fail to pay your premiums for these benefit plans, your benefits may be canceled. See the [Eligibility and enrollment](#) chapter for details.

Your disability coverage will not be canceled while you are receiving disability benefits under this policy. You will not be required to pay truck driver LTD premiums from any truck driver LTD benefit payments you receive. If, however, you receive any other earnings through the Walmart payroll systems while you are receiving truck driver LTD benefits, your premiums will be withheld from those payments.

IF YOU PASS AWAY WHILE RECEIVING TRUCK DRIVER LTD BENEFITS

Coverage under the truck driver LTD plans ends upon your death. However, if you pass away while you are receiving truck driver LTD benefits, a lump sum payment of \$5,000 or three times your gross monthly LTD benefit, whichever is greater, will be paid to your surviving spouse/partner. If you are not survived by a spouse/partner, the payment will be made to your surviving children, including stepchildren and legally adopted children, in equal shares. However, if any of these children are minors or incapacitated, payment will be made on their behalf to the court-appointed guardian of the children's property. If you are not survived by a spouse/partner or children, the payment will be made to your estate.

When truck driver LTD benefit payments end

Truck driver LTD benefit payments will end on the earliest of:

- The date you fail to furnish proof of continued disability and regular attendance of a doctor
- The date you fail to cooperate in the administration of your claim. For example: providing information or documents needed to determine whether benefits are payable and/or determining the benefit amount
- The date you refuse to be examined or evaluated at reasonable intervals
- The date you refuse to receive appropriate available treatment
- The date you refuse a similar job with Walmart, paying comparable wages, where workplace modifications or accommodations are made to allow you to perform the material and substantial duties of your job
- The date you are able to work in your own occupation on a part-time basis but choose not to
- The date your partial disability monthly earnings exceed 80% of your indexed pre-disability earnings
- The date you are no longer totally disabled
- The last day of the maximum period for which benefits are payable (see charts below), or
- The date of your death.

FIVE-YEAR COVERAGE	FULL-DURATION COVERAGE
<p>Five-year coverage pays benefits for 60 months unless the longer of the following time periods is less than 60 months, in which case the monthly benefit will be payable for the longer period:</p> <ul style="list-style-type: none"> • The amount of time shown in the Maximum duration of truck driver LTD chart below; or • The amount of time between the date you become disabled and your normal retirement age under the Social Security Act, as shown in the Social Security normal retirement age chart below. 	<p>Full-duration coverage pays benefits for the longer of:</p> <ul style="list-style-type: none"> • The amount of time shown in the Maximum duration of truck driver LTD chart below; or • The amount of time between the date you become disabled and your normal retirement age under the Social Security Act, as shown in the Social Security normal retirement age chart below.

MAXIMUM DURATION OF TRUCK DRIVER LTD BENEFITS		SOCIAL SECURITY NORMAL RETIREMENT AGE	
Age when you become totally disabled	Benefits duration (months of LTD benefits)	Year of birth	Normal retirement age
Prior to age 62	Until normal retirement age (as listed to the right)	1937 or before	65 + 2 months
62	48 months	1938	65 + 4 months
63	42 months	1939	65 + 6 months
64	36 months	1940	65 + 8 months
65	30 months	1941	65 + 10 months
66	27 months	1942	66
67	24 months	1943 through 1954	66 + 2 months
68	21 months	1955	66 + 4 months
69 or older	18 months	1956	66 + 6 months
		1957	66 + 8 months
		1958	66 + 10 months
		1959	67
		1960 or after	67

IF THE DISABILITY IS DUE TO MENTAL ILLNESS, ALCOHOLISM OR DRUG ADDICTION

To receive truck driver LTD benefits for more than 24 months for the following disabilities, you must be confined in a hospital or other place licensed to provide medical care:

- Mental illness (excluding demonstrable, structural brain damage)
- Any condition that results from mental illness
- Alcoholism, and
- Non-medical use of narcotics, sedatives, stimulants, hallucinogens or similar substances.

When you are not confined to a hospital or other licensed facility, there will be a 24-month lifetime benefit for these disabilities unless you are fully participating in an extended treatment plan for the condition that caused the disability, in which case the benefit will be payable for up to 36 months.

If you return to work and become disabled again

If you return to work for less than six months of active full-time work and become disabled again from the same or a related condition that caused the first period of disability, as determined by Lincoln (formerly Liberty), known as a “relapse/recurrent claim,” the recurrent disability will be part of the same disability. No additional waiting period will be required.

If you return to work as an active full-time associate for six months or more, any recurrence of a disability will be treated as a new disability. A new benefit waiting period must be completed.

Coverage during a leave of absence or temporary layoff

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

When coverage ends

Your truck driver LTD coverage ends:

- At termination of your employment
- On the last day of the pay period when your job status changes from an eligible job status
- Upon failure to pay your premiums
- On the date you lose eligibility
- If you do not return to work after the last day of an approved leave of absence
- When the benefit is no longer offered by the company
- On the day after you drop coverage, or
- On the date of your death.

If you leave the company and are rehired

If you leave the company and return to full-time work for the company within 13 weeks, you will automatically be re-enrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan). If you are automatically re-enrolled in truck driver LTD plan or LTD enhanced plan coverage and choose to drop it after you return, you may do so at any time.

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

If you lose and then regain eligibility

If you lose eligibility and then regain eligibility within 30 days, you will automatically be re-enrolled for the same coverage you had prior to losing eligibility (or the most similar plans offered under the Plan).

If you lose eligibility and then regain eligibility after 30 days, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the [Eligibility and enrollment](#) chapter.

The Associate Stock Purchase Plan (ASPP)

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The Associate Stock Purchase Plan (ASPP)

The Associate Stock Purchase Plan (ASPP or Plan) allows you to buy Walmart stock conveniently through payroll deductions and through direct payments to the Plan Administrator. You can have any amount from \$2 to \$1,000 withheld from your biweekly paycheck (\$1 to \$500 if you are paid weekly) to buy stock. Walmart matches \$0.15 for every dollar that you contribute through payroll deduction to purchase stock, up to the first \$1,800 you contribute to the Plan in each Plan year (April through March).

THE ASSOCIATE STOCK PURCHASE PLAN RESOURCES

Find What You Need	Online	Other Resources
Enroll in the Plan or change your deduction amount		Associates must complete an online enrollment session on the WIRE , WalmartOne.com/ASPP or Workday
<ul style="list-style-type: none"> • Access your account information • Get your account statement • Get a Form 1099 	Go to the Computershare website at computershare.com/walmart	Call Computershare at 800-438-6278 (hearing impaired: 800-952-9245)
Send money directly to Computershare		Send check to: Computershare Attn: Walmart ASPP P.O. Box 43080 Providence, Rhode Island 02940-3080 (Company matching contributions will not be made on money sent directly to Computershare)

What you need to know about the Associate Stock Purchase Plan

- All eligible associates can purchase Walmart stock through convenient payroll deductions and direct payments to Computershare.
- Walmart matches \$0.15 for every \$1 you put into the Plan through payroll deductions, up to the first \$1,800 that you contribute in each plan year.
- There are no fees to purchase shares of Walmart stock through the Plan. You only pay a fee when you sell shares of stock.
- Your shares will be credited to an account that is maintained in your name at Computershare. You can access your account online or by telephone to get your balance or sell stock held in your account.

Associate Stock Purchase Plan eligibility

You are eligible to enroll in the Associate Stock Purchase Plan if you are:

- Not a member of a collective bargaining unit whose benefits were the subject of good faith collective bargaining.
- At least 18 years of age or the legal age of majority in your payroll state to participate (19 is the legal age of majority in Alabama and Nebraska). If you live in Puerto Rico, you must be 21 years of age to participate. If you have questions about the age requirement, review your state laws on legal age of majority.

Enrolling in the Associate Stock Purchase Plan

You can enroll in the Plan by completing an online benefits enrollment session on the [WIRE](#), [WalmartOne.com/ASPP](#) or [Workday](#). Before you enroll in this plan, you should carefully review this Associate Stock Purchase Plan brochure and the Plan Prospectus (a copy of which appears on the following pages), as well as the reports and other documents that the company has incorporated by reference into the Plan Prospectus.

The decision to participate in the Plan and to purchase company stock is an individual decision to be made solely by you. The company is not recommending, endorsing or soliciting your participation in the Plan or purchase of company stock. In making your decision, you should be aware that the past performance of the company stock is not an indication or prediction of future performance. The value of company stock may be affected by many factors, including those outside the company itself, such as economic conditions. The company urges you to consult with your financial and tax advisors regarding your participation in the Plan and investment in company stock.

Walmart's contribution to your company stock ownership

The Associate Stock Purchase Plan allows all eligible associates to buy Walmart stock conveniently through payroll deductions. You can have any whole dollar amount from \$2 to \$1,000 withheld from your paycheck to buy stock (\$1 to \$500 for associates with a weekly paycheck).

Walmart contributes to your stock purchase account by matching \$0.15 for every \$1 you contribute to the Plan through payroll deductions, up to your first \$1,800 you contribute in each Plan year. The Plan year runs from April through March. The company match is reflected as income on your check stub and on your Form W-2.

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

Computershare
Attn: Walmart ASPP
P.O. Box 43080
Providence, Rhode Island 02940-3080

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

The value of the stock you purchase can fluctuate and may decline. There is no way to guarantee that your stock will have the same value in the future that it had when you made the purchase or that the value of the stock will increase. When making a decision about purchasing Walmart stock, consider all your investments, including other Walmart stock you may own. For investment questions, consult a financial advisor. Investment in the stock is subject to certain risks as described in the Plan Prospectus and Walmart's most recent Annual Report on Form 10-K that is incorporated by reference in the Plan Prospectus.

WALMART'S CONTRIBUTION TO YOUR COMPANY STOCK OWNERSHIP

If you contribute	Your Plan year payroll deduction contribution is	Walmart's matching contribution* is	Total amount used to purchase Walmart stock
\$10 biweekly	\$260	\$39	\$299
\$20 biweekly	\$520	\$78	\$598
\$70 biweekly	\$1,820	\$270 (Walmart matches \$0.15 for every \$1 up to \$1,800)	\$2,090

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

Selling stock through the Plan

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

If you choose to sell your stock, your stock will be sold pursuant to a market order. Your stock will be sold as soon as your request can reasonably be processed. Generally, market orders are executed immediately after they are placed. The price at which your order will be executed is not guaranteed, and the Walmart stock price prior to the execution of your order is not necessarily the price at which your order will be executed.

Generally, any sales of your stock will be executed over the New York Stock Exchange (NYSE). If the NYSE is closed when your order is ready to be processed, your order will be processed as early as possible on the next NYSE trading day. The fee is \$25.50 per sale plus \$0.05 (five cents) per share sold for each sell you execute.

To sell stock, call Computershare at **800-438-6278** or go to computershare.com/walmart. A check will be mailed to the address on file at Computershare. You should receive your check within seven to 10 business days after you place an order to sell stock in your Plan account.

The sell fee is automatically deducted from your check for the net proceeds of the sale. Each time you sell stock, you will receive a transaction summary form along with your check. For tax reporting purposes, you'll receive appropriate tax documents (1099B and/or 1099DIV) enclosed with your annual statement in the first quarter of the following year (January through March). These documents will be mailed to your address on file with Computershare and should be used when filing your taxes.

It's important to understand the tax consequences of a stock sale. If you have tax-related questions, please consult a financial advisor or tax consultant.

Keeping track of your Computershare account

You will receive a statement from Computershare at least annually (first quarter) that shows the activity in your account. However, if you opted to receive your statements electronically, you will receive an email informing you that your statement is ready and can be found on computershare.com/walmart.

The annual statement you receive will contain important tax information. It is very important that you keep your statement so that you will know the difference between your purchase price and sale price of any shares of stock you sell. You will need this information for your income taxes.

You can access your account information by phone by calling Computershare at **800-438-6278** (hearing impaired: **800-952-9245**) or the Computershare website at computershare.com/walmart.

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

Ending your participation and closing your account

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

After you cancel your payroll deductions, you can close your account by asking Computershare to issue you a stock certificate or by directing them to sell your stock and send you a check. To avoid paying a sales transaction fee twice, cancel your payroll deductions before closing your account. You also have the option to stop payroll deductions and to continue to hold your shares through the Plan at Computershare.

If you leave the company

If you leave the company, you will have several options concerning the status of your account:

- You can keep your account open without the weekly or biweekly payroll deduction and the company match. You can make voluntary cash purchases and benefit from having no broker's fee. There is an annual maintenance fee of \$35 per year, which will be automatically deducted from your account through the sale of an appropriate number of shares or portion of a share of stock to cover the fee during the first quarter of the year.
- You can close your account and receive all full shares in certificate form and a check for any fraction of a share you own.
- You can close your account and sell some or all of the shares in your account.

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

It is very important that you update Computershare if you have an address change after you have left the company.

PROSPECTUS

Prospectus

The information below constitutes a prospectus under Section 10(a) covering securities that have been registered under the Securities Act of 1933. The information constituting a prospectus ends on page 222.

20,000,000 Shares

WAL-MART STORES, INC.

Common Stock
(\$0.10 par value per share)

WAL-MART STORES, INC.
2016 Associate Stock Purchase Plan
(formerly, the Wal-Mart Stores, Inc. 2004 Associate Stock Purchase Plan and the
Walmart Stores, Inc. Associate Stock Purchase Plan of 1996)

This prospectus relates to the purchase of the number of shares of the common stock, \$0.10 par value per share, of Wal-Mart Stores, Inc. (“Walmart,” the “Company” or “we”) shown above under the Wal-Mart Stores, Inc. 2016 Associate Stock Purchase Plan (the “Plan”) by eligible Walmart associates who elect to participate in the Plan.

These securities have not been approved or disapproved by the Securities and Exchange Commission or any state securities commission nor has the Securities and Exchange Commission or any state securities commission passed upon the accuracy or adequacy of this prospectus. Any representation to the contrary is a criminal offense.

No one is authorized to give any information or to make any representations other than those contained in this Prospectus and, if given or made, you should not rely on them. This Prospectus is not an offer to sell or a solicitation of an offer to buy any of the securities referred to in this Prospectus in any state or other jurisdiction where such an offer or solicitation would be unlawful. Neither the delivery of this Prospectus nor acquisition of securities described in this Prospectus implies that no change in the affairs of the company has occurred since the date of this Prospectus.

Investment in shares of the Common Stock offered hereby involves certain risks. See “Part I, Item 1A. **Risk Factors**” in Walmart’s Annual Report on Form 10-K most recently filed with the Securities and Exchange Commission for a discussion of certain risks that may affect our business, operations, financial condition, results of operations and cash flows. See [Stock Ownership, fees and risks](#) later in this chapter.

The date of this Prospectus is October 11, 2016

Introduction and overview

The Plan is an amendment and restatement of the Wal-Mart Stores, Inc. 2004 Associate Stock Purchase Plan which had previously amended and restated the Wal-Mart Stores, Inc. Associate Stock Purchase Plan of 1996. The Plan was most recently approved by the stockholders of Walmart at our Annual Stockholders’ Meeting held on June 3, 2016. As of June 3, 2016, up to 10,943,171 shares of the company’s common stock, par value \$0.10 per share (the “Stock”), were available from the company or on the open market under the Plan; 20,000,000 shares of Stock were available for purchase from the company under the

Plan; and 100,000,000 shares of Stock were available for purchase on the open market under the Plan. As of the date of this Prospectus, 20,000,000 shares have been registered with the United States Securities and Exchange Commission for offer and sale on Registration Statements on Form S-8. Shares of the Stock are listed for trading on the New York Stock Exchange. Participating associates may be referred to as “you” in this Prospectus.

The Plan has two parts — the Stock Purchase Program and the Outstanding Performance Award Program. The Stock Purchase Program gives eligible associates an opportunity to share in company ownership by allowing them to

PROSPECTUS

purchase shares of Stock by payroll deduction. In addition, if they make or have made purchases through such payroll deductions under the Plan, they may also purchase shares of Stock by making voluntary contributions to the Plan out of their other funds. Under the Outstanding Performance Award Program, the company may reward associates for exceptional job performance by awarding shares of Stock to them.

We believe that the Plan is not subject to any provisions of the Employee Retirement Income Security Act of 1974, as amended. The Plan is not qualified under Section 401(a) or 423 of the Internal Revenue Code of 1986, as amended.

Plan administration; account management

The Plan provides that the Global Compensation Committee of our Board of Directors (the “Committee”) has the overall authority for administering the Plan. The Committee may delegate (and revoke the delegation of) some or all aspects of Plan administration to the officers or managers of the company or of a wholly-owned or majority-owned subsidiary of the company (which subsidiaries are referred to in this Prospectus as “affiliates”), subject to terms as it deems appropriate. The members of the Committee are selected by Walmart’s Board of Directors. The Board of Directors may remove a member from the Committee at its discretion, and a member will cease to be a Committee member if he or she ceases to be a director of Walmart for any reason. At the date of this Prospectus, the members of the Committee were Mr. C. Douglas McMillon, our President and Chief Executive Officer of the company; Mr. Gregory B. Penner, the Chairman of our Board of Directors and Mr. S. Robson Walton. Mr. Walton is the beneficial owner of in excess of 51% of the outstanding shares of the Stock, including the shares of Stock that constitute approximately 45% of the outstanding shares of the Stock that are owned by Walton Enterprises, LLC, of which Mr. Walton is a managing member. Mr. Penner is the son-in-law of Mr. Walton.

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

The Committee, as administrator of the Plan, or its delegate, must follow the terms of the Plan, but otherwise has full power and discretion to administer the Plan, including, but not limited to the power to: (i) determine when, to whom and in what types and amounts contributions should be made; (ii) authorize the company to make contributions

to eligible associates in any number and to determine the terms and conditions applicable to each such contribution; (iii) set a minimum and maximum dollar, share or other limitation on the various contributions permitted under the Plan; (iv) determine whether an entity of which we own more than 50% or otherwise control, directly or indirectly (“an affiliate”) should become (or cease to be) a Participating Employer (as defined below); (v) determine whether (and which) associates of non-U.S. Participating Employers should be eligible to participate in the Plan; (vi) make all determinations deemed necessary or advisable for the administration of the Plan; (vii) make, amend, waive and rescind rules and regulations for the administration of the Plan; and (viii) exercise any powers, perform any acts and make any determinations it deems necessary or advisable to administer the Plan. All decisions made by the Committee under the Plan are final and binding on all persons, including the company and its affiliates, any associate, any person claiming any rights under the Plan from or through any participant, and shareholders of the company. The members of the Committee do not act as the trustees of the participants or hold the Stock credited to the participants’ Plan accounts, any funds contributed to the Plan by any associate or the proceeds of any sale of shares of Stock in trust for the benefit of the participants.

Plan participation and eligibility

If you are eligible to participate in the Plan, you can become a participant in the Plan by enrolling online (where available) on the [WIRE](#), [WalmartOne.com/ASPP](#) or [Workday](#), to authorize payroll deductions to be taken from your regular compensation and contributed to the Plan for the purchase of Stock to be held in your Plan account. You can also become a participant in the Plan if the Committee grants you an award of Stock under the Outstanding Performance Award Program.

All associates of the company and approved affiliates of the company (“Participating Employers”) are eligible to participate in the Plan, except:

- If you are restricted or prohibited from participating in the Plan under the law of your state or country of residence, you may not participate in the Plan or your participation in the Plan may be limited. It is your responsibility to ensure there are no such restrictions or prohibitions on your participation in the Plan.
- You must have attained the age of majority in your state of residence or employment to participate. It is your responsibility to ensure you are of sufficient age to participate. The company may terminate your participation if it discovers you are not of legally sufficient age to participate in the Plan.

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- If you are a member of a collective bargaining unit whose benefits were the subject of good faith collective bargaining, you are excluded from participation in the Plan.
- If your employer is a non-U.S. Participating Employer, you may participate only if you are an approved associate (listed by group, category or by individual).
- If you are an officer of Walmart subject to subsection 16(a) of the Securities Exchange Act of 1934, or otherwise subject to our Insider Trading Policy, your ability to acquire or sell shares of Stock may be restricted.

If you are on a bona fide leave of absence from the company or a Participating Employer, you will continue to be eligible to make contributions to the Plan during your leave of absence, but you will not be eligible for company matching contributions during that time. If you are on a military leave of absence from the company or a Participating Employer, please contact the Benefits Department to see whether you are eligible to receive company matching contributions during your leave. Please note that you must make contributions from your own funds if you are not receiving a paycheck while you are on a leave of absence, as payroll deduction would not be available as an option. Any other circumstances which would permit you to continue to participate in the Plan while on a leave must be approved by the Committee.

Plan contributions – Stock Purchase Program

To make payroll deduction contributions, you need to complete an online benefits enrollment session on the [WIRE](#), [WalmartOne.com/ASPP](#) or [Workday](#). Once you have properly enrolled in the Plan, your payroll deduction contributions will continue in accordance with your most recent payroll deduction authorization (subject to any restrictions imposed by the Plan) as long as you are employed by the company or a Participating Employer, unless you change or terminate your payroll deduction authorization or the Plan itself is terminated.

Please note that no deduction will be drawn from any paycheck in which your payroll deduction contribution exceeds your net pay after taxes are withheld. You can change or terminate your payroll deduction authorization by completing an online benefits enrollment session

on the [WIRE](#), [WalmartOne.com/ASPP](#) or [Workday](#). Your request will be processed as soon as practicable. Your enrollment or request may be delayed or rejected if your enrollment or requested change is prohibited at the time of the attempted enrollment or the request by any company policy, including the company's Insider Trading Policy.

Note that payroll deduction contributions are generally taken from your last paycheck as an associate. If you do not want to have payroll deduction contributions taken from your last paycheck, it is important that you timely terminate your payroll deduction authorization. If you work in a state that requires your last paycheck to be paid outside of the normal payroll cycle, payroll deduction contributions will not be taken out of your last paycheck.

Payroll deductions can be as little as \$2 or as much as \$1,000 per biweekly payroll period. Payroll deductions for associates paid on a weekly basis can be as little as \$1 or as much as \$500 per weekly payroll period. The amount of any biweekly or weekly deduction in excess of the minimum must be in multiples of \$0.50. The Company or your Participating Employer will make a matching cash contribution on your behalf to your Plan account when you make contributions to the Plan by payroll deduction. The matching contribution is currently 15 percent of the first \$1,800 you contribute to the Plan by payroll deduction, or up to \$270 per Plan year. The company's matching contribution will be used to buy Stock for your Plan account.

If you participate or have participated in payroll deductions under the Plan and your Plan account has not been closed as described below, you can also voluntarily contribute cash (in U.S. dollars) from your other resources to fund the purchase of Stock under the Plan to be held in your Plan account, including after your employment with the Company or any Participating Employer has been terminated. Any voluntary contributions must be made directly to Computershare. Instructions for making such voluntary contributions are available from Computershare. Neither the Company nor your Participating Employer will make matching contributions on amounts you contribute directly to Computershare. In addition, you may also deposit shares of Stock that you hold outside of the Plan (whether you originally acquired those shares through the Plan or otherwise) to your Plan account by making arrangements directly with Computershare.

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The total of your payroll deductions and voluntary cash contributions to the Plan cannot exceed \$125,000 per Plan year (April 1 through March 31). Dividends credited to your Plan account will not count against the maximum.

The Committee establishes and may change the maximum and minimum contributions, may change the conditions for voluntary cash or Stock contributions, and may change the amount of the matching contributions of an employer at any time.

OUTSTANDING PERFORMANCE AWARD PROGRAM

Under the Outstanding Performance Award component, you can be granted an award of Stock for demonstrating consistently outstanding performance in your job over the period of a month, a quarter or a year. The Committee approves all Outstanding Performance Awards and sets maximum dollar limitations on these awards from time to time.

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

STOCK PURCHASES

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

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

Typically, when Computershare purchases Stock for the Plan on a national stock exchange, the shares are purchased as part of a bundled group rather than individually for each participant. In some instances, the shares of Stock for a bundled group must be purchased for the Plan over more than one day. When shares of Stock are purchased for you as part of a bundled group, your purchase price for each share of Stock will be equal to the average price of all

shares of Stock purchased for that group as determined by Computershare. A participant is not permitted to direct an order for Computershare to purchase shares of Stock solely for himself or herself that are part of the bundled group.

If Computershare buys shares of Stock from the company, whether authorized but unissued shares or treasury shares, the per-share price paid to the company for those shares of Stock will be equal to the Volume Weighted Average Price (VWAP) as reported on the New York Stock Exchange – Composite Transactions on the date of purchase. The VWAP is the weighted average of the prices at which all trades of the company's Stock are made on the NYSE on the date the Stock is purchased from the company. While the Plan permits the Committee to designate another methodology for valuing Stock purchased from the company, as of the date of this Prospectus no other methodology has been designated.

The number of shares allocated to your Plan account in connection with any purchase of Stock will equal the total amount of the contributions and dividends available for your Plan account and used to fund such purchases, divided by the purchase price for each share of Stock attributable to those purchases as discussed above.

Non-U.S. Participants Please Note: All amounts contributed to the Plan by payroll deduction, all matching contributions, and any contributions made pursuant to the Outstanding Performance Award component will be converted from your local currency to U.S. dollars prior to the time the shares of Stock are purchased. The exchange rate will be the exchange rate published in *The Wall Street Journal* (or other similar source) on a date as soon as practicable prior to the date the cash is sent to Computershare. Generally, the exchange rate used is the one for the business day immediately prior to the day the funds are sent to Computershare, but that may not be practicable in all circumstances. All voluntary cash contributions must be converted to U.S. dollars before being sent to Computershare to purchase shares of Stock.

Stock ownership, fees and risks

STOCK OWNERSHIP

From the time that shares of Stock are credited to your Plan account, you will have full ownership of those shares (including any fractional shares) of Stock. The shares of Stock held in your Plan account will be registered in Computershare's name until you request to have your Stock certificates delivered to you from the Plan account or you sell the shares credited to your Plan account. You may not

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assign or transfer any interest in the Plan before shares are credited to your account. However, you may sell, transfer, assign or otherwise deal with your shares of Stock credited to your Plan account once they are credited to your Plan account, just like any other stockholder of the company. You may not transfer or assign your Plan account to another person who is not an eligible participant in the Plan. There is no automatic lien or security interest on the shares of Stock held in your Plan account, and the terms of the Plan do not provide for anyone to have or to have the ability to create a lien on any funds or shares of Stock credited to your Plan account. However, you may pledge, hypothecate or deal with the shares of Stock credited to your Plan accounts in the same manner as you may do with other shares of Stock you may own, subject to compliance with our Insider Trading Policy. If you pledge shares of Stock credited to your Plan account to secure a loan, the lender will have a security interest in the shares of Stock held in your Plan account. Neither Walmart nor any Participating Employer is a sponsor of or will be responsible for any amounts owed by a participant. If you fail to repay the amounts you owe to the lender for your loan, including the accrued interest and any fees thereon, the lender may foreclose its lien on, and sell, the number of shares pledged to secure the loan that will yield net sales proceeds in an amount necessary to pay the amounts you owe the lender. If the net proceeds from such a sale of shares are less than the amount you owe the lender, you, and not Walmart or a Participating Employer, will be responsible for paying the deficiency from your other resources.

DIVIDENDS AND VOTING

Dividends on shares in your account will be automatically reinvested in additional shares of Stock. You will be able to direct the vote on each full share of Stock held in your Plan account, but not fractional shares. You will receive at no cost and as promptly as practicable (by mail or otherwise) all notices of meetings, proxy statements, notices of internet availability of proxy materials and other materials distributed by the company to its stockholders. To vote the shares of Stock held in your Plan account, you must deliver signed voting instructions, also known as proxy instructions, in a timely manner described in the company's proxy materials. If you do not provide properly completed and executed voting instructions as described in the company's proxy materials, your shares will not be voted with respect to any election of directors, any advisory vote on executive compensation, or many other matters that may be subject to a shareholder vote. However, in those circumstances, your shares of Stock may be voted in the manner recommended by the company in its proxy statement or as directed by the Committee on matters defined by the New York Stock Exchange as "routine," such as the ratification of

the appointment of the company's independent auditors, provided that doing so would comply with applicable law and any applicable listing standard of a national stock exchange.

FEES AND ACCOUNT STATEMENTS

The company pays all fees associated with the purchase of Stock. Generally, no maintenance fees or other charges will be assessed to your Plan account as long as you are employed by the company or one of its affiliates (even if that affiliate is not a Participating Employer). However, you must pay any commissions or charges resulting from other Computershare services you request, for example, brokerage commissions and other fees applicable to the sale of Stock. Computershare can tell you if a particular request would cause you to incur a charge. The fees charged by Computershare described in this Prospectus are subject to change from time to time.

At least annually, you will receive a statement of your account under the Plan, reflecting all activity with respect to your Plan account for the period of time covered by the statement. You may elect to receive your statements online. If you elect to do so, you will receive an email informing you that your statement is ready and can be found on computershare.com/walmart. Your annual statement will also contain important tax information. It is very important that you keep your statement so that you will know the difference between your purchase price and sales price of any shares of Stock you sell. You will need this information for your income taxes.

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

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

RISKS

Many of your risks of Plan participation are the same as those of any other stockholder of the company, in that you assume the risk that the value of the Stock may increase or decrease. There are no guarantees as to the value of a share of Stock. This means that you assume the risk of fluctuations in the value or market price of the Stock. Our latest Annual Report on Form 10-K filed with the SEC and, as noted below, incorporated by reference in this Prospectus, discusses, and other of our reports filed with the SEC may discuss, certain risks relating to the company,

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its operations and financial performance that can affect the value, market price and liquidity of the Stock. The company urges you to review those discussions in connection with any determination to participate in the Plan, to change the terms of your participation in the Plan, to terminate your participation in the Plan or to make any voluntary contributions under the Plan.

If you are a non-U.S. participant, you also assume the risk of fluctuation in currency exchange rates. Also, until your payroll deductions (as well as the corresponding matching contributions) are applied by Computershare to purchase shares of Stock, such funds are considered general assets of the company or the Participating Employer and, as such, are subject to the claims of the company's or Participating Employer's creditors. No interest will be paid on any contributions to the Plan.

Stock certificate delivery and Stock sales

Computershare will send you, on request, a stock certificate representing any or all full shares of Stock credited to your Plan account at no cost to you. Your shares that are represented by a stock certificate will no longer be credited or otherwise related to any Plan account that you continue to have in effect and the dividends paid on those shares will not be reinvested under the Plan.

You may also have Computershare transfer any or all of the shares of Stock credited to your Plan account into your name in the Direct Registration System. Such a transfer means that you would hold your shares as "book-entry" securities and your ownership would be shown on our stock transfer records and represented by a statement which shows your holdings of shares of Stock.

You may request that Computershare sell all or a portion of the shares of Stock (including any fractional interests) credited to your Plan account at any time, whether or not you want to close your Plan account.

You will be charged a brokerage commission, as well as any other applicable fees, if for any reason you have Computershare sell shares of Stock held in your Plan account. Any brokerage commission or fees will be at the rates posted by Computershare from time to time. These rates are available upon request from Computershare. A current schedule of Computershare's fees applicable to the Plan can be found at computershare.com/walmart. The company negotiated the amount of such fees with Computershare.

If you choose to sell your Stock, your Stock will be sold pursuant to a market order. Although the Plan permits sales of shares of Stock held in Plan accounts to be made through

batch orders and such sales have been made through batch orders in the past, sales of shares of Stock under the Plan are now made solely pursuant to market orders. As a result, if you direct Computershare to sell any shares of Stock credited to your Plan account, Computershare will sell those shares in the open market at the then current best available price. However, the price at which your order will be executed is not guaranteed, and the last-traded price for the Stock prior to the execution of your order to sell your shares of Stock is not necessarily the price at which your order will be executed. From time to time, we repurchase shares of Stock in the open market under a stock repurchase program adopted by our Board of Directors. As a result, if Computershare sells shares credited to your Plan account in the open market, we could be the purchaser of such shares. However, we will typically not know if any of the shares of Stock we purchase in the open market are purchased from you. Your shares of Stock will be sold as soon as your request can reasonably be processed. Generally, market orders are executed immediately after they are placed. We expect that any sales of your shares of Stock will be executed over the New York Stock Exchange (the "NYSE"), but orders for those sales need not be executed over the NYSE. If the NYSE is closed when your order is ready to be processed, your sale transaction will be processed as early as practicable on the next NYSE trading day. Orders for the sale of shares of Stock under the Plan may be executed by or through an affiliate of Computershare that is registered with the SEC as a broker-dealer under the Securities Exchange Act of 1934.

Sales of the Stock will be made in U.S. dollars. If you are employed outside the U.S. by a Participating Employer and if provided by Computershare for your country, the proceeds from the sale may be converted for a fee to another currency if you request it when you request your Stock to be sold. If the proceeds are converted to another currency, the exchange rate that will be used is the exchange rate published in *The Wall Street Journal* (or other similar source) on the date your sale transaction is executed. You will assume the risk of any fluctuations in currency exchange rates.

Termination of participation; account closure

Once you become a participant in the Plan, you will remain a participant until you elect to close your Plan account and all Stock and sale proceeds credited to it have been distributed out of your Plan account, or until all Stock and sale proceeds have been distributed from your Plan account after your employment with the company or one of its affiliates has terminated.

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If you terminate your payroll deduction authorization, or your employment with the company and all its affiliates has terminated, you may choose to continue your Plan account; or you may close your Plan account if you specify this to Computershare. Specifically:

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

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

To add or remove a joint tenant to or from your account, call Computershare at **800-438-6278**.

Plan amendment and termination

The Plan has no set expiration date. The Board of Directors of the company, the Committee or any other duly appointed committee of the Board of Directors may amend or terminate the Plan at any time. However, if stockholder approval of an amendment is required under law or the applicable rules of a national stock exchange, the amendment will be subject to that approval. No amendment or termination of the Plan will cause you to forfeit: (1) any funds you have contributed to the Plan or matching funds the company has contributed that have not yet been used to purchase shares of Stock; (2) any shares (or fractional shares) of Stock credited to your Plan account; or (3) any dividends or distributions declared with respect to the Stock after you have made a contribution to the Plan but before the effective date of the amendment or termination.

Tax information

The following summary of the U. S. income tax consequences of the Plan is based on the Internal Revenue Code and any regulations thereunder as in effect as of the date of this Prospectus. The summary does not cover any state or local income taxes or taxes in jurisdictions other than the United States. You should consult your tax advisor regarding individual tax consequences before purchasing Stock under the Plan.

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STOCK PURCHASES UNDER THE STOCK PURCHASE PLAN

You have no federal income tax consequences when you enroll in the Plan or when shares of Stock are purchased for you under the Stock Purchase Plan either by payroll deduction or voluntary contribution. The amount of your payroll deductions and any voluntary contributions under the Plan are not deductible for purposes of determining your federal taxable income. The amount of your wages that you have deducted under the Plan and the full value of company matching contributions are ordinary income to you in the calendar year of deduction or the contribution, as the case may be, and will be reported on your pay stub and your W-2. The company deducts all applicable wage withholding and other required taxes from your other compensation (by increasing your payroll withholding and other tax deductions for such purposes) with respect to the amount of your wages deducted under the Plan and the matching contributions to your Plan account, if any. The company is entitled to a tax deduction for the amount of the matching contribution in the same year as you realize the income.

OUTSTANDING PERFORMANCE AWARDS UNDER THE OUTSTANDING PERFORMANCE AWARD PROGRAM

Stock grants under the Outstanding Performance Award Program are taxable as ordinary income in the calendar year of the award, regardless of whether the Stock certificates are given directly to you or the Stock is awarded to your Plan account. Your ordinary income will be the market value of a share of Stock on the date the award is granted, times the number of shares of Stock granted. The market value of any Stock awarded will be reported to you on your W-2. The company will deduct applicable wage withholding and other required taxes from your other compensation (by increasing your payroll deduction for such purposes). The company is entitled to a tax deduction in the same amount and in the same year as you realize the ordinary income.

STOCK SALES OR CERTIFICATE DISTRIBUTIONS

You will not recognize any taxable income when you request to have certificates delivered to you for some or all of the shares of Stock held in your Plan account. However, when you sell or otherwise dispose of your shares of Stock — whether through Computershare or later after you have received your Stock certificates — the difference between the fair market value of the Stock at the time of sale and the fair market value of the Stock on the date you acquired it will be taxed as a capital gain or loss. The holding period to determine whether the capital gain or loss is long-term or short-term will begin on the date you acquire the Stock (i.e., the date the Stock is credited to your Plan account). The company will have no deduction as a result of your disposition of shares of Stock and will not be liable for the payment of any income or other taxes payable by you on any gain you may realize on the sale of the shares of Stock or imposed on or in connection with the sale transaction.

Available information

To obtain additional information about the Plan or its administrators, please call People Services at 800-421-1362. You can also write to:

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

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

Computershare
Attn: Wal-Mart ASPP
P.O. Box 43080
Providence, Rhode Island 02940-3080

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Electronic delivery of prospectuses and other documents

To help reduce costs of operating the Plan and to help with our sustainability efforts, we ask you to allow us to deliver prospectuses and other documents related to the Plan electronically and that you access the prospectuses and documents we provide to participants in the Plan over WalmartOne.com. Your enrollment in the Plan will constitute your consent to receive or access communications from us about the Plan and prospectuses relating to the purchase of shares of Stock under the Plan electronically through access on WalmartOne.com, unless you affirmatively elect to receive paper copies of such communications. At any time after enrollment you may revoke that consent by sending a written revocation of the consent to receive Plan documents electronically to the Benefits Department at the address appearing below. In addition, you may request a paper copy of the then current prospectus relating to purchases of shares of Stock under the Plan and of our most recent Annual Report on Form 10-K by writing the Benefits Department and those documents will be provided to you free of charge.

Documents incorporated by reference

The following documents filed by the company with the Securities and Exchange Commission (the “Commission”) (File No. 1-6991) are hereby incorporated by reference in and made a part of this Prospectus:

- The company’s Annual Report on Form 10-K for the fiscal year ended January 31, 2016;
- The company’s Quarterly Reports on Form 10-Q for the fiscal quarters ended April 30, 2016, and July 31, 2016;
- The company’s Current Reports on Form 8-K filed with the Commission on June 7, 2016, and June 20, 2016
- The company’s definitive Proxy Statement for the 2016 Annual Shareholders’ Meeting, filed with the Commission on April 20, 2016, and
- Exhibit 99.1 to the Company’s Registration Statement on Form S-8 (File No. 333-214060).

All documents filed by the company pursuant to Sections 13(a), 13(c), 14 and 15(d) of the Securities Exchange Act of 1934 (the “Exchange Act”) on or after the date of this Prospectus shall be deemed to be incorporated by reference in this Prospectus and to be a part hereof from the date of filing of such documents, except for information furnished to the Commission that is not deemed to be “filed” for purposes of the Exchange Act (such documents, and the documents listed above, being hereinafter referred to as “Incorporated Documents”). Any statement contained in an Incorporated Document shall be deemed to be modified or superseded for purposes of this Prospectus to the extent that a statement contained herein or in any other subsequently filed Incorporated Document modifies or supersedes such statement. Any such statement so modified or superseded shall not be deemed, except as so modified or superseded, to constitute a part of the Section 10(a) prospectus of the company relating to purchases under the Plan of the shares of Stock described on the cover page of this Prospectus. This document and the documents incorporated by reference herein constitute such Section 10(a) prospectus.

These documents and the company’s latest Annual Report to Stockholders and any other documents required to be delivered to you under Rule 428(b) under the Securities Act of 1933, as amended, are available to you without charge upon written or oral request. Please direct your requests for documents to:

**Wal-Mart Stores, Inc.
Benefits Department
508 SW 8th Street
Bentonville, Arkansas 72716-0295**

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

The Walmart 401(k) Plan

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The legal name of the Plan is the Walmart 401(k) Plan. This document is being provided solely by your employer. No affiliate of Bank of America Corporation has reviewed or participated in the creation of the information contained herein.

The Walmart 401(k) Plan

THE WALMART 401(k) PLAN RESOURCES

Find What You Need	Online	Other Resources
Enroll in or change your 401(k) contribution and your catch-up contribution	Go to the WIRE , WalmartOne.com , Workday or the Plan's website at benefits.ml.com	Call the Customer Service Center at 888-968-4015
<ul style="list-style-type: none"> Request a rollover packet to make a rollover contribution Get a fee disclosure sheet Get information about your Plan accounts Get a copy of your quarterly statement Request a hardship withdrawal or a withdrawal after you reach age 59½ Change your investment fund choices Request a payout when you leave Walmart Get information about your Plan investment options Request a withdrawal of your rollover contributions Request a loan from your Plan account 	Go to benefits.ml.com	Call the Customer Service Center at 888-968-4015
<ul style="list-style-type: none"> Designate a beneficiary 	Go to the WIRE , or WalmartOne.com or Workday	

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

- You are eligible to make your own contributions to the Plan as soon as administratively feasible after your date of hire is entered into the payroll system. You can contribute from 1% to 50% of your eligible pay each pay period.
- You will begin receiving matching contributions on the first day of the calendar month following your first anniversary of employment with Walmart if you are credited with at least 1,000 hours of service during your first year and you are contributing to your 401(k) Account. (Matching contributions will not be made with respect to contributions you make before you become eligible for matching contributions.)
- The matching contribution will be a dollar-for-dollar match on each dollar you contribute to the Plan after you become eligible for matching contributions, up to 6% of your eligible annual pay.
- You will always be 100% vested in the money you contribute to your 401(k) Account and the money Walmart contributes to your Company Match Account.
- You choose how to invest all contributions to your Plan account.
- If you do not choose how your current contributions to the Plan will be invested, they will be automatically invested in the Plan's default investment option, currently the myRetirement Funds.
- You pay no federal income tax on contributions or any investment earnings until you receive a payout from the Plan.
- You can access and monitor your account any time at [benefits.ml.com](#).
- You can withdraw your rollover contributions at any time.
- You may also request a loan from your Plan account. Loans are subject to certain requirements outlined later in this summary.

This is a summary of benefits offered under the Plan as of October 1, 2017. Should any questions ever arise about the nature and extent of your benefits, the formal language of the Plan document, not the informal wording of this summary, will govern.

Walmart 401(k) Plan eligibility

ASSOCIATES WHO ARE ELIGIBLE TO PARTICIPATE IN THE PLAN

All associates of Wal-Mart Stores, Inc. or a participating subsidiary are eligible to participate in the Plan, except:

- Leased employees; nonresident aliens with no income from U.S. sources; independent contractors or consultants
- Anyone not treated as an employee of Walmart or its participating subsidiaries
- Associates covered by a collective bargaining agreement, to the extent that the agreement does not provide for participation in this Plan
- Associates represented by a collective bargaining representative after Walmart has negotiated in good faith to impasse with the representative on the question of benefits, and
- Certain other associates who may be jointly employed by Walmart and a subsidiary that is not a participating subsidiary in the Plan.

For purposes of this Summary Plan Description, all participating subsidiaries are referred to as “Walmart.”

WHEN PARTICIPATION FOR PURPOSES OF YOUR CONTRIBUTIONS BEGINS

Eligible associates may begin making their own contributions to the Plan as soon as administratively feasible after their date of hire is entered into the payroll system.

To begin making contributions to the Plan, you can enroll on [WalmartOne.com](https://www.walmart.com), the [WIRE](#), [Workday](#), or through benefits.ml.com (see [Enrolling in the Plan](#) later in this summary).

WHEN PARTICIPATION FOR PURPOSES OF MATCHING CONTRIBUTION BEGINS

If you are an eligible associate, you will begin receiving matching contributions on the first day of the calendar month following your first anniversary of employment with Walmart if you are credited with at least 1,000 hours of service during the first year and are contributing to your 401(k) Account. (Matching contributions will not be made with respect to contributions you make before you become eligible for matching contributions.) For example, if your date of hire was December 15, 2017, and you are credited with 1,095 hours by December 15, 2018 (your first anniversary), then you will begin receiving matching contributions on January 1, 2019, with respect to any contributions you make to the Plan on or after that date. As an additional example, if your date of hire was December 1, 2017, and you are credited with 1,095 hours

by December 1, 2018 (your first anniversary), then you will begin receiving matching contributions on January 1, 2019 with respect to any contributions you make to the Plan on or after that date.

If you are not credited with 1,000 hours of service during that first year, your eligibility for the matching contributions will be determined on hours worked during the Plan year, which runs from February 1 to January 31. You will be eligible to receive matching contributions on any contributions you make to the Plan on or after the February 1 that follows the Plan year in which you are credited with at least 1,000 hours of service. For example, if your date of hire is December 15, 2017, and you are credited with only 595 hours by December 15, 2018 (your first anniversary), but you work 1,095 hours during the February 1, 2018–January 31, 2019 Plan year, you will begin receiving matching contributions on February 1, 2019 with respect to any contributions you make to the Plan on or after that date.

HOW HOURS OF SERVICE ARE CREDITED UNDER THE PLAN

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

- Hours, including overtime hours, worked by hourly associates for Walmart or any subsidiary are counted.
- Hours for which an associate receives paid leave or personal time off are also counted.
- When a payroll period overlaps two Plan years, hours are credited toward the Plan year in which they are actually worked. However, before February 1, 2015, hours for a payroll period that overlapped Plan years were prorated between the two years.

For salaried associates and truck drivers, the hours counted toward the 1,000-hour requirement are credited as follows:

- Salaried associates and truck drivers are credited with 190 hours per month for each month in which they work at least one hour for Walmart or a subsidiary.
- In general, you must work at least six months of the Plan year to have 1,000 hours credited for the year. (Vacation pay after you leave Walmart will not give you an additional 190 hours of credit.)

If you become an associate of Walmart or any subsidiary as the result of the acquisition of your prior employer, special service crediting rules may apply to you.

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), veterans who return to Walmart or a subsidiary after a qualifying deployment may be eligible to have their qualified military service considered toward their hours of service under the Plan. If you think you may be affected by this rule, call People Services at **800-421-1362** for more details.

Enrolling in the Plan

Shortly after you become eligible to contribute to the Plan, (i.e., shortly after your date of hire), you will receive an enrollment packet at your home address on file. This packet tells you how you can make contributions from your pay on a pretax basis into your 401(k) Account and explains how you can direct the investment of your Plan funds by choosing from among a menu of investment options with varying investment objectives and associated risks. Because the Plan is intended to be an important source for your financial security at retirement, you should read all information pertaining to the Plan carefully, and consult with your family, tax and financial advisors before making any decisions.

Once you satisfy the matching contribution eligibility requirements, Walmart will match all of your subsequent contributions dollar-for-dollar up to 6% of eligible annual pay, as explained in the [Walmart's contributions to your Company Match Account](#) section.

To begin making contributions to the Plan, you can enroll online at [WalmartOne.com](#), the [WIRE](#), [Workday](#), or [benefits.ml.com](#). You can also call the Customer Service Center at **888-968-4015**. You can enroll at any time after you become eligible.

When you enroll, you can choose:

- The percentage of your pay that you want to contribute on a per-pay-period basis (see [Making contributions to your 401\(k\) Account](#) later in this summary), and
- How to invest your accounts among the Plan's investment options. The Plan's investment options and procedures are described in the enrollment packet.

After you enroll, a confirmation notice will be mailed to your home address, or, if you have chosen electronic delivery of Plan materials, you will receive an email notification when the confirmation is available. The confirmation will show the percentage of your pay that you have chosen to contribute from each check and the investment option(s) you have elected. You should review the confirmation to make sure your enrollment information is correct.

Your contributions to the Plan will be effective as soon as administratively feasible, normally within two pay periods. No contributions will be taken from your pay before you become an eligible participant in the Plan. Only participants who elect to contribute their own funds to the Plan will have those contributions matched by the Company (after they meet the eligibility requirements for matching contributions, as explained in the [Walmart's contributions to your Company Match Account](#) section).

It is your responsibility to review your paychecks to confirm that your election was implemented. If you believe your election was not implemented, you must promptly notify the Customer Service Center at **888-968-4015**, but in no event later than six months after your election, for corrective steps to be taken.

Your Walmart 401(k) Plan accounts

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

- **401(k) Account:** This account holds your contributions to the Plan (including your catch-up contributions, if any), as adjusted for earnings or losses on those contributions.
- **Company Match Account:** This account holds Walmart's matching contributions, as adjusted for earnings or losses on those contributions.
- **401(k) Rollover Account:** This account holds any contributions that you rolled over to this Plan from another eligible retirement plan, as adjusted for earnings or losses on those contributions.
- **Company Funded 401(k) Account:** This account holds the discretionary Company contributions to the 401(k) portion of the Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.
- **Company Funded Profit Sharing Account:** This account holds the discretionary Company contributions to the profit-sharing portion of the Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.

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

Making a rollover from a previous employer's plan or IRA

When you come to work for Walmart, you may have pretax funds owed to you from a previous employer's retirement plan (including a 401(k) plan, a profit-sharing plan, a 403(b) plan of a tax-exempt employer or a 457(b) plan of a governmental employer). If so, you may be able to roll over that money to this Plan. You may also roll over pretax funds you have in an Individual Retirement Account (IRA). If you roll over funds to this Plan, you should keep these points in mind:

- Once you roll funds into the Walmart 401(k) Plan, those funds will be subject to the rules of this Plan, including payout rules, and not the rules of your former employer's plan or your IRA
- Your rollover contribution will be placed in your 401(k) Rollover Account and will be 100% vested, and
- You may withdraw all or any portion of your rollover contributions at any time.

If you're interested in making a rollover contribution to the Plan, you should contact the Customer Service Center at **888-968-4015** or go online to [benefits.ml.com](#) to obtain a rollover packet.

Making contributions to your 401(k) Account

After you become a participant in the Plan, you may generally choose to contribute from 1% up to 50% of each paycheck to your 401(k) Account. Your contributions in any calendar year, however, may not exceed a limit set by the IRS. For 2017, the limit is \$18,000. This amount will be increased from time to time by the IRS. You are always 100% vested in all amounts contributed into your 401(k) Account.

The IRS limits the amount of annual compensation that can be taken into account under the Plan for any participant. For 2017, this limit is \$270,000.

Contributions to your 401(k) Account are deducted from your pay before federal income taxes are withheld. This means that you don't pay federal income taxes on amounts

you contribute to the Plan. Earnings on these contributions continue to accumulate tax-free and are not taxed until your 401(k) Account is actually distributed to you from the Plan. You may also save on state and local taxes as well, depending on your location. Please note that your contributions are subject to Social Security taxes in the year the amount is deducted from your pay. Distributions from the Plan, however, are not subject to Social Security taxes.

In addition, if you contribute your own pay to your 401(k) Account, you may be eligible for a "Saver's Credit." If you are a married taxpayer who files a joint tax return with a modified adjusted gross income (MAGI) of \$62,000 or less (for 2017) or a single taxpayer with \$31,000 or less (for 2017) in MAGI on your tax return, you are eligible for this tax credit, which can reduce your taxes. For more details, your tax preparer may refer to IRS Announcement 2001-106.

PROFIT SHARING AND 401(k) ACCOUNT DIFFERENCES

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

HOW YOUR 401(k) CONTRIBUTION IS DETERMINED

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

- Regular salary or wages, including bonuses and any pretax dollars you use for your 401(k) contributions or to purchase benefits available under Wal-Mart Stores, Inc. Associates' Health and Welfare Plan
- Overtime, paid time off (used and paid out), bereavement, jury duty and premium pay
- Most incentive plan payments
- Holiday bonuses
- Special recognition awards, such as the Outstanding Performance Award
- Differential wage payments you receive from Walmart while you are on a qualified military leave. This means that the contribution you have in effect when you go on the leave will continue to be applied to your differential wage payments while you are on the leave unless you change your election, and
- Effective February 1, 2018, transition pay designated as relating to a WARN Act event.

The percentage of pay you elect to contribute to the Plan will not be applied to the following types of pay:

- The 15% Walmart match on the Associate Stock Purchase Plan
- Reimbursement for expenses like relocation
- Approved disability pay
- Equity income, including income from stock options or restricted stock rights, or A final paycheck upon your termination of employment that is paid prior to the end of a normal pay cycle (unless it is administratively practicable to withhold your contribution from that paycheck).

CHANGING YOUR 401(k) CONTRIBUTION AMOUNT

You can increase, decrease, stop, or begin your contributions at any time by logging on to WalmartOne.com, the WIRE, Workday or benefits.ml.com. You may also call the Customer Service Center at **888-968-4015**. Your change will be effective as soon as administratively feasible, normally within two pay periods. If you change your contribution amount, a confirmation notice will be sent to your home address or, if you have chosen electronic delivery of Plan documents, you will receive an email notification when the confirmation is available. It is your responsibility to review your paychecks to confirm that your election was implemented. If you believe your election was not implemented, you must notify the Customer Service Center at **888-968-4015** in a timely manner, so that corrective steps can be taken. Your notification will

not be considered timely if it is more than six months after the date your election is made. If you do not notify the Customer Service Center in a timely manner, the amount that is being withheld from your paycheck will be treated as your deferral election.

IF YOU ARE AGE 50 OR OLDER (CATCH-UP CONTRIBUTIONS)

If you are age 50 or older (or will be age 50 by the end of the applicable calendar year) and you are contributing up to the Plan or legal limits, you are allowed to make additional contributions. These are called catch-up contributions and are made by payroll deduction just like your normal contributions. For 2017, your catch-up contributions may be any amount up to the lesser of \$6,000 or 75% of your eligible annual pay. This amount may be adjusted from time to time by the IRS. Your catch-up contributions will be credited to your 401(k) Account.

For example, if you elect to contribute the maximum amount of \$18,000 in the 2017 calendar year, or if you elect to contribute the maximum percentage of your eligible annual pay allowed under the Plan, you could elect to contribute up to an additional \$6,000 during the 2017 calendar year. If you are interested in making catch-up contributions, you can enroll online at WalmartOne.com, the WIRE, Workday or benefits.ml.com, or by calling the Customer Service Center at **888-968-4015**.

CONTRIBUTING TO MORE THAN ONE PLAN DURING THE YEAR

The total amount you can contribute to this Plan and to any other employer plan (including 403(b) annuity plans, simplified employee pensions or other 401(k) plans) is \$18,000 for the 2017 calendar year, or \$24,000 if you are eligible for catch-up contributions. This amount may be increased from time to time by the IRS. If you contribute to more than one plan during the year, it is your responsibility to determine if you have exceeded the legal limit.

If your total contributions go over the legal limit for a calendar year, you should request that the excess amount be refunded to you. The excess amount must be included in your income for that year and will be taxed. In addition, if the excess amount is not refunded to you by April 15 following the year the amount was deferred, you will be taxed a second time when the excess amount is distributed to you. If you wish to request that the excess be returned to you from this Plan, you must contact People Services at **800-421-1362** no later than March 1 following the calendar year in which the excess contributions were made. Any matching contributions related to refunded contributions will be forfeited.

IF YOU HAVE QUALIFIED MILITARY SERVICE

If you missed work because of qualified military service, you may be entitled under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) to make up contributions you missed during your military service (that is, to make contributions equal to the amount you would have been eligible to make if you were working for Walmart).

Because you will only have a certain period of time after you return to work to make these contributions (generally three times the period of military service, up to five years), you should contact People Services at **800-421-1362** if you think you may be affected by these rules.

Walmart's contributions to your Company Match Account

As explained above, you are eligible to receive matching contributions on the first day of the calendar month following your first anniversary of employment with Walmart if you are credited with at least 1,000 hours of service during the that year. Once you have satisfied these requirements, Walmart will make matching contributions to your Company Match Account equal to 100% of your subsequent contributions to your 401(k) Account, including catch-up contributions, up to 6% of your eligible annual pay. Matching contributions will not be made with respect to contributions you make before you become eligible for matching contributions. After you become eligible for matching contributions, the company matching contribution will be made into your Company Match Account each pay period until you reach the full amount of the company matching contribution for which you are eligible for that Plan year. Your eligible annual pay for this purpose is the same as outlined above for determining your 401(k) contributions to the Plan, but does not include amounts paid to you before you become eligible to receive matching contributions.

As previously noted, if you miss work because of qualified military service, you may be entitled under USERRA to make up 401(k) contributions that you missed during your military service. If you do make up any 401(k) contributions, Walmart is required to make up matching contributions you would have received with respect to those contributions. If you think this rule may apply to you, you should contact People Services at **800-421-1362**.

VESTING IN YOUR COMPANY MATCH ACCOUNT

You are always 100% vested in Walmart's matching contributions to your Company Match Account.

VESTING IN YOUR COMPANY FUNDED PROFIT SHARING ACCOUNT

If you have a Company Funded Profit Sharing Account (see [Your Walmart 401\(k\) Plan accounts](#) earlier in this summary), the vested percentage of your Company Funded Profit Sharing Account is the portion that you are entitled to receive if you leave Walmart. Your account statements show your vested percentage.

You become vested in your Company Funded Profit Sharing Account (other than rollovers in that account, which are always 100% vested) depending on your years of service with Walmart as follows:

PROFIT SHARING VESTING SCHEDULE*

Years of Service	Vested percentage
Less than two	0%
Two	20%
Three	40%
Four	60%
Five	80%
Six or more	100%

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

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

A year of service for this purpose is a Plan year (February 1–January 31) in which you are credited with at least 1,000 hours of service under the hours of service rules (see [How hours of service are credited under the Plan](#) earlier in this summary). If you are credited with less than 1,000 hours in a Plan year, your vesting does not increase. (Please note that years of service for this purpose are not determined by your anniversary date.)

If you leave Walmart because of retirement (at age 65 or older) or death, your Company Funded Profit Sharing Account will be 100% vested, regardless of your years of service. Your Company Funded Profit Sharing Account will also be 100% vested if the Plan is ever terminated.

VESTING IN YOUR COMPANY FUNDED 401(k) ACCOUNT

You are always 100% vested in Walmart's contributions to your Company Funded 401(k) Account.

Investing your account

YOUR INVESTMENT OPTIONS

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

- **The myRetirement Funds.** The myRetirement Funds are a series of customized investment options created solely for Plan participants by the Benefits Investment Committee, and are commonly known as “target retirement date” funds. The myRetirement Funds are diversified investment options that automatically change their asset allocation over time to become more conservative as a participant gets closer to retirement. This is done by shifting the amount of money that is invested in more aggressive investments, such as stocks, and allocating those amounts to more conservative investments, such as bonds, as a participant gets closer to retirement. “myRetirement Funds” is a term developed by Walmart for describing these specific Plan investment options.
- **From among a menu of investment options made available under the Plan.** Note that Walmart stock is an investment option only for your Company Funded Profit Sharing Account. Walmart stock is not available for investment through any of your other Plan accounts (although to the extent these other accounts hold Walmart stock, you may always sell such shares, but no future purchases of Walmart stock are allowed).

You may choose one of the investment options or you may spread your money among the various investment options. The investment gains or losses on your accounts will depend upon the performance of the investments you choose.

If you do not make an investment choice for current contributions to your account, they will be invested in one of the myRetirement Funds based on your age. For more information, refer to the Qualified Default Investment Alternative (QDIA) notice and your enrollment packet. These documents can both be obtained by going to benefits.ml.com or by calling the Customer Service Center at 888-968-4015.

Because the Company Funded Profit Sharing Account is an Employee Stock Ownership Plan, for Plan years ending prior to January 31, 2006, all or a significant portion of Walmart’s profit-sharing contribution was invested in Walmart stock. If you were a participant in the Plan prior to that date, you may have Walmart stock in your Company Funded Profit Sharing Account. For Plan years ending January 31, 2007 or later, Walmart’s profit-sharing contribution was not invested in Walmart stock.

A description of all investment options, including the myRetirement Funds, is included in the enrollment packet you receive when you are eligible to enroll. You also may obtain additional information for each investment option by reviewing the Annual Participant Fee Disclosure

Notice. You may obtain a copy free of charge by accessing your account online at benefits.ml.com or by calling the Customer Service Center at 888-968-4015.

Please note that this Plan is intended to be an “ERISA Section 404(c) plan.” This means that you assume all investment risks connected with the investment options you choose in the Plan, or in which your funds are invested if you fail to make investment selections, including the increase or decrease in market value. Walmart Stores, Inc., the Benefits Investment Committee and the trustee are not responsible for losses to your accounts which are the direct and necessary result of investment decisions you make or, if you fail to make an affirmative investment decision, as a result of your accounts being invested in a default fund.

If you have a Company Funded Profit Sharing Account (see [Your Walmart 401\(k\) Plan accounts](#) earlier in this summary) and you choose to invest some or all of your Company Funded Profit Sharing Account in Walmart stock or retain Walmart stock in your other accounts, be aware that since this option is a single stock investment, it generally carries more risk than the options offered through the Plan.

HOW TO OBTAIN MORE INVESTMENT INFORMATION

It is also important to periodically review your investment portfolio, your investment objectives and the investment options under the Plan to help ensure that your investments are in line with your objectives and your risk tolerance. If you would like more sources of information on individual investing and diversification, you may go to the website of the Department of Labor, <http://www.dol.gov/ebsa/investing.html>.

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

CHANGING YOUR INVESTMENT CHOICES

You can change your investment choices at any time online at benefits.ml.com or by calling the Customer Service Center at 888-968-4015. If you make an investment change, a confirmation notice will be sent to your home address or you will receive an email notification when the confirmation is available if you have chosen electronic delivery of your Plan materials. It is your responsibility to make sure your change is made. If you do not receive a confirmation notice or you do not see that your change has been applied, contact the Customer Service Center at 888-968-4015.

If you call the Customer Service Center at 888-968-4015 prior to 3:00 p.m. Eastern time, your investment change generally will be processed on the day you call. Depending on the investment change, there may be up to a three-day settlement period before your funds are invested in your new election.

DIVERSIFICATION

To help you diversify your retirement savings, the Plan offers a variety of investment options with different levels of risk and potential for increase in value. To “diversify” means that you “put your eggs in more than one basket.” To help achieve long-term retirement security, you should give careful consideration to the benefits of a well-balanced and diversified investment portfolio. This strategy can help reduce risk and may provide consistent returns because a decline in the value of one investment may potentially be offset by an increase in the value of another. If you invest more than 20% of your retirement savings in any one stock, such as Walmart stock, or any one industry, your savings may not be properly diversified. Although diversification cannot ensure a profit or protect against loss, it can be an effective strategy to help you manage investment risk.

When deciding how to invest your retirement savings, you should take into account all of your assets, including any retirement savings outside of the Plan. For example, you may own Walmart stock through other means. No single approach is right for everyone because, among other factors, individuals have different financial goals, different time horizons for meeting their goals, and different tolerances for risk. Therefore, you should keep in mind your rights to diversify your Plan account and carefully consider how you choose to invest your Plan account. You can obtain information about your right to diversify your account and all of the investment options available under the Plan by accessing your account online at benefits.ml.com or by calling the Customer Service Center at 888-968-4015. It is also important to periodically review your investment portfolio, your investment objectives and the investment options under the Plan to help ensure that your investments remain appropriate for your retirement goals and your tolerance for investment risk. If you would like more sources on individual investing and diversification, you may go to the website of the Department of Labor, <http://www.dol.gov/ebsa/investing.html>.

More about owning Walmart stock

VOTING

If any of your account is invested in Walmart stock through the Plan, each year you will receive all of the materials generally distributed to the shareholders of Walmart, including an instruction card telling the trustee how you would like the shares in your Plan account to be voted. The materials will be mailed to your home address or sent electronically, based on your online elections.

You can instruct the trustee, through the company’s transfer agent, to vote Walmart stock held in your Plan accounts. This usually occurs in May of each year. Your instructions to the transfer agent and the trustee are

kept confidential at all times. You will send your voting instructions directly to the transfer agent, who will compile the votes and notify the Benefits Investment Committee of the total votes cast. The Benefits Investment Committee will then notify the Plan trustee of the total votes that are to be cast.

If you do not provide instruction to the trustee on how you would like your shares voted, the Benefits Investment Committee will vote those shares at its discretion. If neither you nor the Benefits Investment Committee exercise voting rights, the trustee or an independent fiduciary appointed by the trustee may vote the unvoted shares.

CONFIDENTIALITY

Procedures have been designed to protect the confidentiality of your rights with respect to shares of Walmart stock held under the Plan, including the right to purchase, sell, hold or vote on proxy matters. For example, procedures with the Company’s transfer agent for Walmart stock have been implemented that prevent Wal-Mart Stores, Inc. and the Benefits Investment Committee from finding out how any individual participant or beneficiary voted (except as necessary to comply with securities laws) and from having access to your individual proxy cards or proxy card shareholder comments.

In addition, access to information about your decisions to buy, sell or hold Walmart stock generally is limited to those assisting in the administration of the Plan. The Benefits Investment Committee is responsible for ensuring that these procedures are sufficient to protect the confidentiality of this information and that the procedures are being followed. If the Benefits Investment Committee determines that a situation has potential for undue influence by the Walmart with respect to your rights as shareholder (through your Plan Account), the Benefits Investment Committee will appoint an independent party to perform activities that are necessary to prevent undue influence.

DIVIDENDS ON YOUR WALMART STOCK

If you have Walmart stock in your accounts, your accounts will be credited with any dividends paid by Wal-Mart Stores, Inc. with respect to its stock. Dividends allocated to your 401(k) Account, your Company Funded 401(k) Account or your 401(k) Rollover Account will be automatically reinvested in Walmart stock. Dividends allocated to your Company Funded Profit Sharing Account (and Profit Sharing Rollover Account) will also be reinvested in Walmart stock, except as noted below.

If you are an active participant (excludes beneficiaries and alternate payees, as defined in the [If you get divorced](#) section) with six or more years of service, you have an option to take a cash payout of any dividends paid on Walmart stock held in your Company Funded Profit Sharing Account or

Profit Sharing Rollover Account. Also, if you are a terminated participant who had more than six years of service when you terminated and you continue to maintain your accounts in the Plan after you leave, you will have the option to elect a cash payout of dividends paid on Walmart stock held in your Company Funded Profit Sharing Account or Profit Sharing Rollover Account. If you do not opt for the cash payout, your dividends will be reinvested in Walmart stock.

You may make an election any time by calling the Customer Service Center at **888-968-4015**. Your most recently filed election will apply to all subsequent dividends until you change your election. (You may change your election only once each business day.) Keep in mind that your election must be made no later than the close of business on the day prior to the record date for the dividend in order to be effective for that dividend. You will not be able to make any elections or election changes during the period from the record date of the dividend through the dividend pay date (which is usually three to four weeks after the record date).

Each year, Wal-Mart Stores, Inc. releases the quarterly record dates for dividend payouts. You can find this information on walmart.com. You may also contact the Customer Service Center at **888-968-4015** if you need information about upcoming record dates for dividends. You should keep in mind that a dividend payout will be taxable to you.

Please note that if you request a hardship payout from your 401(k) Account within five business days of the record date for a dividend and you have the right to elect a cash distribution of the dividend, tax laws require that the dividend be automatically paid to you in cash.

Account balances and statements

At least once a year, you'll receive a statement on your accounts showing contributions made by you and by Walmart, if any, the performance of your investment options, the values of your accounts and fees assessed to your account during the quarter. You can easily get information about your accounts, including a quarterly statement, at any time online at benefits.ml.com or by calling the Customer Service Center at **888-968-4015**. You can also request a paper copy of any quarterly statement at any time free of charge by calling the Customer Service Center at **888-968-4015**.

FEES CHARGED TO YOUR ACCOUNT

Administrative and investment fees may be assessed to your accounts. You can find information on fees in the Annual Participant Fee Disclosure Notice and online at benefits.ml.com.

Receiving a payout while working for Walmart

Generally, you are not entitled to a payout from the Walmart 401(k) Plan until you stop working for Walmart. However, in the following limited situations you may be entitled to receive a payout or loan of some or all of your accounts while you're still working:

- You may request a loan from your Plan account.
- Rollovers can be withdrawn at any time.
- In the case of a financial hardship or after you attain age 59½.

It's important to understand how any type of payout or loan from the Walmart 401(k) Plan affects your tax situation. For more information, see [The income tax consequences of a payout](#) later in this summary.

FINANCIAL HARDSHIP WITHDRAWALS

You may withdraw some or all of your 401(k) Account (other than earnings on those contributions) and your 401(k) Rollover Account as necessary to meet a "financial hardship."

Under IRS guidelines, a financial hardship may exist if the request is for:

- Payment of medical care expenses not covered by insurance for you, your spouse, your dependents or your affirmatively-designated primary beneficiary
- Costs directly related to the purchase of your primary residence (home)
- Payment of tuition, fees, and room and board expenses for up to the next 12 months of post-high school education for you, your spouse, your dependents or your affirmatively-designated primary beneficiary
- Payments necessary to prevent eviction from, or foreclosure on, your primary residence
- Payment for burial or funeral expenses for your deceased parent, spouse, children, dependent or your affirmatively-designated primary beneficiary, or
- Expenses for the repair of damage to your principal residence that would qualify for a casualty deduction under federal income tax rules.

Federal tax law requires that you must have already obtained all in-service payouts available (including in-service withdrawals of rollover contributions or at age 59½ and any nontaxable participant loans available to you under this Plan) before you can request a financial hardship payout.

Also, federal tax laws will not allow you to contribute to this Plan and certain other retirement or stock purchase plans (including the Associate Stock Purchase Plan) for six months after the date of your financial hardship payout. If you are a management associate with stock options, you may not

exercise options during this six-month period. Also, please note that if you request a financial hardship payout within five business days of the record date of a dividend and you are entitled to elect a cash payout of that dividend, the dividend will automatically be distributed to you in cash.

A financial hardship payout is immediately taxable to you, including a 10% penalty tax if you are under age 59½ or if the payout is not for certain medical purposes. For more information, see [The income tax consequences of a payout](#) later in this chapter.

You can make a request for a financial hardship payout online at benefits.ml.com or by calling the Customer Service Center at **888-968-4015**.

WITHDRAWALS AFTER YOU REACH AGE 59½

Any time after you reach age 59½, you may elect to withdraw all or any portion of your Plan accounts, to the extent vested, even though you are still working for Walmart. You can make a request for a withdrawal online at benefits.ml.com or by calling the Customer Service Center at **888-968-4015**.

WITHDRAWALS OF ROLLOVER CONTRIBUTIONS

You may withdraw all or any portion of your 401(k) Rollover Account and your Profit Sharing Rollover Account at any time even if you are still working for Walmart or its subsidiaries.

PLAN LOANS

You may apply for a loan from the vested portion of your Plan account while you are still working for Walmart. The Administrator has established a written loan program which explains these requirements in more detail. You can request a copy of the loan program or make a request for a loan online at benefits.ml.com or by calling the Customer Service Center at **888-968-4015**.

Generally, the rules for loans include the following:

- The maximum loan amount is limited by IRS rules, which generally limit your total loan balances to the lesser of (1) 50% of the total of your vested Plan account or (2) \$50,000 (reduced by the excess, if any, of your highest outstanding loan balance during the one-year period prior to the date of the loan over your current outstanding balance of loans). The minimum loan amount is \$1,000.
- All loans must be secured by a pledge of up to one-half of your vested Plan account.
- A fee will be charged to process your loan application. Additional fees may be assessed for residential loans. (This amount may change from time to time.)

- All loans will bear a commercially reasonable rate of interest set by the Administrator from time to time.
- Loans must be repaid in regular installments over a one- to five-year period, unless you are using the loan proceeds to buy a house for yourself, in which case the repayment period may be longer as set forth in the written loan program from time to time.
- You may have only one general purpose loan and one residential loan outstanding at any time.
- All loans will be considered a directed investment from your account under the Plan. Your payments of principal and interest on the loan will be credited to your Plan accounts.
- If you fail to make payments when due under the loan, you will be considered to be in default. Under certain circumstances, a loan that is in default may be considered a distribution from the Plan. The significance of the loan balance being treated as a distribution is that the amount of this distribution will be taxable to you as ordinary income and could be subject to excise taxes. A Form 1099-R will be issued to you and the total amount of the distribution will be reported to the IRS.

When you are on an authorized unpaid leave of absence, you may be excused from making scheduled loan repayments for a period up to one year. If you have an outstanding loan when you are called to qualified military service, special rules under USERRA may apply. If you think you may be affected by these rules, call the Customer Service Center at **888-968-4015** for more details.

If you die: your designated beneficiary

In the event of your death, your entire Plan balance will be paid out to your beneficiary. It is very important for you to keep your beneficiary information up to date. Beneficiary choices should be made at WalmartOne.com, the **WIRE** or **Workday**. Since your spouse or partner has certain rights in the death benefit, you should immediately update your beneficiary election if there is a change in your relationship status.

If you have a spouse and wish to name someone other than your spouse as your designated beneficiary, your spouse must consent to that designation. You must complete the Alternate Beneficiary Form for Married Participants Form B and your spouse must complete the Spousal Consent portion of that form. The Spousal Consent form must be notarized and must accompany the Form B in order to be valid. Form B and the Spousal Consent form can be found on the **WIRE**, or you may talk to the personnel representative at your facility. Any beneficiary designation you make will be effective for all of your Plan accounts.

If you do not designate a beneficiary, your death benefit will be distributed in accordance with the Plan's default provisions in the following order, as stated below:

- Spouse or partner (as defined below); if none, then
- Living children (stepchildren are not included); if none, then
- Living parents; if none, then
- Living siblings; if none, then
- The estate.

Please note that if you designate your spouse as your beneficiary and you later divorce, your designation will not be effective after the divorce unless you complete a new designation form. Similarly, if you do not have a spouse and you later marry, your prior beneficiary designation will not be effective after the marriage unless you complete a new designation form with your spouse's consent.

Also, note that if you designate a beneficiary and your beneficiary dies before the benefit check is issued, the benefit will be paid to your contingent beneficiary or, if none, under the default rules above. If your beneficiary dies after the benefit check has been issued, the benefit will be paid to your beneficiary's estate. Note, however, that if your spouse or partner is your beneficiary, the benefit will always be paid to the spouse's or partner's estate if he or she dies after you but before the benefit is paid. Again, it is very important for you to keep your beneficiary information up to date. Beneficiary choices should be made at [WalmartOne.com](https://www.walmartone.com), the [WIRE](#) or [Workday](#).

NOTE: Effective June 26, 2013, your same-sex spouse will be treated in the same manner as an opposite-sex spouse for Plan purposes. Keep in mind that if you had a same-sex spouse on that date, any beneficiary designation you had in effect which designated someone other than your spouse as your beneficiary immediately became invalid on that date. Your spouse will automatically be your beneficiary unless you make a new beneficiary designation with your spouse's consent.

Effective January 1, 2014, if you have a "partner" and you have not made an affirmative beneficiary designation, your partner will be your beneficiary unless you affirmatively designate a different beneficiary (regardless of whether the designation occurred before or after your partnership began). Your "partner" for Plan purposes means:

- Your domestic partner, as long as you and your domestic partner:
 - Are in an ongoing, exclusive and committed relationship similar to marriage and have been for at least 12 months and intend to continue indefinitely;
 - Are not married to each other or to anyone else;

- Meet the age for marriage in your home state and are mentally competent to consent to contract in that state;
 - Are not related in a manner that would bar a legal marriage in the state in which you live, and
 - Are not in the relationship solely for the purpose of obtaining benefits coverage, or
- Any other person to whom you are joined in a legal relationship recognized as creating some or all of the rights of marriage in the state or country in which the relationship was created.

You should take action to ensure that your beneficiary under the Plan reflects your current intent. Beneficiary choices should be made at [WalmartOne.com](https://www.walmartone.com), the [WIRE](#) or [Workday](#).

BENEFICIARY DESIGNATIONS MADE BEFORE OCTOBER 31, 2003

If you made a beneficiary designation under the 401(k) Plan on or before October 31, 2003, that designation will continue to apply to your 401(k) Account, your Company Funded 401(k) Account, your Company Match Account, and your 401(k) Rollover Account. Similarly, if you made a beneficiary designation under the Profit Sharing Plan on or before October 31, 2003, that designation will continue to apply to your Company Funded Profit Sharing Account and Profit Sharing Rollover Account. If you change your beneficiary designation after October 31, 2003, it will apply to all Plan accounts and any prior designations will be ineffective.

Note that changes in your relationship status may affect your beneficiary designation, as explained above.

Again, it is very important for you to keep your beneficiary information up to date. Beneficiary designations should be made at [WalmartOne.com](https://www.walmartone.com), the [WIRE](#) or [Workday](#).

If you get divorced

If you go through a divorce, all or part of your Plan balance may be awarded to an "alternate payee" in the court order, called a "Qualified Domestic Relations Order" (QDRO). An alternate payee may be your spouse or former spouse, child or other dependent. (Federal law at this time does not permit the recognition of a QDRO for a partner unless the partner is also a dependent of the participant.) Because there are very strict requirements for these cases, you should contact the QDRO Administrator at **877-MER-QDRO (877-637-7376)** for a free copy of the procedures your attorney should use in drafting the court order. After the court order is received by the QDRO Administrator, it must be reviewed to determine if it meets legal requirements for this type of order and will take a period of time to be processed. The administrative fee for processing your QDRO will be charged to your account or as directed in the Order.

If you leave Walmart

When you stop working for Walmart, you are entitled to receive a payout of all of your vested accounts in the Plan.

It is important to understand how any type of payout from the Walmart 401(k) Plan affects your tax situation. For more information, see [The income tax consequences of a payout](#) later in this summary.

You may elect to receive your payout 30 calendar days after your termination is entered into the payroll system. For example, if your termination is entered into and processed by the payroll system on July 19, 2017, you may elect your payout on or after August 18, 2017.

A notice will normally be mailed to your home address or sent electronically, based on your delivery elections, after you leave Walmart and its subsidiaries to inform you that you are entitled to payment. Please make sure that your address is correct on your payroll check when you leave Walmart and its subsidiaries or that you give a forwarding address during your exit interview. If you have not received any information regarding your payout within 60 days of your termination date, you should contact the Customer Service Center at **888-968-4015**. To request your payout, you will need to access your account on benefits.ml.com or by calling the Customer Service Center at **888-968-4015**.

Your consent to the payout is not required and your payout will automatically be made to you:

- **If your total vested Plan balance (excluding your 401(k) Rollover Account) is \$1,000 or less at any time.** This automatic payout will be made as soon as possible after the last business day of the third calendar month following the calendar month in which your termination date is entered into the payroll system, unless you consent to an earlier payout, as described above. In the example above, if your account is eligible for automatic payout and you do not consent to payout on or after August 19, 2017, your payout will automatically be made to you as soon as possible after October 31, 2017, or
- **If you are over age 70, regardless of the amount of your total vested Plan balance.** This automatic payout will be made as soon as possible after the last business day of the second calendar month following the calendar month in which you turn age 70, unless you consent to an earlier payout, as described above. For instance, if you turn age 70 in July 2017 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, 2017, according to Plan provisions.

If your total vested Plan balance is more than \$1,000 and you are under age 70, you must consent to your payout. Payout will be made as soon as possible after your

consent is received by the Customer Service Center at **888-968-4015**, but no earlier than 30 calendar days after your termination is entered into the payroll system.

If your total vested Plan balance is more than \$1,000, you can choose to delay your payout until any date up to age 70, but your Plan balance will be subject to an annual maintenance fee and possibly other expenses. For more information regarding these charges, refer to the Annual Participant Fee Disclosure Notice. If you choose to delay your payout, you will be able to continue to make changes in your investment choices just as you did while you were an active participant in the Plan.

If you return to work with Walmart before your payout is completed, the payout will be canceled and no payout will be made from your account.

THE AMOUNT OF YOUR PAYOUT

The entire value of your 401(k) Account, your Company Funded 401(k) Account, your 401(k) Rollover Account and the Company Match Account will be paid out to you. In addition, if you have a Company Funded Profit Sharing Account (see [Your Walmart 401\(k\) Plan accounts](#) earlier in this summary), you will also be paid the value of the vested portion of your Company Funded Profit Sharing Account. You will forfeit (give up) the nonvested portion of your Company Funded Profit Sharing Account, as explained in the [Vesting in your Company Funded Profit Sharing Account](#) earlier in this summary.

The amount you will receive will be based on the value of your accounts as of the date the payout is processed. If a cash payout is made directly to you rather than rolled over to an IRA or other employer plan, applicable taxes will be withheld from your check.

A check processing fee will be applied to your Plan balance when it is paid out to you.

HOW YOU RECEIVE YOUR PAYOUT

You have several options for receiving your payout.

Your accounts will be distributed in a single lump-sum payment directly to you, unless you elect to roll them over to an IRA or to another employer's retirement plan.

Your accounts will normally be paid to you in cash. However, you may elect to have your Company Funded Profit Sharing Account (and Profit Sharing Rollover Account) distributed to you in the form of Walmart stock (even if it is not invested in Walmart stock at the time your payout is processed) or partly in cash and partly in Walmart stock. You may also elect to have your 401(k) Account, your Company Funded 401(k) Account and your 401(k) Rollover Account paid to you in Walmart stock to the extent those accounts are invested in Walmart stock

at the time your payout is processed. Any part of those accounts that is not invested in Walmart stock at the time of your payout will be distributed in cash.

If the total of your vested accounts is \$1,000 or less, or if you are over age 70 (regardless of the amount of your vested accounts), your payout will be made directly to you in a single cash payout. If you wish to take any of your payout in the form of Walmart stock or if you wish to roll over your payout to an IRA or other employer plan, you must contact the Customer Service Center at **888-968-4015** with your payout instructions within the time period shown in your payout notice. If you fail to contact the Customer Service Center at **888-968-4015** in a timely manner, your payout will be made in a single cash payment to you.

If the total of your vested accounts in the Plan is more than \$1,000, your payout will not be made until you make an election regarding the form of payout and consent to the distribution, or until you reach age 70. To obtain your payout, you should contact the Customer Service Center at **888-968-4015**.

If you leave and are rehired by Walmart

If you leave Walmart and its subsidiaries and are later rehired as an eligible associate, you will be immediately eligible to make your own contributions to the Plan on your date of rehire.

If you leave Walmart and its subsidiaries after you became eligible to receive matching contributions and are later rehired by Walmart, you will automatically be eligible to receive matching contributions on your rehire date. Similarly, if you leave Walmart and its subsidiaries after you met the 1,000-hour requirement for matching contribution eligibility but before your actual participation date, you will be eligible to receive matching contributions beginning on the later of the date you would have initially become a participant or your rehire date (with respect to contributions you make after that date). If you were not a participant when you left, or had not satisfied the 1,000-hour requirement, you will be treated as a new associate when you are rehired and will be required to complete the eligibility requirements (see **When participation begins** earlier in this summary) in order to be eligible to receive matching contributions under the Plan.

THE NONVESTED PORTION OF YOUR COMPANY FUNDED PROFIT SHARING ACCOUNT

When you terminate employment, the portion of your Company Funded Profit Sharing Account that is not vested (if any) will not be paid to you. This nonvested amount is called a “forfeiture.”

- If you receive a total payout of your vested Plan balance after your termination of employment and while your Company Funded Profit Sharing Account is partially

vested, the nonvested portion of your Company Funded Profit Sharing Account will be forfeited on the date of your payout.

- If you do not receive a total payout of your vested Plan balance after your termination of employment, the nonvested portion of your Company Funded Profit Sharing Account will not be forfeited until you have five consecutive “breaks in service.” A break in service is a Plan year (February 1–January 31) in which you are credited with 500 hours of service or less. If you are absent from work due to an FMLA leave and have worked 500 hours or less in the Plan year, you will be credited with enough hours to bring you up to 500.01 hours so that you will not incur a break in service.

The nonvested portion of your Company Funded Profit Sharing Account that was forfeited will be reinstated (at its former value) if you are rehired by Walmart or subsidiary before you have five consecutive breaks in service and you pay back to the Plan the total amount of your payout within five years after you are rehired. If you return to work with Walmart or a subsidiary after five or more consecutive breaks in service, or if you chose not to repay your payout as discussed above, the nonvested portion of your Company Funded Profit Sharing Account that was forfeited will not be reinstated.

If you were zero percent vested in your Company Funded Profit Sharing Account when you terminated employment, your nonvested Company Funded Profit Sharing Account will automatically be reinstated if you are rehired prior to five consecutive breaks in service.

Forfeitures of nonvested Company Funded Profit Sharing Accounts of terminated participants generally are used to pay Plan expenses and for certain other purposes, such as to restore account balances as discussed above.

When you are rehired, your years of service with Walmart before you left will be counted for purposes of determining your vesting in Walmart’s contributions to your Company Funded Profit Sharing Account.

The income tax consequences of a payout

The tax consequences of your participation in the Plan are your responsibility. This explanation is only a brief description of the U.S. federal tax consequences related to your participation in the Plan. This description is based on current law and current interpretations of the law by the Internal Revenue Service. Because the law is subject to change and because the application of the law may vary depending on your particular circumstances, this description is general in nature and you should not rely on it in determining your tax consequences. You are strongly urged to consult a tax advisor.

Walmart is entitled to a deduction on the amount of its contributions, as well as your contributions, to the Plan. Your contributions and Walmart's contributions to the Plan, as well as earnings on those contributions, generally are not subject to federal income taxes until they are paid to you.

Special taxation rules apply to Roth contributions transferred from another Plan as part of a Plan merger. Contact the Plan Administrator or your tax advisor for more information.

POSTPONE PAYING TAXES ON PAYOUTS THROUGH A ROLLOVER

Although payouts from the Plan are subject to federal income taxes, the Internal Revenue Code provides favorable tax treatment to payouts in certain circumstances. For example, you can postpone paying taxes on your payout if you direct the Plan to issue your payout directly to an IRA or to another employer's qualified retirement plan, a 403(b) plan or a governmental 457 plan. This is called a direct rollover. (The check will be made payable to the IRA or other plan trustee and will be delivered to you or your IRA or rollover institution. If the check is mailed to you, you will be responsible for delivering it to the IRA or other plan trustee within 60 days.)

If you elect this method for your payout, no taxes will be withheld from the amount you are rolling over. It will not be taxed until you later receive a payout from the IRA or other plan.

If you do not elect to have your payout directly rolled over, federal law requires that Walmart withhold 20% of the payout for federal taxes, in addition to any required state withholding. In some cases, 20% withholding may not be enough, which could mean that you will owe additional taxes when you file your income tax return.

If you do not elect a direct rollover (and instead receive an actual payout from the Plan), you may still roll over those funds to an IRA or an employer's qualified retirement plan, 403(b) plan or governmental 457 plan, as long as you do so within 60 calendar days after you received the distribution. The amount rolled over will not be subject to federal income tax until you take it out of the IRA or other plan. If you want to roll over 100% of your payout to an IRA or other plan, however, you will have to use other money to replace the 20% that was withheld from your payout. If you roll over only the 80% that you received, you will be taxed on the 20% that was withheld.

NOTE: You may roll over all or any portion of your account that is eligible for rollover to a Roth IRA. Any amount rolled over that would have been taxable if not rolled over will be taxable at the time of the rollover to the Roth IRA. (Note that you may voluntarily choose to have taxes withheld from amounts at the time you roll over to a Roth IRA.)

For more information regarding these rollover rules, you should review the [Special tax notice addendum](#) that follows. You should retain this addendum for review when you are eligible to take a distribution.

EARLY WITHDRAWAL PENALTY

In addition to the income tax withholding, if you take a payout prior to age 59½ rather than rolling it over, in most cases you will be subject to a 10% early withdrawal penalty by the IRS. There are some exceptions to the penalty, such as death, disability, retirement after age 55 and payouts for certain medical expenses. Special rules also apply to distributions made to reservists who are called to active military duty.

TAXATION OF PAYOUTS OF WALMART STOCK

There are also special rules for distributions of Walmart common stock. If you receive cash (in excess of \$200) in addition to Walmart stock and the cash is not directly rolled over, some withholding may apply, but the withheld amount will not be greater than the amount of cash you receive.

Generally, if you receive Walmart common stock as part of your payout that is not rolled over, you are taxed only on the value of the stock at the time it was purchased by the Plan.

You should also keep in mind that if you elect cash payouts of dividends paid on Walmart stock held in your Company Funded Profit Sharing Account, the dividend is taxable to you and is not eligible for rollover. The dividend is also taxable if you request a financial hardship payout from your 401(k) Account within five business days of the record date for a dividend and the dividend is automatically paid out to you in cash. The dividend payout is not subject to the 10% early withdrawal penalty discussed above. In some cases, Wal-Mart Stores, Inc. will be entitled to deduct dividends paid on shares subject to this election.

TAXATION OF PAYOUTS TO BENEFICIARIES AND ALTERNATE PAYEES

The tax treatment discussed above applies only to payouts to participants. Different rules may apply to payouts to beneficiaries of deceased participants. In general, if your spouse is your beneficiary, he or she will have the same federal income tax treatment and rollover options that you would have had. Other beneficiaries, including partners, will only be entitled to a direct rollover to an inherited IRA or Roth IRA. The 10% early withdrawal penalty does not apply to payouts to your beneficiary.

The spouses or former spouse of a participant who receives a payout from the Plan under a qualified domestic relations order (QDRO) generally have the same federal income tax treatment and options as the participant would have had. In some cases, however, a payout on behalf of a non-spouse

dependent, including a partner, pursuant to a QDRO (e.g., state-ordered child support) may result in federal income taxation to the participant even though the payout is made to or on behalf of the dependent alternate payee.

TAXATION OF LOANS

Under current tax law, loans made from the Plan, regardless of their purpose, are not considered taxable income to the participant unless a default occurs. If you default on a loan from the Plan (as discussed above), your tax statement will show the amount of income to report for the year of the default. You may also be subject to 10% early withdrawal penalty.

Filing a Walmart 401(k) Plan claim

If you think you are entitled to a benefit beyond that processed by the Plan's recordkeeper (Merrill Lynch), you may file a claim with the Administrator or its delegate at:

Wal-Mart Stores, Inc.
Attn: Financial Benefits
508 SW 8th Street
Bentonville, Arkansas 72716-0295

For questions about filing a claim, contact People Services at **800-421-1362**.

If your claim is partially or fully denied, you will receive written notice of the decision within a reasonable time, but no later than 90 days after the Administrator receives your claim. The Administrator or its delegate can extend this period for up to an additional 90 days if it determines that special circumstances require an extension. You will receive notice of any extension before the expiration of the original 90-day period. The written notice you receive will state the specific reasons for the denial of your claim, a specific reference to the provisions of the Plan upon which the denial is based, and a description of the review procedures and the time limits applicable to such procedures, including your right to bring a court action following a denial on appeal.

If you do not agree with the decision of the Administrator or its delegate, you can request a review of the decision by the Administrator. The Administrator has discretionary authority to resolve all questions concerning administration, interpretation or application of the Plan. Your request must be made in writing and sent to the Administrator at:

Wal-Mart Stores, Inc.
Attn: Financial Benefits
508 SW 8th Street
Bentonville, Arkansas 72716-0295

Your request must be made within 60 calendar days of the denial. Your written request must contain all additional information that you wish the Administrator to consider. If you do not request a review within this time period, you will be deemed to have waived your right to a review.

The Administrator will promptly conduct the review. Written notice of the Administrator's decision on review will be provided to you within 60 calendar days after the receipt of your request, unless special circumstances require an extension of up to 60 additional days. In those circumstances where the review is delayed to allow you to provide additional information necessary for a proper review, the length of the delay will not be included in the calculation of the 60-day deadline and extension periods set forth above. The written notice of the Administrator's decision will include specific reasons for the decision and will refer to the specific provisions of the Plan on which the decision is based.

You must exhaust these procedures before you can file a lawsuit with respect to your Plan benefits. If you file a lawsuit, it must be filed within one year from the date of your payout or, if no payout is made, the date your request for benefits is denied, in whole or in part, by the Administrator on appeal (or, if earlier, the date the Administrator fails to respond to your claim or appeal within the time periods provided above).

Administrative information

PLAN NAME

The legal name of the Plan is the Walmart 401(k) Plan.

PLAN SPONSOR AND ERISA PLAN ADMINISTRATOR

Wal-Mart Stores, Inc. is the Plan Sponsor. Its contact information for matters pertaining to the Plan is:

Wal-Mart Stores, Inc.
Attn: Financial Benefits
508 SW 8th Street
Bentonville, Arkansas 72716-0295 800-421-1362

As the ERISA Plan Administrator, Wal-Mart Stores, Inc. is responsible for reporting and disclosure obligations under the Employee Retirement Income Security Act of 1974 (ERISA) and all other obligations required to be performed by plan administrators under the Internal Revenue Code and ERISA, except for those obligations delegated to the Administrator, the Benefits Investment Committee or the trustee of the Trust. ERISA is the federal law that imposes certain responsibilities on Wal-Mart Stores, Inc., the Administrator, the Benefits Investment Committee and the trustee with respect to your retirement benefits.

Subsidiaries of Wal-Mart Stores, Inc. are permitted to participate in the Plan. You may obtain a list of subsidiaries currently participating in the Plan by contacting People Services.

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER

71-0415188

NAMED ADMINISTRATIVE FIDUCIARY

The individual from time to time holding the position of Senior Vice President, Global Benefits Division, of Walmart is the Administrator. The Administrator is the named administrative fiduciary of the Plan. As the named administrative fiduciary of the Plan, the Administrator is generally responsible for the management, interpretation and administration of the Plan, including but not limited to eligibility determinations, benefit payments and other functions required, necessary or advisable to carry out the purpose of the Plan.

You may contact the Administrator at the following address:

Senior Vice President, Global Benefits Division/Administrator
c/o Wal-Mart Stores, Inc.
508 SW 8th Street
Bentonville, Arkansas 72716-0295

NAMED INVESTMENT FIDUCIARY

The Benefits Investment Committee is the named investment fiduciary of the Plan. As the named investment fiduciary, the Committee is responsible for the Plan's investment policies, including selection of investment options to be made available under the Plan and the selection of the default investment option.

You may contact the Benefits Investment Committee at the following address:

Benefits Investment Committee
c/o Wal-Mart Stores, Inc.
508 SW 8th Street
Bentonville, Arkansas 72716-0295

PLAN TRUSTEE

Northern Trust Company
50 S. LaSalle Street
Chicago, Illinois 60603

One or more trusts hold all Plan assets, such as contributions by participants and Walmart's contributions. As trustee of the Trust, Northern Trust Company receives and holds contributions made to the Plan in trust and invests those contributions according to the policies established under the Plan.

AGENT FOR SERVICE OF LEGAL PROCESS

Corporation Trust Company
1209 Orange Street
Corporation Trust Center
Wilmington, Delaware 19801

Service of legal process may also be made on the ERISA Plan Administrator or the trustee.

PLAN NUMBER

003

PLAN YEAR

February 1 through January 31

TYPE OF PLAN

The Walmart 401(k) Plan is a defined contribution plan (401(k), profit sharing and employee stock ownership plan).

ASSIGNMENT

Because this is a retirement plan governed by ERISA and other federal laws, your accounts cannot be assigned or used as collateral for a loan, nor can your accounts be garnished or be subject to bankruptcy proceedings. They can, however, be part of a divorce settlement, as explained in the [If you get divorced](#) section earlier in this summary.

NO PBGC COVERAGE

ERISA created a governmental agency called the Pension Benefit Guaranty Corporation (PBGC). One of the purposes of the PBGC is to provide plan benefit insurance. However, this insurance is available only to defined benefit pension plans, and our Plan is a defined contribution plan. Therefore, benefits under the Plan are not insured by the PBGC.

PLAN AMENDMENT OR TERMINATION

Walmart reserves the right to amend or terminate the Plan at any time. Amendments are made by Walmart's Board of Directors or by its Executive Vice President, Global People Division. Neither the Plan nor the benefits described in

this summary may be orally amended. All oral statements and representations have no force or effect, even if the statements and representations are made by a management associate of Walmart or a participating subsidiary, by the Administrator, by any member of the Benefits Investment Committee or by Merrill Lynch.

You may obtain a copy of the formal Plan document by writing to:

Wal-Mart Stores, Inc.
Attn: People Services
508 SW 8th Street
Bentonville, Arkansas 72716-0295

You can also contact the Customer Service Center at **888-968-4015**.

MISTAKEN PAYOUTS

If any payout is made under the Plan to the wrong party, or if a payout is made to the right party but in the wrong amount, the Administrator can recover the mistaken payout from the recipient by either reducing his or her Plan account or future payouts due to the recipient, or may demand that the recipient promptly repay the Plan.

STATEMENT OF ERISA RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the ERISA Plan Administrator's office and at other specified facilities, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the ERISA Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The ERISA Plan Administrator may make a reasonable charge for the copies. Your request must be mailed to:

Wal-Mart Stores, Inc. — ERISA Section 104(b) Request
Attn: People Services
508 SW 8th Street
Bentonville, Arkansas 72716-0295

- Receive a summary of the Plan's annual financial report. The ERISA Plan Administrator is required by law to furnish each participant with a copy of the summary financial report.
- Obtain a statement telling you the current balance of your account and the portion of your account that is nonforfeitable (vested). This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and in that of other Plan participants and beneficiaries. No one, including your employer or any other person, may fire or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the ERISA Plan Administrator or the Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the ERISA Plan Administrator or the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the ERISA Plan Administrator or the Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest regional office of the Employee Benefits Security Administration, U.S.

Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Special tax notice addendum

YOUR ROLLOVER OPTIONS

The law requires that participants receive this notice before receiving a distribution from the Plan that is eligible to be rolled over to an IRA or an employer plan. You may or may not currently be eligible to receive a distribution from the Plan. If you are eligible for a distribution, however, you should review this notice carefully before you elect a distribution from the Plan. This notice is intended to help you decide whether to elect a rollover. If you are not currently eligible for a distribution, you should retain this notice and review it when you are eligible for a distribution.

Rules that apply to most payments from the Plan are described in the [General information about rollovers](#) section. Special rules that only apply in certain circumstances are described in the [Special rules and options](#) section.

GENERAL INFORMATION ABOUT ROLLOVERS

How can a rollover affect my taxes? You will be taxed on a payment from the Plan if you do not roll it over. If you are under age 59½ and do not do a rollover, you will also have to pay a 10% additional income tax on early distributions (unless an exception applies, as explained below). If you do a rollover, however, you will not have to pay tax until you receive payment later and the 10% additional income tax will not apply if the payment is made after you are age 59½ (or if an exception applies).

Where may I roll over the payment? You may roll over the payment to either an IRA (an individual retirement account or individual retirement annuity, including a Roth IRA) or an employer plan (a tax-qualified plan, section 403(b) plan or governmental section 457(b) plan) that will accept the rollover. The rules of the IRA or employer plan that holds the rollover will determine your investment options, fees and rights to payment from the IRA or employer plan (for example, no spousal consent rules apply to IRAs and IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the IRA or employer plan.

How do I do a rollover? There are two ways to do a rollover. You can do either a “direct rollover” or a “60-day rollover.”

If you do a “direct rollover,” the Plan will make the payment directly to your IRA or an employer plan. You should contact the IRA sponsor or the administrator of the employer plan for information on how to do a direct rollover.

If you do not do a direct rollover, you may still do a “60-day rollover” by making a deposit into an IRA or eligible employer plan that will accept it. You will have 60 days after you receive the payment to make the deposit. If you do not do a direct rollover, the Plan is required to withhold 20% of the payment for federal income taxes (up to the amount of cash received). This means that, in order to roll over the entire payment in a 60-day rollover, you must use other funds to make up for the 20% withheld. If you do not roll over the entire amount of the payment, the portion not rolled over will be taxed and will be subject to the 10% additional income tax on early distributions if you are under age 59½ (unless an exception applies).

How much may I roll over? If you wish to do a rollover, you may roll over all or part of the amount eligible for rollover. Generally, any payment from the Plan is eligible for rollover, except:

- Required minimum distributions after age 70½ (or after death)
- Hardship distributions
- ESOP dividends
- Corrective distributions of contributions that exceed tax law limitations
- Loans treated as deemed distributions (for example, loans in default due to missed payments before your employment ends)

The Plan Administrator or the payer can tell you what portion of a payment is eligible for rollover.

If I don't do a rollover, will I have to pay the 10% additional income tax on early distributions? If you are under age 59½, you will have to pay the 10% additional income tax on early distributions for any payment from the Plan (including amounts withheld for income tax) that you do not roll over, unless one of the exceptions listed below applies. This tax is in addition to the regular income tax on the payment not rolled over.

The 10% additional income tax does not apply to the following payments from the Plan:

- Payments made after you separate from service if you will be at least age 55 in the year of the separation
- Payments made due to disability
- Payments after your death
- Payments of ESOP dividends
- Corrective distributions of contributions that exceed tax law limitations
- Payments made directly to the government to satisfy a federal tax levy
- Payments made under a qualified domestic relations order (QDRO)
- Certain payments made while you are on active duty if you were a member of a reserve component called to duty after September 11, 2001 for more than 179 days

If I do a rollover to an IRA, will the 10% additional income tax apply to early distributions from the IRA? If you receive a payment from an IRA when you are under age 59½, you will have to pay the 10% additional income tax on early distributions from the IRA, unless an exception applies. In general, the exceptions to the 10% additional income tax for early distributions from an IRA are the same as the exceptions listed above for early distributions from a plan. However, there are a few differences for payments from an IRA, including:

- There is no exception for payments after separation from service that are made after age 55.
- The exception for qualified domestic relations orders (QDROs) does not apply (although a special rule applies under which, as part of a divorce or separation agreement, a tax-free transfer may be made directly to an IRA of a spouse or former spouse).
- An exception for payments made at least annually in equal or close to equal amounts over a specified period applies (without regard to whether you have had a separation from service).
- There are additional exceptions for (1) payments for qualified higher education expenses, (2) payments up to \$10,000 used in a qualified first-time home purchase, and (3) payments after you have received unemployment compensation for 12 consecutive weeks (or would have been eligible to receive unemployment compensation but for self-employed status).

Will I owe state income taxes? This notice does not describe any state or local income tax rules (including withholding rules).

SPECIAL RULES AND OPTIONS

If you miss the 60-day rollover deadline: Generally, the 60-day rollover deadline cannot be extended. However, the IRS has the limited authority to waive the deadline under certain extraordinary circumstances, such as when external events prevented you from completing the rollover by the 60-day rollover deadline. To apply for a waiver, you must file a private letter ruling request with the IRS. Private letter ruling requests require the payment of a nonrefundable user fee. For more information, see IRS Publication 590, *Individual Retirement Arrangements (IRAs)*.

If your payment includes employer stock that you do not roll over: If you do not do a rollover, you can apply a special rule to payments of employer stock that are paid in a lump sum after separation from service (or after age 59½, disability, or the participant's death). Under the special rule, the net unrealized appreciation on the stock will not be taxed when distributed from the Plan and will be taxed at capital gain rates when you sell the stock. Net unrealized appreciation is generally the increase in the value of employer stock after it was acquired by the Plan. If you do a rollover for a payment that includes employer stock (for example, by selling the stock and rolling over the proceeds within 60 days of the payment), the special rule relating to the distributed employer stock will not apply to any subsequent payments from the IRA or employer plan. The Plan Administrator can tell you the amount of any net unrealized appreciation.

If you have an outstanding loan that is being offset: If you have an outstanding loan from the Plan, your Plan benefit may be offset by the amount of the loan, typically when your employment ends. The loan offset amount is treated as a distribution to you at the time of the offset and will be taxed (including the 10% additional income tax on early distributions, unless an exception applies) unless you do a 60-day rollover in the amount of the loan offset to an IRA or employer plan.

If you were born on or before January 1, 1936: If you were born on or before January 1, 1936 and receive a lump sum distribution that you do not roll over, special rules for calculating the amount of the tax on the payment might apply to you. For more information, see IRS Publication 575, *Pension and Annuity Income*.

If you roll over your payment to a Roth IRA: If you roll over a payment to a Roth IRA, a special rule applies under which the amount of the payment rolled over will be taxed. However, the 10% additional income tax on early distributions will not apply (unless you take the amount rolled over out of the Roth IRA within five years, counting from January 1 of the year of the rollover). For payments

from the Plan during 2010 that are rolled over to a Roth IRA, the taxable amount can be spread over a two-year period starting in 2011. If you roll over the payment to a Roth IRA, later payments from the Roth IRA that are qualified distributions will not be taxed (including earnings after the rollover). A qualified distribution from a Roth IRA is a payment made after you are age 59½ (or after your death or disability, or as a qualified first-time homebuyer distribution of up to \$10,000) and after you have had a Roth IRA for at least five years. In applying this five-year rule, you count from January 1 of the year for which your first contribution was made to a Roth IRA. Payments from the Roth IRA that are not qualified distributions will be taxed to the extent of earnings after the rollover, including the 10% additional income tax on early distributions (unless an exception applies). You do not have to take required minimum distributions from a Roth IRA during your lifetime. For more information, see IRS Publication 590, Individual Retirement Arrangements (IRAs).

You cannot roll over a payment from the Plan to a designated Roth account in an employer plan.

If you are not a plan participant

Payments after death of the participant. If you receive a distribution after the participant's death that you do not roll over, the distribution will generally be taxed in the same manner described elsewhere in this notice. However, the 10% additional income tax on early distributions does not apply, and the special rule described under the section **If you were born on or before January 1, 1936** applies only if the participant was born on or before January 1, 1936.

If you are a surviving spouse: If you receive a payment from the Plan as the surviving spouse of a deceased participant, you have the same rollover options that the participant would have had, as described elsewhere in this notice. In addition, if you choose to do a rollover to an IRA, you may treat the IRA as your own or as an inherited IRA.

An IRA you treat as your own is treated like any other IRA of yours, so that payments made to you before you are age 59½ will be subject to the 10% additional income tax on early distributions (unless an exception applies) and required minimum distributions from your IRA do not have to start until after you are age 70½.

If you treat the IRA as an inherited IRA, payments from the IRA will not be subject to the 10% additional income tax on early distributions. However, if the participant had started taking required minimum distributions, you will have to receive required minimum distributions from the inherited IRA. If the participant had not started taking required minimum distributions from the Plan, you will not have to start receiving required minimum distributions from the inherited IRA until the year the participant would have been age 70½.

If you are a surviving beneficiary other than a spouse:

If you receive a payment from the Plan because of the participant's death and you are a designated beneficiary other than a surviving spouse, the only rollover option you have is to do a direct rollover to an inherited IRA or Roth IRA. Payments from the inherited IRA or Roth IRA will not be subject to the 10% additional income tax on early distributions. You will have to receive required minimum distributions from the inherited IRA or Roth IRA.

Payments under a qualified domestic relations order. If you are the spouse or former spouse of the participant who receives a payment from the Plan under a qualified domestic relations order (QDRO), you generally have the same options the participant would have (for example, you may roll over the payment to your own IRA or an eligible employer plan that will accept it). Payments under the QDRO will not be subject to the 10% additional income tax on early distributions.

If you are a nonresident alien: If you are a nonresident alien and you do not do a direct rollover to a U.S. IRA or U.S. employer plan, instead of withholding 20%, the Plan is generally required to withhold 30% of the payment for federal income taxes. If the amount withheld exceeds the amount of tax you owe (as may happen if you do a 60-day rollover), you may request an income tax refund by filing Form 1040NR and attaching your Form 1042-S. See Form W-8BEN for claiming that you are entitled to a reduced rate of withholding under an income tax treaty. For more information, see also IRS Publication 519, *U.S. Tax Guide for Aliens*, and IRS Publication 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*.

If you have Roth contributions that were merged into the Walmart 401(k) Plan, those contributions are subject to special tax rules when they are distributed from the Walmart 401(k) Plan. In general, your Roth contributions are not taxed upon distribution, even if you do not elect a rollover.

Earnings on those contributions are also not taxed if the distribution is a "qualified distribution." A "qualified distribution" is a payment made after age 59½ (or after your death or disability) and after you have had a Roth account for at least five years (counting from January 1 of the year you made your first Roth contribution). If the distribution is not a qualified distribution, the earnings will be taxed and, if you are under 59½ (and no other exception applies), the additional 10% income tax would also apply, unless you elect a rollover.

You may roll over your Roth contributions only to a Roth IRA or to a designated Roth account in another employer plan that will accept the rollover. The rules of the Roth IRA or employer plan that holds the rollover will determine your investment options, fees, and rights to payment from the Roth IRA or employer plan (for example, no spousal consent

rules apply to Roth IRAs and Roth IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the Roth IRA or the designated account in the employer plan. In general, these tax rules are similar to those described above, but differences include:

- If you do a rollover to a Roth IRA, all of your Roth IRAs will be considered for purposes of determining whether you have satisfied the 5-year rule (counting from January 1 of the year for which your first contribution was made to any of your Roth IRAs).
- If you do a rollover to a Roth IRA, you will not be required to take a distribution from the Roth IRA during your lifetime and you must keep track of the aggregate amount of the after-tax contributions in all your Roth IRAs (in order to determine your taxable income for later Roth IRA payments that are not qualified distributions).
- Eligible rollover distributions from a Roth IRA can only be rolled over to another Roth IRA.

The tax rules governing Roth contributions are complex. You should consult with your tax advisor before electing distribution.

OTHER SPECIAL RULES

If your payments for the year are less than \$200, the Plan is not required to allow you to do a direct rollover and is not required to withhold for federal income taxes. However, you may do a 60-day rollover.

FOR MORE INFORMATION

You may wish to consult with the Plan Administrator or payer, or a professional tax advisor, before taking a payment from the Plan. Also, you can find more detailed information on the federal tax treatment of payments from employer plans in: IRS Publication 575, *Pension and Annuity Income*; IRS Publication 590, *Individual Retirement Arrangements (IRAs)*; and IRS Publication 571, *Tax-Sheltered Annuity Plans (403(b) Plans)*. These publications are available from a local IRS office, on the web at www.irs.gov, or by calling **800-TAX-FORM**.

Claims and appeals

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Claims and appeals

As a participant in the Associates' Health and Welfare Plan (the Plan), you have the right to appeal a decision regarding Plan eligibility and benefits. This chapter describes the process and the deadlines for appealing a claim that has been partially or fully denied in the areas of eligibility, medical, pharmacy, dental, vision, HMO plans, life insurance, AD&D, disability or critical illness and accident insurance. To protect your right to appeal, it's important to follow these procedures and meet the deadlines.

CLAIMS AND APPEALS RESOURCES

Find What You Need

Submit a claim for benefits	For medical, pharmacy, dental and vision claims, see your plan ID card for the claims address or call your health care advisor at the number on your plan ID card. Submit Centers of Excellence claims to the administrator as shown in the chart later in the chapter. Submit all other claims to the Plan's Third Party Administrators as shown later in this chapter.
Appeal the denial of a claim	Submit appeals to the addresses provided in this chapter for the Plan's Third Party Administrators and/or People Services, depending on the nature of your appeal. Your initial denial letter will also specify where to file an appeal.
Appeal a decision on eligibility for coverage under the benefit plans	Write to: Walmart People Services Attn: Internal Appeals Or for COBRA appeals, write to: WageWorks Addresses are listed later in this chapter.
Designate an authorized representative to submit appeals on your behalf	Call the number on your plan ID card or call People Services at 800-421-1362

What you need to know about claims and appeals

- You have the right to appeal an adverse eligibility decision affecting your or a family member's coverage.
- You have the right to appeal an adverse preauthorization decision regarding your requested benefits.
- You must submit claims for benefits directly to the Third Party Administrator or provider of the Plan.
- You have the right to appeal a benefit claim that has been partially or fully denied.
- You can appoint another party to appeal on your behalf. The Plan will provide the appropriate form for you to complete and sign. This is the only authorization form that will be accepted for another party to appeal on your behalf.
- After a final decision of an appeal of a medical, pharmacy or Centers of Excellence claim is made by the Third Party Administrator or the Plan, you may have the right to request an independent external review of the decision if your claim involves medical judgment.
- Decisions regarding enrollment, eligibility status and questions related to eligibility waiting periods are not eligible for external review, but will be eligible for voluntary review under the Plan. In addition, for the medical, dental, and vision plans, appeals denied for nonmedical administrative reasons (e.g., because you exceeded the Plan's visit limits) are eligible for voluntary review under the Plan.

Deadlines to file a claim or bring legal action

Unless otherwise specified in the chapter describing the applicable benefit, you or your dependent(s) must file an initial claim for benefits under the Plan within 18 months from the date of service. Since the procedures for filing a claim or an appeal of a decision are different for different benefit plans and Third Party Administrators, be sure to review the relevant section of this chapter for more information. You or your dependent(s) must complete the required claims and appeals process described in this [Claims and appeals](#) chapter before you may bring legal action or, for certain medical, pharmacy, Centers of Excellence, transplant, dental or weight loss surgery claims, or pursue an external review. You may not file a lawsuit for benefits if the initial claim or appeal is not made within the time periods set forth in the claims procedures of the Plan.

You must file any lawsuit for benefits within 180 days after the final decision on appeal (whether by the Plan or after external review). You may not file suit after that 180-day period expires. You or your dependent(s) are not required to request a voluntary review by the Plan or an external review of the decision on appeal before filing a lawsuit. If you or your dependent(s) request a voluntary review or an external review of the decision on appeal, where applicable, the time taken by the voluntary review or external review will not be counted against the 180 days you have to file a lawsuit.

Benefits may not be assigned

You may not assign your legal rights or rights to any payments under this Plan. However, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by you or your dependents, but only as a convenience to you. Health care providers are not, and shall not be construed as, either “participants” or “beneficiaries” under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) you or your dependents under any circumstances.

Appealing an enrollment or eligibility status decision

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

If you disagree with the Plan Administrator’s determination regarding your enrollment or eligibility status, you have 365 days from your eligibility enrollment event to appeal in writing to the following address:

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Eligibility decisions regarding the transplant and weight loss surgery benefit waiting period will be determined under the claims and appeals time frames for medical claims, as described below.

COBRA participants should send the appeal, in writing, to the following address:

WageWorks (COBRA Appeals)
P.O. Box 226591
Dallas, Texas 75222-6591

Your appeal will be handled within 60 days from the date it is received (30 days for COBRA appeals), unless an extension is required.

The 60-day period may be extended if it is determined that an extension is necessary due to matters beyond the Plan’s control. You will be notified prior to the end of the 60-day period if an extension or additional information is required. Appeals of enrollment or eligibility decisions are not eligible for external review but will be eligible for voluntary review.

Medical, pharmacy, Centers of Excellence, dental and vision benefits claims process

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

- Medical, pharmacy and Centers of Excellence benefits except for HMO Plans and the eComm PPO Plan; see [HMO plan claims and appeals procedures](#) and [eComm PPO Plan claims and appeals procedures](#) later in this chapter
- Dental benefits (through Delta Dental)
- Vision benefits (through VSP), and
- A rescission of coverage, which is a cancellation of coverage that has a retroactive effective date, except where cancellation of coverage is due to failure to pay required contributions or premiums in a timely manner.

If you choose to prenotify the Third Party Administrator of a scheduled medical service before you receive treatment or file a claim for benefits, where it is not otherwise required under the Plan, the Third Party Administrator’s response is nonbinding on the Plan and not subject to appeal. However, if the Third Party Administrator requires you or your provider to preauthorize services (including under the Centers of Excellence program and the Accountable Care Plans), and your request for prior authorization is denied, that decision is subject to appeal.

Refer to the respective chapters in this Summary Plan Description for information on filing your initial claim. Initial claims will be determined by Plan Administrators as listed in the chart on the following page:

CLAIMS AND APPEALS ADMINISTRATION: ROUTINE MEDICAL, PHARMACY, DENTAL AND VISION

Medical (For Centers of Excellence claims, see below)	Your Third Party Administrator (see your plan ID card) Including services performed at a Centers of Excellence facility but not covered under the Centers of Excellence program and transplant claims not required to be performed at Mayo Clinic. If you are a participant in one of the Mercy Accountable Care Plans, Mercy will handle prior authorizations and HealthSCOPE Benefits will process claims.
Pharmacy	Express Scripts
Dental	Delta Dental
Vision	VSP

CENTERS OF EXCELLENCE

NOTE: If you are enrolled in an Accountable Care Plan, please call your health care advisor to be directed to the appropriate administrator.

Heart surgery	Health Design Plus
Breast, lung, and colorectal cancer travel review	HealthSCOPE Benefits
Spine surgery	Health Design Plus
Hip and knee replacement	Health Design Plus
Transplant	HealthSCOPE Benefits
Weight loss surgery	Health Design Plus

The time period in which your claim will be determined depends on the type of claim. The Plan requires prior authorization for all Centers of Excellence services and certain other services, as described in the [Preauthorization](#) section of [The medical plan](#) chapter. For these benefits, you or your provider must file a claim for approval before you receive treatment, or your claim may not be paid. These are called “pre-service claims.” If your pre-service claim is urgent, your claim will be decided under the urgent care time frames. A claim is urgent where making a determination under the normal time frames could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

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

The chart on the following page shows deadlines for making claims determinations for these types of claims.

CLAIMS PROCESS AND TIMING

<p>Urgent claims Any claim for medical care or treatment where making a determination under the normal time frames could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.</p>	<p>Notice will be sent as soon as possible, taking into account the medical exigencies, and in no case later than 72 hours after receipt of the claim.</p> <p>You may receive notice orally, in which case a written notice will be provided within three days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information.</p> <p>If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request.</p>
<p>Pre-service claims A claim for services that have not yet been rendered and for which the Plan requires prior authorization.</p>	<p>If your pre-service claim is improperly filed, you will be sent notification within five days of receipt of the claim.</p> <p>If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the claim.</p> <p>If the Plan determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Plan expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Plan then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.</p>
<p>Post-service claims A claim for services that already have been rendered, or where the Plan does not require prior authorization.</p>	<p>A notice will be sent within a reasonable time period, but not longer than 30 days from receipt of the claim.</p> <p>If the Plan determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Plan expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Plan then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.</p>
<p>Concurrent care claims A claim related to a reduction of ongoing services.</p>	<p>You will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction so that you will be able to appeal the decision before the coverage is reduced or terminated, unless such a reduction or termination is due to a Plan amendment or termination of the Plan.</p>

If your claim is denied, the denial will include the following information:

- The specific reason(s) for the denial
- Reference to provisions of the Plan on which the denial was based
- Information regarding time limits for appeal
- A description of any additional information necessary to consider your claim and why such information is necessary
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitation, an explanation of this rule (or a statement that it is available upon request), and

- Notice regarding your right to bring legal action following a denial on appeal.

For medical, pharmacy, Centers of Excellence and vision benefits, the denial also will include:

- Information sufficient to identify the claim involved, including, as applicable, the date of service, health care provider and claim amount
 - Upon written request, the Plan will provide you with the diagnosis and treatment codes (and their corresponding meanings) associated with any denied claim or appeal.
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal, and

- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist participants with the internal and external appeals process.

Internal appeal process

APPEALING A MEDICAL, CENTERS OF EXCELLENCE, PHARMACY, DENTAL OR VISION CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

You may request an appeal of the decision. In order for your appeal to be considered, it must:

- Be in writing
- Be sent to the correct address
- Be submitted within 365 days of the date of the initial denial (for medical, Centers of Excellence and dental claims) or 180 days (for pharmacy and vision claims), and
- Contain any additional information/documentation you would like considered.

If your appeal involves an urgent claim, please contact your Third Party Administrator for information about how to file your claim orally.

Aetna and Express Scripts allow two levels of review. The second appeal must be submitted within 60 days of the date of the first appeal denial. All other Third Party Administrators have one level of appeal.

Send your written request for review of the initial claim to the Third Party Administrator that administers your claims:

Appeals for medical and transplant benefits not required to be performed at Mayo Clinic, services performed at a Centers of Excellence facility but not covered under the Centers of Excellence program, and for weight loss services not performed under the weight loss surgery benefit

Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, Kentucky 40512
855-548-2387

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas 72203-1460
866-823-3790

HealthSCOPE Benefits
Attn: Appeals
P.O. Box 2359
Little Rock, Arkansas 72203
800-804-1272

UnitedHealthcare National Appeals Service Center
P.O. Box 30575
Salt Lake City, Utah 84130-0575
888-285-9255

Centers of Excellence for heart, spine, and hip and knee replacement surgeries and weight loss surgery: Health Design Plus

Centers of Excellence: Walmart
Attn: Appeals Coordinator
1755 Georgetown
Hudson, Ohio 44236

Centers of Excellence for heart and weight loss surgery at Emory Accountable Care Plan

HealthSCOPE Benefits, Inc.
Attn: Appeals Coordinator
27 Corporate Hill Drive
Little Rock, Arkansas 72205

Centers of Excellence for weight loss surgery at Mercy Accountable Care Plan

HealthSCOPE Benefits, Inc.
Attn: Appeals Coordinator
27 Corporate Hill Drive
Little Rock, Arkansas 72205

Centers of Excellence for weight loss surgery at Banner Accountable Care Plan

Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, Kentucky 40512

Centers of Excellence for cancer care and Mayo Clinic transplant appeals: HealthSCOPE Benefits

HealthSCOPE Benefits, Inc.
Attn: Appeals Coordinator
27 Corporate Hill Drive
Little Rock, Arkansas 72205

Pharmacy appeals

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, Missouri 63166-6588

Dental appeals

Delta Dental of Arkansas
Appeals Committee
P.O. Box 15965
Little Rock, Arkansas 72231-5965

Vision appeals

VSP

Member Appeals

3333 Quality Drive

Rancho Cordova, California 95670

NOTE: There is a special claims and appeals process for certain Centers of Excellence benefits (see details later in this chapter).

Your appeal will be conducted without regard to your initial determination by someone other than the party who decided your initial claim. No deference will be afforded to the initial determination. You will have the opportunity to submit written comments, documents or other information in support of your appeal. You have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. The Third Party Administrator, on behalf of the Plan, will provide you with any new or additional evidence or rationale considered in connection with your claim sufficiently in advance of the appeals determination date to give you a reasonable opportunity to respond.

If your claim involves a medical judgment question, the Plan will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the Plan will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

A final decision on appeal will be made within the time periods specified in the chart that follows, depending on the type of claim:

APPEAL PROCESS AND TIMING

Urgent claims	You will be notified of the determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim (36 hours for Aetna appeals).
Pre-service claims	You will be notified of the determination within a reasonable period of time, taking into account the medical circumstances, but no later than 30 days from the date your request is received (15 days for Aetna appeals).
Post-service claims	You will be notified of the determination within a reasonable period of time, but no later than 60 days from the date your request is received (30 days for Aetna appeals).

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

- The specific reason(s) for the denial
- Reference to provisions of the Plan on which the denial was based
- A statement describing your right to request copies, free of charge, of all documents, records or other information relevant to your claim
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on a medical necessity or similar limitation, an explanation of this rule (or a statement that it is available upon request)
- A description of any voluntary review procedures available, and
- Notice regarding your right to bring legal action following a denial on appeal.

For medical, pharmacy and Centers of Excellence benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount (if applicable)
 - Upon written request, the Plan will provide you with the diagnosis and treatment codes (and their corresponding meanings) associated with any denied claim or appeal.
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal, and
- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist participants with the internal and external appeals process.

SPECIAL PROCEDURES FOR APPROVAL OF A TRANSPLANT LOCATION OTHER THAN MAYO CLINIC

As described in [The medical plan](#) chapter, all transplant recipients (except kidney, cornea and intestinal recipients) must undergo a pre-transplant evaluation at Mayo Clinic. For these transplants, Mayo Clinic will make a recommendation regarding transplant services at Mayo Clinic. You may file a prior authorization request to receive a transplant at a facility other than Mayo Clinic if there is significant risk that travel to Mayo Clinic could result in death. In addition, if Mayo Clinic does not recommend a transplant because it is not deemed the appropriate medical course of treatment or the patient is not an appropriate candidate, you may file a prior authorization request with the Plan.

These requests will be considered by an Independent Review Organization appointed by the Plan Administrator, which may approve the transplant for a different acceptable facility.

The Independent Review Organization will not include any employee of Walmart, Mayo Clinic or a Third Party Administrator of the Plan. The Independent Review Organization will review any pertinent medical files that were reviewed or generated by Mayo Clinic, as well as any additional materials you submit, and will consider your condition, alternative courses of treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit the transplant would have.

Send your written request for review of preauthorization transplant claims to:

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500
800-421-1362

If you are filing a claim for services at a facility other than Mayo Clinic because there is significant risk that travel to Mayo Clinic could result in death, you should file as soon as possible. If you are filing a claim because Mayo Clinic has determined that the transplant is not an appropriate medical course of treatment, your claim must be received by the Plan within 120 calendar days of the initial denial of transplant treatment by Mayo Clinic (where Mayo has determined that treatment is inappropriate). If the claim is urgent, the Independent Review Organization will make its determination within 72 hours after receipt of the claim (otherwise, the Independent Review Organization will make its determination within 15 days of receipt of the claim). An urgent claim is any claim for medical care or treatment where making a determination under the normal time frame could seriously jeopardize the life, health or ability to regain maximum function, or, in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.


If the urgent claim is determined to be incomplete, you will receive a notice within 24 hours of receipt of the claim, and you will have 48 hours to provide additional information.

For non-urgent claims, the deadline to decide the claim may be extended 15 days, and the Independent Review Organization will send a notice explaining the extension. If the extension is necessary to request additional information, the extension notice will describe the required information and you will be given at least 45 days to submit the information. The Plan will make a determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.

You will have 180 days to request internal review of a denial by the Independent Review Organization. The Independent Review Organization will decide a request for urgent review within 72 hours and non-urgent review within 30 days after receipt. You then may appeal a denial of an internal review appeal under the external appeal process described in this section if your claim involves medical judgment.

Kidney, cornea and intestinal transplants, and any other transplant service or claim where treatment already has been rendered, will be decided under the regular medical claims and appeals procedures for post-service claims outlined earlier in this chapter.

SPECIAL PROCEDURES FOR APPROVAL OF EXCEPTIONS TO PLAN COVERAGE TERMS FOR SPINE SURGERY AND HIP AND KNEE REPLACEMENT

 **Please see page 287** for information replacing this section in its entirety.

As described in [The medical plan](#) chapter, spine surgery and hip and knee replacement that are eligible to be performed at a Centers of Excellence facility must be pre-approved by the administrator of the program and performed at a Centers of Excellence facility in order for Centers of Excellence benefits to be payable. You may file a prior authorization request to receive services at a non-Centers of Excellence facility and receive in-network benefits if there is significant risk that travel could result in paralysis or death (a "pre-service" claim) or where a Center of Excellence facility does not recommend spine surgery or hip or knee replacement because it is not deemed the appropriate medical course of treatment or the patient is not an appropriate candidate for surgery (also a "pre-service" claim).

In addition, if you have already received surgical treatment because your circumstances called for immediate surgery, without which you would likely have suffered paralysis or loss of life, or if spine surgery or hip or knee replacement has been provided by a network provider in a course of treatment that began prior to the effective date of this provision, you may request that the services you received at a non-Centers of Excellence facility be covered as in-network services (a "post-service" claim).

These claims will be considered by an Independent Review Organization appointed by the Plan Administrator, which may approve coverage at the in-network level for the spine surgery or hip or knee replacement at a non-Centers of Excellence facility.

The Independent Review Organization will not include any employee of Walmart, the Centers of Excellence facility for spine surgery or hip or knee replacement, or a Third Party Administrator of the Plan. The Independent Review Organization will review any pertinent medical files that were reviewed or generated by the Centers of Excellence facility, as well as any additional materials you submit, and will consider your condition, alternative courses of

treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit the surgical procedure would have.

Send your written request for an exception to the Plan's coverage terms for spine surgery or hip or knee replacement to:

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500
800-421-1362

If you are filing a pre-service claim for services at a non-Centers of Excellence facility because there is significant risk that travel could result in paralysis or death, you should file as soon as possible. If you are filing a pre-service claim because a Center of Excellence facility determined that the surgery is not an appropriate medical course of treatment, your claim must be received by the Plan within 120 calendar days of the initial denial by the Centers of Excellence facility. If you are filing a post-service claim because you already received surgery elsewhere, as described above, you must file your claim within 120 calendar days of the date of service.

If a pre-service claim is urgent, the Independent Review Organization will make its determination within 72 hours after receipt of the claim (otherwise, the Independent Review Organization will make its determination within 15 days of receipt of a pre-service claim or within 30 days of receipt of a post-service claim). An urgent claim is any claim for medical care or treatment where making a determination under the normal time frame could seriously jeopardize the life, health or ability to regain maximum function, or, in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim. If the urgent claim is determined to be incomplete, you will receive a notice within 24 hours of receipt of the claim, and you will have 48 hours to provide additional information. For non-urgent claims, the deadline to decide the claim may be extended 15 days, and the IRO will send a notice explaining the extension. If the extension is necessary to request additional information, the extension notice will describe the required information and you will be given at least 45 days to submit the information. The Plan will make a determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.

You will have 180 days to request internal review of a denial by the Independent Review Organization. The Independent Review Organization will decide a request for urgent review of a pre-service claim within 72 hours after receipt, non-urgent review of a pre-service claim within 30 days after

receipt, and review of a post-service claim within 60 days of receipt. You then may appeal a denial of an internal review appeal under the external appeal process described in this section if your claim involves medical judgment.

REQUESTING TO WAIVE THE ONE-YEAR WAITING PERIOD FOR TRANSPLANT BENEFITS

If the treating physician certifies that, absent the transplant, the individual's death is imminent within 48 hours, the otherwise applicable 12-month waiting period for transplant benefits may be waived. To request this waiver, the claimant must file a prior-authorization request.

These requests will be considered by the Plan Administrator, which may approve the waiver of the one-year waiting period. Send your written request to:

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500
800-421-1362

Your request will be treated as an urgent or pre-service claim. See the [Appeal process and timing](#) chart earlier in this chapter for details on the time frames under which the Plan Administrator will notify you of its determination in response to your request.

REQUESTING A VOLUNTARY REVIEW OF YOUR DENIED APPEAL FOR ENROLLMENT OR ELIGIBILITY STATUS DETERMINATIONS (INCLUDING COBRA)

If you have additional information that was not in your appeal, you may ask for a voluntary review of the decision on your appeal within 180 days of the date on the appeal denial letter. The same criteria and response times that applied to your appeal are generally applied to this voluntary level of review.

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

Walmart People Services
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

See [Deadlines to file a claim or bring legal action](#) earlier in this chapter regarding the deadline to bring legal action.

REQUESTING A VOLUNTARY REVIEW OF YOUR DENIED MEDICAL, DENTAL OR VISION BENEFIT APPEAL FOR ADMINISTRATIVE REASONS

You may request a voluntary review of the decision on your appeal of a denied medical, dental or vision benefit claim if your appeal was denied for an administrative reason, such as exceeding the number of allowed visits, and not for a

medical judgment reason. You must file your request within 180 days of the date on the appeal denial letter. The same criteria and response times that applied to your appeal are generally applied to this voluntary level of review.

The claimant must send a written request for a voluntary appeal for administrative denial to:

Walmart People Services
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

External appeal process for medical, pharmacy or Centers of Excellence benefits

If your internal appeal for medical, pharmacy or Centers of Excellence benefits under the Plan is denied based on medical judgment, you may have the right to further appeal your claim pursuant to an independent external review process.

Your external appeal will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan's decision, and the independent review organization's decision will be binding on the Plan. Your internal appeal denial notice will include more information about your right to file a request for an external review as well as contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

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

Walmart People Services
Attn: External Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500
800-421-1362

External pharmacy appeals should be sent to:

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, Missouri 63166-6587

Information regarding rights related to medical, pharmacy, Centers of Excellence, dental, vision and short-term disability benefits

RIGHT TO REQUEST MEDICAL RECORDS

The Plan has the right to request medical records for any associate or covered individual.

THE PLAN'S RIGHT TO RECOVER OVERPAYMENT

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan (or the Third Party Administrator) will try to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from any participant, beneficiary or dependent. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan's collection effort is not successful. The Plan may also bring a lawsuit to enforce its rights to recover overpayments.

If the overpayment is made to a provider, the Plan (or any Third Party Administrator) may reduce or deny benefits, in the amount of the overpayment, for otherwise covered services for current and/or future claims with the provider on behalf of any participant, beneficiary or dependent in the Plan. If a provider to whom an overpayment was made has patients who are participants in other health and welfare plans administered by the Third Party Administrator, the Third Party Administrator may reduce payments otherwise owed to the provider from such other health plans by the amount of the overpayment.

YOUR RIGHT TO RECOVER OVERPAYMENT

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

RIGHT TO AUDIT

The Plan has the right to audit your and your dependents' claims, including claims of medical providers. The Plan (or the Third Party Administrator) may reduce or deny benefits for otherwise covered services for all current and/or future claims with the provider made on behalf of you or your dependent, or a participant in any other health and welfare plan administered by the Third Party Administrator based

on the results of an audit. The Plan may also reduce or deny benefits for otherwise covered services for all current and/or future claims filed by you or a dependent based on the results of an audit.

RIGHT TO SALARY/WAGE DEDUCTION

To the extent that the Plan may recover from you or your dependents all or part of benefits previously paid, you shall be deemed, by virtue of your enrollment in this medical coverage, to have agreed that the company may deduct such amounts from your wages or salary and pay the same to the Plan until recovery is complete. If you enroll for coverage under the Plan, you will be treated by the Plan as if you had consented to the applicable payroll deductions for such coverage. In addition, if you fail to affirmatively enroll or re-enroll during annual enrollment, you will be treated by the Plan as if you had consented to the automatic re-enrollment described in the [Eligibility and enrollment](#) chapter, including the applicable payroll deductions.

RIGHT TO REDUCTION, REIMBURSEMENT AND SUBROGATION

The Plan has the right to:

- Reduce or deny benefits otherwise payable by the Plan, and
- Recover or subrogate 100% of the benefits paid or to be paid by the Plan for covered persons, to the extent of any and all of the following payments:
 - Any judgment, settlement or payment made or to be made because of an accident or malpractice (except for malpractice that results in paraplegia/quadruplegia, severe burns, total and permanent physical or mental disability, or death), including but not limited to other insurance
 - Any auto or recreational vehicle insurance coverage or benefits, including but not limited to uninsured/underinsured motorist coverage
 - Business medical and/or liability insurance coverage or payments, and
 - Attorney's fees.

The Plan's lien exists at the time the Plan pays medical benefits. If a covered person files a petition for bankruptcy, the covered person agrees that the Plan's lien existed in time prior to the creation of the bankruptcy estate.

Also note that:

- "Covered person" means any participant (as defined by ERISA) or dependent of a participant who is entitled to medical coverage under the Plan
- The Plan has first priority with respect to its right to reduction, reimbursement and subrogation
- The Plan has the right to recover interest on the amount paid by the Plan because of the accident

- The Plan has the right to 100% reimbursement in a lump sum
- The Plan is not subject to any state laws or equitable doctrine, including but not limited to the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of a covered person's attorney's fees and costs
- The Plan is not responsible for the covered person's attorney's fees, expenses or costs
- The right of reduction, reimbursement and subrogation is based on the Plan language in effect at the time of judgment, payment or settlement
- The Plan's right to reduction, reimbursement and subrogation applies to any funds recovered from another party, by or on behalf of the estate of any covered person, and
- The Plan's right to first priority shall not be reduced due to the participant's own negligence.

The Plan will not pursue reduction, reimbursement or subrogation where the injury or illness that is the basis of the covered person's recovery from any party results in:

- Paraplegia or quadriplegia
- Severe burns
- Total and permanent physical or mental disability, or
- Death.

In addition to the exceptions listed above, the Plan Administrator has the authority, in its sole discretion, to determine not to pursue the Plan's rights to reduction, reimbursement or subrogation. For more information, contact the Plan Administrator.

Whether a covered person has a "total and permanent physical or mental disability" will be determined based on criteria developed and applied by the Plan Administrator in its sole discretion. One way of demonstrating total and permanent physical or mental disability is for a covered person to show that the covered person has qualified for Social Security disability income benefits. The Plan Administrator will consider claims for physical and mental disability, even if the covered person does not qualify for Social Security disability income benefits, under criteria developed by the Plan Administrator.

Even in circumstances where the Plan is not prohibited from seeking reduction, reimbursement or subrogation based on the exceptions described previously in this chapter, the Plan's right to reduction, reimbursement or subrogation will be limited to no more than 50% of the total amount recovered by or on behalf of the covered person from any party (which shall not be reduced for the covered person's attorney's fees or costs). The Plan requires all covered persons and their representatives to cooperate in order to guarantee reimbursement to the Plan from third-party benefits. Failure to comply with this request

will entitle the Plan to withhold benefits due to you or your dependents under the Plan. You, your dependents and/or your representatives cannot do anything to hinder reimbursement of overpayment to the Plan after benefits have been accepted by you, your dependents and/or your representatives.

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

- Pain and suffering, or
- Medical benefits.

The Plan's rights apply regardless of whether a covered person has been made whole or fully compensated for his or her injuries.

Additionally, the Plan has the right to file suit on your behalf for the condition related to the medical expenses in order to recover benefits paid or to be paid by the Plan.

Claims for benefits and right to appeal reduction, reimbursement and subrogation decisions

The Plan's decision to seek reduction, reimbursement or subrogation is a determination of benefits under the Plan and may be appealed in accordance with the procedures below.

DEFINITIONS

For purposes of the claims procedures specified below, a "claim for benefits" means a request by a participant, beneficiary or dependent ("claimant") to have the benefits provided under the Plan not reduced through the application of the Plan's right to reduction, reimbursement or subrogation.

INITIAL CLAIM FOR BENEFITS

If the Plan decides to seek reduction, reimbursement or subrogation, the claimant will be notified of the Plan's decision in a written notice ("notice") from the Plan or an agent of the Plan that administers the Plan's claims for reduction, reimbursement or subrogation.

If a claimant receives a notice that the claimant's benefit is subject to reduction, reimbursement or subrogation and believes that the claimant's case falls within one of the exceptions or limitations to the Plan's right to reduction, reimbursement or subrogation, the claimant may file a claim for benefits with the Plan. The claimant may also designate an authorized representative to submit claims for benefits or appeals on the claimant's behalf.

For an initial claim for benefits to be considered, it must:

- Be in writing
- Be sent to the correct address
- Be submitted within 12 months of the date of the notice that a benefit is subject to reduction, reimbursement or subrogation
- Identify the exception or limitation to the Plan's right to reduction, reimbursement or subrogation that the claimant believes applies to the claimant's case, and
- Include documentation that will assist the Plan in making its decision (e.g., medical and hospital records, physician letters).

The claimant must send a written request for review of the initial claim for benefits to:

Walmart People Services
Attn: Subrogation Review
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Within a reasonable time, but no later than 30 days after a claimant's initial claim for benefits is made, the Plan will provide written notice of its decision to the claimant. If the claim for benefits is partially or fully denied, the notice will include the following information:

- The specific reason(s) for the denial
- Reference to provisions of the Plan on which the denial was based
- A description of any additional material or information necessary to perfect the claimant's claim for benefits and an explanation of why such material or information is necessary
- A statement that the claimant has the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making the Plan's determination
- A description of the Plan's appeal procedures and the time limits for appeal, and
- Notice regarding the claimant's right to bring a court action following a denial on appeal.

The 30-day period may be extended for 15 days if it is determined that an extension is necessary due to matters beyond the Plan's control. The Plan will notify the claimant prior to the end of the 30-day period if an extension or additional information is required. If asked to provide additional information, the claimant will have 45 days from the date notified to provide the information. The time to make a determination will be suspended until the claimant provides the requested information (or the deadline to provide the information, if earlier).

IF A CLAIM RELATED TO A REDUCTION, REIMBURSEMENT OR SUBROGATION DECISION IS FULLY OR PARTIALLY DENIED

The claimant may request an appeal of the decision. For a claimant's appeal to be considered, it must:

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

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

Walmart People Services

Attn: Internal Appeals

508 SW 8th Street

Bentonville, Arkansas 72716-3500

The appeal will be conducted without regard to the initial determination by someone other than the party who decided the initial claim for benefits. The claimant has the right to request copies, free of charge, of all documents, records or other information relevant to the claimant's claim for benefits. The claimant also has the right to submit written comments, documents, records and other information, which the Plan will take into account in making its decision on appeal. In deciding any claim for benefits that is based in whole or in part on a medical judgment, the Plan's claims fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be an individual who is neither an individual who was consulted in connection with the Plan's decision on the initial claim for benefits, nor the subordinate of the health care professional. If the advice of a health care professional is obtained in deciding an appeal, the name of the health care professional will be provided to the claimant upon request, regardless of whether the Plan relied on the advice. The Plan must provide the claimant written notice of the Plan's decision on review within 60 days following the Plan's receipt of the claimant's appeal.

If the claim for benefits is denied on appeal, the Plan will provide a denial notice to the claimant that includes:

- The specific reason(s) for the denial
- Specific reference to provisions of the Plan on which the denial was based
- A statement describing the claimant's right to request copies, free of charge, of all documents, records or other information relevant to the claimant's claim for benefits
- A statement that the claimant has the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination

- A description of available voluntary review procedures, if any, and
- Notice regarding the claimant's right to bring a court action following a denial on appeal.

The only method by which the claimant can request the Plan not to reduce benefits is to file a claim for benefits. An initial claim for benefits must be filed within 12 months from the date of the notice. The claimant must complete the required claims and appeals process described in these claims procedures before bringing legal action. A claimant may not file a lawsuit for benefits if the claimant's initial claim for benefits or appeal is not made within the time periods set forth in these claims procedures. A claimant must file any lawsuit for benefits within 180 days after the decision on appeal. A claimant may not file suit after that 180-day period expires.

Covered person's responsibility regarding right of reduction and/or recovery

To aid the Plan in its enforcement of its right of reduction, recovery, reimbursement and subrogation, you and/or your designated representative must, at the Plan's request and at its discretion:

- Take any action
- Give information, or
- Sign documents so required by the Plan.

Failure to aid the Plan and to comply with such requests may result in the Plan's withholding or recovering benefits, services, payments or credits due or paid under the Plan.

The Plan can seek reimbursement of 100% of medical benefits paid from any judgment, payment or settlement that is made on behalf of the covered person for whom the medical benefits were paid. Reimbursement to the Plan of 100% of these charges shall be made at the time the payment is received by you, your dependent(s) or your representative.

HMO plan claims and appeals procedures

In some facilities, Walmart offers health insurance coverage through a Health Maintenance Organization (HMO) as part of the Associates' Health and Welfare Plan. If you participate in an HMO, the HMO will provide a benefit booklet that, together with this document, will serve as the Summary Plan Description for the HMO coverage and will describe its claims and appeals procedures. Contact your HMO for additional information.

eComm PPO Plan claims and appeals procedures

In some facilities, Walmart offers the eComm PPO Plan as part of the Associates' Health and Welfare Plan. If you participate in the eComm PPO Plan, Aetna, the Plan's Third Party Administrator, will provide a booklet that, together with this document, will serve as the Summary Plan Description for the eComm PPO Plan coverage and describe its claims and appeals procedures. Contact Aetna for additional information.

Accident and critical illness insurance claims process

Accident and critical illness insurance claims should be submitted within 60 days of the occurrence or commencement of any covered accident or critical illness to:

Allstate Benefits Workplace Division
Walmart Claims Unit
P.O. Box 414848
Jacksonville, Florida 32203-1488

You may also provide notice of claim as follows:

Online: allstatebenefits.com/mybenefits
 By phone: 800-514-9525
 By fax: 877-423-8804

Be sure to provide the following information for the covered person:

- Name
- Social Security number, and
- Date the covered illness or accident occurred or commenced.

You may request a claim form from Allstate Benefits or visit the [WIRE](#), WalmartOne.com or allstateatwork.com/walmart to obtain an online copy. If you do not receive a claim form within 15 days of your request, you may send a notice of the claim to Allstate Benefits by providing Allstate Benefits with a statement of the nature and extent of the loss.

CRITICAL ILLNESS

When you submit a claim to Allstate Benefits and your claim is denied, a notice will be sent within a reasonable time period, but no later than 30 days after Allstate Benefits receives the claim (filed in accordance with the Critical Illness Certificate of Insurance). In special circumstances, an extension of time may be needed to make a decision. In that case, Allstate Benefits may take a 15-day extension. You will receive written notice of the extension before the end of the 30-day period.

If your claim is denied, your denial will consist of a written explanation, which will include:

- The specific reason(s) for the denial
- Reference to provisions of the Plan on which the denial was based
- Information regarding time limits for appeal
- A description of additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that it is available upon request), and
- Notice regarding your right to bring a court action following a denial on appeal.

APPEALING A CRITICAL ILLNESS CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

You may appeal any denial of a claim for benefits by filing a written request with Allstate Benefits. In connection with an appeal, you may request, free of charge, all documents that are relevant (as defined by ERISA) to your claim. You may also submit with your appeal any comments, documents, records and issues that you believe support your claim, even if you have not previously submitted such documentation. You may have representation throughout the review procedure.

An appeal must be filed with Allstate Benefits in accordance with the claim filing procedures described in your denial letter within 180 days of receipt of the written notice of denial of a claim. Allstate Benefits will render a decision no later than 60 days after receipt of your written appeal. The decision after your review will be in writing and will include:

- The specific reason(s) for the denial
- Reference to provisions of the Plan on which the denial was based
- A statement that you have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that it is available upon request)
- A description of any voluntary review procedures offered by the Plan and your right to obtain information about such procedures, and
- A statement regarding your right to bring court action following a denial on appeal.

You also will receive a notice if the claim on appeal is approved. If your claim is denied, you have the right to bring action in federal court in accordance with ERISA Section 502(a). You cannot take any legal action until you have exhausted the Plan's claims review procedure described earlier.

ACCIDENT INSURANCE

When you submit a claim to Allstate Benefits and your claim is denied, a notice will be sent within a reasonable time period, but no later than 30 days after Allstate Benefits receives the claim (filed in accordance with the Accident Certificate of Insurance). In special circumstances, an extension of time may be needed to make a decision. In that case, Allstate Benefits may take a 15-day extension. You will receive written notice of the extension before the end of the 30-day period.

If your claim is denied, your denial will consist of a written explanation, which will include:

- The specific reason(s) for the denial
- Reference to provisions of the Plan on which the denial was based
- Information regarding time limits for appeal
- A description of additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that it is available upon request), and
- Notice regarding your right to bring a court action following a denial on appeal.

You also will receive a notice if the claim on appeal is approved.

APPEALING AN ACCIDENT CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

You may appeal any denial of a claim for benefits by filing a written request with Allstate Benefits. In connection with an appeal, you may request, free of charge, all documents that are relevant (as defined by ERISA) to your claim. You may also submit with your appeal any comments, documents, records and issues that you believe support your claim, even if you have not previously submitted such documentation. You may have representation throughout the review procedure.

An appeal must be filed with Allstate Benefits in accordance with the claim filing procedures described in your denial letter within 180 days of receipt of the written notice of

denial of a claim. Allstate Benefits will render a decision no later than 60 days after receipt of your written appeal. The decision after your review will be in writing and will include:

- The specific reason(s) for the denial
- Reference to provisions of the Plan on which the denial was based
- A statement that you have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that is available upon request)
- A description of any voluntary review procedures offered by the Plan and your right to obtain information about such procedures, and
- A statement regarding your right to bring court action following a denial on appeal.

You also will receive a notice if the claim on appeal is approved. If your claim is denied, you have the right to bring action in federal court in accordance with ERISA Section 502(a). You cannot take any legal action until you have exhausted the Plan's claims review procedure described earlier.

See [Deadlines to file a claim or bring legal action](#) earlier in this chapter regarding the deadlines to bring legal action.

Company-paid life insurance, optional associate and dependent life insurance, business travel accident insurance and AD&D claims process

Company-paid, optional associate and dependent life insurance, business travel accident insurance and AD&D claims should be submitted to:

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

Life insurance and business travel accident claims must be filed within 12 months of date of death or loss. AD&D claims must be filed within 90 days of loss. See the applicable insurance chapter for details on the information required to file each type of claim. When you submit a claim to Prudential and your claim is denied, a notice will be sent within a reasonable time period, but not longer than 90 days from receipt of the claim. If Prudential determines that an

extension is necessary due to matters beyond Prudential's control, this time may be extended for an additional 90-day period. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which Prudential expects to render a determination.

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

- State the specific reason(s) for the adverse benefit determination
- Reference the specific plan provisions on which the determination is based
- Describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary, and
- Describe Prudential's claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

APPEALING A PRUDENTIAL CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

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

You will have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. Your appeal will be reviewed without regard to your initial determination by someone other than the party who decided your initial claim. Prudential will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial that will include:

- The specific reason(s) for the adverse determination
- Reference to the specific plan provisions on which the determination was based
- A statement describing your right to request copies, free of charge, of all documents, records or other information relevant to your claim

- A description of Prudential's review procedures and applicable time limits
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- A statement describing any appeals procedures offered by the Plan and your right to bring a civil suit under ERISA.

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

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

If your appeal is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a voluntary second appeal of your denial in writing to Prudential. You must submit your second appeal within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit any written comments, documents, records and any other information relating to your claim. The same criteria and response times that applied to your first appeal are generally applied to this voluntary second appeal.

See [Deadlines to file a claim or bring legal action](#) earlier in this chapter regarding the deadline to bring legal action.

Claims process for disability coverage claims

NOTE: This section describes the claims and appeals process for the short-term disability plan for hourly associates (basic and enhanced), the long-term disability plan and the truck driver long-term disability plan. For claims and appeals information for the short-term disability plans for salaried associates and truck drivers, refer to the respective chapters.

Claims under the short-term disability plan for hourly associates for all states except California, Hawaii, New Jersey, New York and Rhode Island should be submitted to:

Sedgwick Claims Management Services, Inc.
National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

Claims under the short-term disability plan for hourly associates who work in Hawaii, New Jersey and New York only, and all claims under the long-term disability and truck driver long-term disability plans should be submitted to Lincoln Financial Group (formerly Liberty Life Assurance Company of Boston) at the following address:

Group Benefits Claims Appeal Unit
Lincoln Financial Group
Group — Charlotte WM
P.O. Box 7216
London, Kentucky 40742-7216

 **See page 289**


Short-term disability claims for hourly associates who work in Rhode Island and California should be submitted directly to the applicable state. For information, call the phone number listed in [Short-term disability resources](#) at the beginning of the [Short-term disability](#) chapter.

Claims for short-term disability benefits in Hawaii, New Jersey and New York must be submitted to Sedgwick within 30 days of the date your disability begins. Sedgwick will notify Lincoln (formerly Liberty) of your disability claim.

For all other states, you must submit your short-term disability claim to Sedgwick within 90 days of the date your disability begins in order to assure consideration for benefits. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

If you are on approved short-term disability and are eligible for long-term disability, you claim automatically will be transitioned to Lincoln (formerly Liberty) for consideration.

Once a claim has been filed, a decision will be made in no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for up to two additional 30-day periods, provided that, prior to any extension period, you are notified in writing that an extension is necessary due to matters beyond control, those matters are identified and you are given the date by which a decision will be rendered. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date your response is received. If your claim is approved, the decision will contain information sufficient to reasonably inform you of that decision.

 **Please see page 288** for information replacing the remainder of the text on this page.

Any adverse benefit determination will be in writing and will include:

- Specific reasons for the decision
- Specific reference to the policy provisions on which the decision is based
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- A description of the review procedures and time limits applicable to such procedures
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA after you appeal the decision if you receive a written denial on appeal, and
 - If an internal rule, guideline, protocol or other similar criteria was relied upon in making the denial, either
 - The specific rule, guideline, protocol or other similar criteria, or
 - A statement that such a rule, guideline, protocol or other similar criteria was relied upon in making the denial and that a copy will be provided free of charge to you upon request.

APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for benefits is denied and you would like to appeal, you must submit a written or oral appeal to Sedgwick or Liberty (as applicable) within 180 days of the denial. Your appeal should include any comments, documents, records or any other information you would like considered

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

Sedgwick or Liberty (as applicable) will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if it is determined that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification of the denial that will include:

- The specific reason(s) for the adverse determination
- Reference to the specific plan provisions on which the determination was based
- A statement describing your right to request copies, free of charge, of all documents, records or other information relevant to your claim
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- A statement describing any appeal procedures offered by the Plan and your right to bring a civil suit under ERISA.

See [Deadlines to file a claim or bring legal action](#) earlier in this chapter regarding the deadline to bring legal action.

For hourly associates, short-term disability appeals should be sent to:

Walmart Disability and Leave Service Center at Sedgwick National Appeals Unit
P.O. Box 14028
Lexington, Kentucky 40512

Statutory disability appeals for associates who work in Hawaii, New Jersey and New York need to be submitted directly to the applicable state. Associates can get information on this process by reviewing the claim denial information provided by Lincoln (formerly Liberty) or by calling Lincoln at **877-353-6404**.

Short-term disability appeals for associates who work in Rhode Island and California should be submitted directly to the applicable state. For information, call the phone number listed in [Short-term disability resources](#) at the beginning of the [Short-term disability for hourly associates](#) chapter.

For salaried associates and truck drivers, see the [Salaried short-term disability plan](#) chapter or the [Truck driver short-term disability plan](#) chapter, as appropriate, for detailed information on the appeals process for those plans.

Long-term disability and truck driver long-term disability appeals should be sent to Lincoln Financial Group (formerly Liberty Life Assurance Company of Boston) at the following address:

Group Benefits Claims Appeal Unit
Lincoln Financial Group
Group — Charlotte WM
P.O. Box 7216
London, Kentucky 40742-7216

VOLUNTARY SECOND APPEAL OF A CLAIM FOR BENEFITS UNDER THE HOURLY SHORT-TERM DISABILITY PLAN

If you are an hourly associate whose short-term disability coverage is administered through Sedgwick and your appeal is denied, you may make a voluntary second appeal of your denial orally or in writing to Sedgwick. You must submit your second appeal within 180 days of the receipt of the written notice of denial. You may submit any written comments, documents, records and any other information relating to your claim. The same criteria and response times that applied to your first appeal, as described earlier, are generally applied to this voluntary second appeal.

All short-term disability appeals should be sent to:

Walmart Disability and Leave Service Center at Sedgwick National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

See [Deadlines to file a claim or bring legal action](#) earlier in this chapter regarding the deadlines to bring legal action.

Resources for Living benefits

You do not have to file a claim or appeal for Resources for Living benefits. You may access the Resources for Living website or contact Resources for Living at any time.

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

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

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

International business travel medical insurance

Claim forms are generally not required for GeoBlue services. However, if you have a question about your benefits or disagree with the benefits provided, you may contact GeoBlue or file a claim by writing the following address:

GeoBlue
One Radnor Corporate Center, Suite 100
Radnor, Pennsylvania 19087

Any claims and appeals will be determined under the time frames and requirements set out in the GeoBlue policy. Contact GeoBlue at any time by calling **888-412-6403**. Outside the U.S. call collect: **610-254-5830**.

Legal information

WHERE CAN I FIND?

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Legal information

This chapter describes your legal rights as a participant in the Associates' Health and Welfare Plan, including information about the confidentiality of your personal medical information as spelled out in the Notice of Privacy Practices – HIPAA Information. You will also find information on your rights to enrollment or premium assistance under Medicaid or the Children's Health Insurance Program (CHIP), the prescription drug coverage available through Medicare Part D and the decisions you need to make about your prescription drug coverage, if you're eligible for Medicare.

LEGAL INFORMATION RESOURCES

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

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

- As a participant in the Associates' Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.
- The HIPAA privacy notice in this chapter describes how medical information about you may be used and disclosed and how you can get access to this information.
- The [Medicare and your prescription drug coverage](#) section in this chapter explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.
- The Medicaid/Children's Health Insurance Program (CHIP) notice explains special enrollment and premium assistance rights for individuals eligible for these programs.

Associates' Health and Welfare Plan

The Plan is an employer-sponsored health and welfare employee benefit plan governed under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The terms and conditions of the Associates' Health and Welfare Plan are set forth in this book, in the Associates' Health and Welfare Plan Wrap Document (Wrap Document), and in the insurance policies and other welfare program documents incorporated into the Wrap Document. The Wrap Document, together with this book and the other incorporated documents, constitutes the written instrument under which the Associates' Health and Welfare Plan is established and maintained. This book also serves as a Summary Plan Description (SPD) for the Associates' Health and Welfare Plan.

Plan Year: January 1 through December 31

Plan Number: 501

Type of Plan: Welfare, including medical, dental, vision, short-term disability, long-term disability, truck driver long-term disability, business travel accident insurance, accidental death and dismemberment (AD&D), company-paid life, optional associate and dependent life, accident insurance, critical illness insurance and Resources for Living.

Type of Administration: The Plan Administrator (or its delegates, including Third Party Administrators deciding appeals) shall have complete discretion to interpret and construe the provisions of the Plan, make findings of fact, correct errors and supply omissions. All decisions and interpretations of any of the Plan (or its delegates) made pursuant to the Plan shall be final, conclusive and binding on all persons, and may not be overturned unless found by a court to be arbitrary and capricious. Benefits will be paid only if the Plan Administrator (or its delegate) determines in its discretion that the claimant is entitled to them.

Plan Sponsor:

Wal-Mart Stores, Inc.
702 SW 8th Street
Bentonville, Arkansas 72716-0295

Plan Administrator/Named Fiduciary:

Senior Vice President, Global Benefits Division,
Wal-Mart Stores, Inc.
Associates' Health and Welfare Plan
508 SW 8th Street
Bentonville, Arkansas 72716-3500
479-621-2058

Agent for Service of Legal Process:

Corporation Trust Company
1209 Orange Street Corporation Trust Center
Wilmington, Delaware 19801

Legal process may also be served on the Plan Administrator or Trustee.

Plan Sponsor's EIN: 71-0415188

FUNDING FOR THE PLAN

Wal-Mart Stores, Inc. may fund Plan benefits out of its general assets or through contributions made to the Wal-Mart Stores, Inc. Associates' Health and Welfare Trust. Contributions also may be required by employees, in an amount determined by Wal-Mart Stores, Inc. in its discretion. All assets of the Plan, including associate contributions and any dividends or earnings of the Plan, shall be available to pay any benefits provided under the Plan or expenses of the Plan, including insurance premiums.

Plan Trustee:

J. P. Morgan
4 New York Plaza, 15th Floor
New York, New York 10004-2413

Plan amendment or termination

Walmart reserves the right to amend or terminate at any time and to any extent the Associates' Health and Welfare Plan and any of the benefits (whether self-insured or insured under a policy paid by the company) described in this book.

Neither the Plan nor the benefits described in this book can be orally amended. All oral statements and representations shall be without force or effect, even if such statements and representations are made by the Plan Administrator or by a management associate of the company. Only written statements by the Plan Administrator shall bind the Plan.

Your rights under ERISA

As a participant in the Associates' Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified facilities, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department

of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You have the right to continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights. (See the [COBRA](#) chapter for more information.)

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage.

Note that the Associates' Medical Plan does not have a pre-existing condition exclusion.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, can fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request materials from the Plan and do not receive them within 30 days, you can file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you can file suit in a state or federal court. Generally, you must complete the appeals process before filing a lawsuit against the Plan. However, you should consult with your own legal counsel in determining when it is proper to file a lawsuit against the Plan.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you can file suit in a federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you can seek assistance from the U.S. Department of Labor, or you can file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the:

**Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210**

You can also obtain certain publications about your rights under ERISA by calling the Employee Benefits Security Administration publications hotline at **866-444-3272** or by going to dol.gov/ebsa.

Notice of privacy practices — HIPAA information

Effective date of this notice: September 23, 2013

ASSOCIATES' MEDICAL PLAN (AMP), DENTAL PLAN, VISION PLAN AND RESOURCES FOR LIVING (RFL) NOTICE OF PRIVACY PRACTICES



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 Information Portability and Accountability Act (HIPAA). HIPAA governs when and how your medical health information held by the AMP, dental plan, vision plan and RFL may be used and disclosed and how you can get access to this information. Please share a copy of this notice with your family members who are covered under the AMP, dental plan, vision plan and RFL.

WALMART'S COMMITMENT TO YOUR PRIVACY

This HIPAA Notice of Privacy Practices applies only to the self-insured AMP, dental and vision plans and to RFL (Plans) maintained by Wal-Mart Stores, Inc. (Walmart). References to “we” and “us” throughout this notice mean the Plans. Walmart also provides benefits for some associates through a Health Maintenance Organization (HMO), a fully insured PPO Plan and a fully insured international business travel medical plan. For these benefit options, the insurer of the HMO or PPO Plan or international business travel medical plan is responsible to protect your health information under the HIPAA rules, including providing you with its own notice of privacy practices.

The Plans are dedicated to maintaining the privacy of your health information for as long as the Plans hold your health information or for fifty years after your death. In operating the Plans, we create records regarding you and the benefits we provide to you. This notice will tell you about the ways in which we may use and disclose health information about you. We will also describe your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to:

- Maintain the privacy of your health information, also known as Protected Health Information (PHI)
- Provide you with this notice
- Comply with this notice, and
- Notify you if there is a breach of your unsecured PHI.

The Plans reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If there is a material

revision to this notice, the new notice will be distributed to you. You may obtain a paper copy of the current notice by contacting the Plans using the contact information listed at the end of this notice. The most current notice is also available on the benefits website on the [WIRE](#).

HOW THE AMP, DENTAL PLAN, VISION PLAN AND RFL MAY USE AND DISCLOSE YOUR PHI

The law permits us to use and disclose your protected health information (PHI) for certain purposes without your permission or authorization. The following gives examples of each of these circumstances:

1. **For Treatment.** We may use or disclose your PHI for purposes of treatment. For example, we may disclose your PHI to physicians, nurses and other professionals who are involved in your care.
2. **For Payment.** We may use or disclose your PHI to provide payment for the treatment you receive under the Plans. For example, we may contact your health care provider to certify that you have received treatment (and for what range of benefits), and we may request details regarding your treatment to determine if your benefits will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members or other insurance companies.
3. **For Health Care Operations.** We may use or disclose your PHI for our health care operations. For example, our claims administrators in some states or the Plans may use your PHI to conduct cost-management and planning activities. Any information which we use or disclose for underwriting purposes will not include any of your PHI which is genetic information.
4. **To the Plans' Sponsor.** The Plans may use or disclose your PHI to Walmart, the Plan Sponsor. The Plans' Sponsor will only use your PHI as necessary to administer the Plans. The law only permits the Plans to disclose your PHI to Walmart, in its role as the Plans' Sponsor, if Walmart certifies, among other things, that it will only use or disclose your PHI as permitted by the Plan, will restrict access to your PHI to those Walmart employees whose job it is to administer the Plan and will not use PHI for any employment-related actions.
5. **For Health-Related Programs and Services.** The Plans may contact you about information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.
6. **To Individuals Involved in Your Care or Payment for Your Care.** The Plans may disclose your PHI to a third party involved in your health care including a family member, close friend or a person you identified to the Plan as involved in your health care, provided that you agree to this disclosure. If you are not present or available to agree or disagree to disclose your PHI to a third person requesting

the PHI, then the Plans may use professional judgment to determine if the disclosure of PHI is in your best interests. If it is determined that a disclosure of PHI is then in your best interest, the Plans may disclose the minimum amount of PHI necessary to meet the need. Additionally, you have the right to request that the Plans limit any disclosure of PHI to specific individuals involved in your health care.

OTHER USES OR DISCLOSURES OF YOUR PHI WITHOUT AN AUTHORIZATION

The law allows us to disclose your PHI in the following circumstances without your permission or authorization:

1. **When Required by Law.** The Plans will use and disclose your PHI when we are required to do so by federal, state or local law.
2. **For Public Health Risks.** The Plans may disclose your PHI for public health activities, such as those aimed at preventing or controlling disease, preventing injury, reporting reactions to medications or problems with products, and reporting the abuse or neglect of children, elders and dependent adults.
3. **For Health Oversight Activities.** The Plans may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include investigations, inspections, audits and licensure.
4. **For Lawsuits and Disputes.** The Plans may use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we receive satisfactory assurances from the party seeking the information that reasonable efforts have been made to inform you of the request and given you the opportunity to raise an objection to the court or obtain an order protecting the information the party has requested.
5. **To Law Enforcement.** The Plans may release your PHI if asked to do so by a law enforcement official in certain circumstances, including but not limited to the following:
 - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
 - Concerning a death we believe might have resulted from criminal conduct
 - Regarding criminal conduct at our offices
 - In response to a warrant, summons, court order, subpoena or similar legal process
 - To identify/locate a suspect, material witness, fugitive or missing person
 - In an emergency, to report a crime (including the location or victim(s) of the crime or the description, identity or location of the person who committed the crime), and
- In cases where a law enforcement agency has requested PHI for purposes of identifying or locating an individual, HIPAA permits that if certain specific situations are met, the Plans must disclose to the law enforcement agency limited information such as name, address, Social Security number, ABO blood type, type of injury, date and time of treatment or death and distinguishing physical characteristics.
6. **To Avert a Serious Threat to Health or Safety.** The Plans may use or disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
7. **For Military Functions.** The Plans may use or disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans), and if required to assure the proper execution of a military mission if the appropriate military authority has published the required information in the Federal Register.
8. **For National Security.** The Plans may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state or to conduct investigations.
9. **Inmates.** The Plans may disclose your health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: for the institution to provide health care services to you; for the safety and security of the institution; and/or to protect your health and safety or the health and safety of other individuals.
10. **To Workers' Compensation Programs.** The Plans may release your health information for workers' compensation and similar programs.
11. **For Services Related to Death.** The Plans may disclose your PHI upon your death to a coroner, funeral director or to tissue or organ donation services, as necessary to permit them to perform their functions.
12. **Research.** HIPAA permits the Plans to disclose PHI for government-approved research purposes. It is the policy of the Plans not to disclose PHI for research purposes and will not disclose your PHI for such purposes unless the PHI is required to be disclosed under law.
13. **Psychotherapy Notes.** An authorization is always required to use or disclose psychotherapy notes to a third person unless the use or disclosure is permitted under HIPAA regulations. Permissible uses or disclosures include: use for treatment, payment or health care operations; use by the originator of the notes for treatment; use by the Plans to defend themselves in a lawsuit that you initiate; when required by the Secretary of the Department of Health

and Human Services; when such disclosure is required by law; for health oversight activities as permitted under the regulations; disclosure to a person who can reasonably prevent serious harm to an individual or the public; and disclosure to a medical examiner or coroner for the purpose of identifying a deceased person, determining cause of death or such other purposes permitted by law. While the regulations permit covered entities to use and disclose psychotherapy notes for purposes of training health professionals or students, the Plans do not engage in such training exercises and cannot disclose the information for these purposes.

14. **Victims of Abuse, Neglect or Domestic Violence.** The Plans may disclose your PHI if there is reasonable belief that you are a victim of abuse, neglect or domestic violence. Such disclosure is permitted under HIPAA only if required by law or with your permission or to the extent the disclosure is expressly authorized by statute and only if, in the Plan's best judgment, the disclosure is necessary to prevent serious harm to you or other potential victims.
15. **Health Oversight Activities and Joint Investigations.** The Plans must disclose PHI requested of health oversight agencies for purposes of legally authorized audits, investigations including joint investigations, inspections, licensure, disciplinary actions or other oversight activities of authorized entities.
16. **Disaster Relief Efforts.** The Plans may use or disclose your PHI to notify a family member or other individual involved in your care of your location, general condition or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notification.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

The Plans will obtain your written authorization for any other uses or disclosures of your PHI, including for most uses and disclosures of psychotherapy notes, except in situations noted above, uses and disclosures of PHI for marketing purposes, and uses or disclosures that are a sale of PHI. The Plan will not condition your eligibility to participate in the Plan or payment of benefits under the Plan upon your authorization, except where allowed by law. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization at any time in writing. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization, except for where we have taken action in reliance on your authorization before we received your written revocation.

STRICTER STATE PRIVACY LAWS

Under the HIPAA Privacy Regulations, the Plan is required to comply with state laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws.

YOUR RIGHTS RELATED TO YOUR PHI

You have the following rights regarding your PHI that we maintain:

1. **Right to Request Confidential Communications.** You have the right to request that the Plans communicate with you about your health and related issues in a particular manner or at a certain location if you feel that your life may be endangered if communications are sent to your home. For example, you may ask that we contact you at work rather than home. In order to request a type of confidential communication, you must make a written request to the address at the end of this section specifying the requested method of contact or the location where you wish to be contacted. For us to consider granting your request for a confidential communication, your written request must clearly state that your life could be endangered by the disclosure of all or part of this information.
2. **Right to Request Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. We generally are not required to agree to your request except in limited circumstances; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. To request a restriction in our use or disclosure of your PHI, you must make your request in writing to the address at the end of this section. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit the Associates' Medical Plan's, dental plan's, vision plan's or RFL's use, disclosure or both; and (c) to whom you want the limits to apply.
3. **Right to Inspect and Copy.** Except for limited circumstances, you have the right to inspect and copy the PHI that may be used to make decisions about you. Usually, this includes medical and billing records. To inspect or copy your PHI, you must submit your request in writing to the address listed at the end of this section. The Plans must directly provide to you, and/or the individual you designate, access to the electronic PHI in the electronic form and format you request, if it is readily producible, or, if not, then in a readable electronic format as agreed to between you and the Plan. The Plans may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances, in which case you may submit a request to the Plan at the address on the following page that the denial be reviewed.
4. **Right to Request Amendment.** You have the right to request that we amend your PHI if you believe it is incorrect or incomplete. To request an amendment, you must submit a written request to the address listed at the end of this section. You must provide a reason that supports your request for amendment. We may deny your request if you ask us to amend PHI that is: (a) accurate

and complete; (b) not part of the PHI kept by or for the Plan; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by the Plan, unless the individual or entity that created the PHI is not available to amend it. Even if we deny your request for amendment, you have the right to submit a statement of disagreement regarding any item in your record you believe is incomplete or incorrect. If you request, it will become part of your medical record and we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

5. **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures. An accounting of disclosures is a list of certain disclosures we have made of your PHI, for most purposes other than treatment, payment, health care operations and other exceptions pursuant to law or pursuant to your authorization. To request an accounting of disclosures, you must submit a written request to the address at the end of this section. You must specify the time period, which may not be longer than the six-year period prior to your request. We will notify you of the cost involved in complying with your request and you may choose to withdraw or modify your request at that time.
6. **Paper Notice.** You have a right to request a paper copy of this notice, even if you have agreed to receive this notice electronically.

If you believe your privacy rights have been violated, you may file a complaint with the Associates' Medical Plan, dental plan, vision plan or RFL, or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, you must submit it in writing to the address listed at the end of this section. Neither Walmart nor the Plans will retaliate against you for filing a complaint.

If you have questions about this notice or would like to exercise one or more of the rights listed in this notice, please contact:

Walmart People Services

Attn: HIPAA Compliance Team

508 SW 8th Street

Mail Stop #3500

Bentonville, Arkansas 72716-3500

 **See page 289**

Effective Jan. 1, 2018 email your questions to:

AHWPrivacy@walmart.com

Telephone: 800-421-1362

Medicare and your prescription drug coverage

Please read this notice about Medicare and your prescription drug coverage carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the Associates' Health and Welfare Plan (the Plan) and your prescription drug coverage option under

Medicare. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

There are important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Some of the Walmart prescription drug plans (as described later in this notice under the heading **Which Walmart plans are considered creditable coverage?**) are, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and are therefore considered creditable coverage. If you are a participant in one of these plans, you may keep your current coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
- Other Walmart plan options (as described later in this notice under the heading **Which Walmart plans are considered non-creditable coverage?**) are, on average for all Plan participants, not expected to pay out as much as the standard Medicare prescription drug coverage will pay. If you are a participant in one of these plans, your coverage is non-creditable coverage. This is important because for most people enrolled in these plan options, enrolling in Medicare prescription drug coverage means you will get more help with drug costs than if you had prescription drug coverage exclusively through the Plan. This is also important because it may mean that you pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

If you have non-creditable coverage under the Plan, it may affect how much you pay for Medicare D drug coverage in the future. When you become eligible for Medicare D, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offered by Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

CREDITABLE AND NON-CREDITABLE COVERAGE

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

WHICH WALMART PLANS ARE CONSIDERED CREDITABLE COVERAGE?

Walmart has determined that the following Plans' prescription drug coverages are considered creditable according to Medicare guidelines:

- HRA High Plan
- HRA Plan
- Select Network Plan
- Accountable Care Plan
- HMO Plans
- eComm PPO Plan

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

If you are enrolled in any of the Plans listed above, you can choose to join a Medicare prescription drug plan later without paying extra because you have existing prescription drug coverage that, on average, is as good as Medicare's coverage.

If you are enrolled in Medicare Part D, you are not eligible to enroll in any of the Plans listed above. If your dependent is enrolled in Medicare Part D and you are not, you are eligible to enroll in a Walmart medical or HMO plan, but your dependent would not be eligible for coverage.

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

WHICH WALMART PLANS ARE CONSIDERED NON-CREDITABLE COVERAGE?

The following Plan's prescription drug coverage is considered non-creditable according to Medicare guidelines:

- HSA Plan

If your coverage is non-creditable, you might want to consider enrolling in Medicare prescription drug coverage or a Walmart creditable Plan listed above because the coverage you have is, on average for all participants, not expected to pay out as much as the standard Medicare prescription drug coverage will pay.

WHEN CAN I ENROLL FOR MEDICARE PRESCRIPTION DRUG COVERAGE?

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

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

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

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

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

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

Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may always be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following Medicare annual enrollment period beginning in October to join.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current coverage under the Associates' Medical Plan (AMP) will be affected. Plan guidelines restrict you from enrolling in the AMP if you are enrolled in Medicare Part D. If your dependent is enrolled in Medicare Part D and you are not, you are able to enroll in the AMP, but your dependent would not be eligible for coverage.

If you decide to join a Medicare drug plan and drop your coverage under the Walmart AMP, be aware that you and your dependents will be able to get your AMP coverage back, but only during annual enrollment or due to a status change event.

If you enroll in a Medicare Part D plan and decide within 60 days to switch back to a plan under the Walmart AMP, you will automatically be re-enrolled for the same coverage you had prior to the status change event. See the [Eligibility and enrollment](#) chapter for further details.

FOR MORE INFORMATION ABOUT MEDICARE AND YOUR PRESCRIPTION DRUG COVERAGE

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

ADDITIONAL INFORMATION AVAILABLE

More detailed information about Medicare plans that offer prescription drug coverage is available through the “Medicare & You” handbook from Medicare. You may also be contacted directly by Medicare-approved prescription drug plans. You will get a copy of the handbook in the mail every year from Medicare. You can also get more information about Medicare prescription drug plans from these sources:

- Visit [medicare.gov](https://www.medicare.gov).
- Call your state health insurance assistance program for personalized help. (See your copy of the “Medicare & You” handbook for its telephone number.)
- Call **800-MEDICARE (800-633-4227)**. TTY users should call **877-486-2048**.

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

REMEMBER

Keep this notice. If you enroll in one of the Medicare prescription drug plans, you may need to provide a copy of this notice when you join to show whether or not you have creditable coverage and therefore whether or not you are required to pay a higher premium (a penalty).



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

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your Wal-Mart Stores, 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](https://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed on the following pages, 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 [insurekidsnow.gov](https://www.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 Wal-Mart Stores, 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](https://www.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 August 10, 2017. 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:

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

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & 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+: Colorado.gov/HCPF/Child-Health-Plan-Plus

CHP+ Customer Service: 800-359-1991 State Relay 711

FLORIDA – Medicaid

Website: <http://flmedicaidtprecovery.com/hipp/>
Phone: 877-357-3268

GEORGIA – Medicaid

Website: <http://dch.georgia.gov/medicaid>

Click on Health Insurance Premium Payment (HIPP)

Phone: 404-656-4507

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: <http://www.indianamedicaid.com>

Phone: 800-403-0864

IOWA – Medicaid

Website:

<http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>

Phone: 888-346-9562

KANSAS – Medicaid

Website: <http://www.kdheks.gov/hcf/>
Phone: 785-296-3512

KENTUCKY – Medicaid

Website: <http://chfs.ky.gov/dms/default.htm>
Phone: 800-635-2570

LOUISIANA – Medicaid

Website: <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>
Phone: 888-695-2447

MAINE – Medicaid

Website:

<http://www.maine.gov/dhhs/ofi/public-assistance/index.html>

Phone: 800-442-6003

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website:

<http://www.mass.gov/eohhs/gov/departments/masshealth/>

Phone: 800-862-4840

MINNESOTA – Medicaid

Website: <http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.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

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid website: <https://dwss.nv.gov/>

Medicaid phone: 800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <http://www.dhhs.nh.gov/oii/documents/hippapp.pdf>

Phone: 603-271-5218

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://dma.ncdhhs.gov/>
 Phone: 919-855-4100

NORTH DAKOTA – Medicaid

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

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
 Phone: 888-365-3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
 Phone: 800-699-9075

PENNSYLVANIA – Medicaid

Website: <http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm>
 Phone: 800-692-7462

RHODE ISLAND – Medicaid

Website: <http://www.eohhs.ri.gov/>
 Phone: 855-697-4347

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
 Phone: 888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>
 Phone: 888-828-0059

TEXAS – Medicaid

Website: <http://gethipptexas.com/>
 Phone: 800-440-0493

UTAH – Medicaid and CHIP

Medicaid website: <https://medicaid.utah.gov/>
 CHIP website: <http://health.utah.gov/chip>
 Phone: 877-543-7669

VERMONT– Medicaid

Website: <http://www.greenmountaincare.org/>
 Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid website: http://www.coverva.org/programs_premium_assistance.cfm
 Medicaid phone: 800-432-5924
 CHIP website: http://www.coverva.org/programs_premium_assistance.cfm
 CHIP phone: 855-242-8282

WASHINGTON – Medicaid

Website: <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program>
 Phone: 800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: <http://mywvhipp.com/>
 Toll-free phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>
 Phone: 800-362-3002

WYOMING – Medicaid

Website: <https://wyequalitycare.acs-inc.com/>
 Phone: 307-777-7531

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
dol.gov/ebsa
 866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
cms.hhs.gov
 877-267-2323, Menu Option 4, Ext. 61565

Valued Plan Participant

THE ASSOCIATES' HEALTH AND WELFARE PLAN (AHWP) RESPECTS THE DIGNITY OF EACH INDIVIDUAL WHO PARTICIPATES IN THE PLAN.

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

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

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

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: OCRCompliant@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 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.

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

ਪੰਜਾਬੀ
ਦੇਭਾਸ਼ੀਆ 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.

Glossary of terms

Glossary of terms

Accountable Care Plan: A type of plan in which a group of doctors, clinics, hospitals and other providers work together in an effort to coordinate efficient and high-quality care for participants within the organization's service area. Care is coordinated through care management processes and through a close relationship between participants and their primary care physicians. The Plan's terms for paying providers for their services include financial incentives to manage care.

Active work or actively at work: For medical, dental, vision, Resources for Living, critical illness, accidental death and dismemberment, and accident insurance coverage, "active work" means you have reported to work for Walmart.

For company-paid life insurance, optional associate life insurance, optional dependent life insurance, business travel accident insurance and all types of disability coverage, "active work" means you are actively at work with the company on a day that is one of your scheduled work days and you are performing all of the regular duties of your job on a full-time basis or a part-time basis (depending on your classification as a full-time or part-time associate). You will be deemed to be actively at work on a day that is not one of your scheduled work days only if you were actively at work on the preceding scheduled work day.

Annual deductibles: The amount you pay each year for eligible charges before the Plan pays a portion of your covered expenses. Under the Accountable Care Plans and the Select Network Plan, doctor visits are not subject to the deductible but are subject to a copayment that must be paid each time you use the service. If you choose one of the HRA plans, your Walmart-provided HRA funds will be used toward your annual deductibles. See [The medical plan](#) chapter for specific details.

Annual enrollment: The period, usually in the fall of each year, during which associates make benefit elections for the next Plan year.

Associates' Health and Welfare Plan (the Plan): The employer-sponsored health and welfare employee benefit plan sponsored by Wal-Mart Stores, Inc. and governed under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Associates' Medical Plan (AMP): Refers to the medical plans offered by Walmart (the HRA High Plan, HRA Plan, HSA Plan, Accountable Care Plans and Select Network Plan). See [The medical plan](#) chapter for more information.

Authorized company business travel: A trip the company authorizes you to take for the purpose of furthering the company's business. An authorized trip:

- Begins when you leave your residence or regular place of employment, and
- Ends when you return to your residence or regular place of employment.

Behavioral health benefits: The benefits for mental health and substance abuse, including alcohol and drug abuse.

Behavioral health facility: With respect to behavioral health benefits, a medical facility that provides:

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

Brand-name drug: A drug manufactured by a single manufacturer that has been evaluated for safety and effectiveness when compared with similar drugs treating the same condition and identified for inclusion on the covered brand-name drug list.

Catch-up contributions: Additional contributions allowed by the IRS to an associate's Health Savings Account if the account holder is age 55 or older. Catch-up contributions are also allowed by the IRS to an associate's 401(k) plan if the associate is age 50 or older.

COBRA: The Consolidated Omnibus Budget Reconciliation Act, which allows associates and their eligible dependents who experience a loss in coverage due to a qualifying event to continue medical, dental and vision coverage.

Coinsurance: The amount you pay for eligible expenses under the medical and dental plans after you've met your annual deductible. See [The medical plan](#) and [The dental plan](#) chapters for specific coinsurance details.

Company: Wal-Mart Stores, Inc. and its participating subsidiaries.

Coordination of benefits: When two benefit plans insure the same participant and coordinate coverage, the process of designating one plan as primary and the other as secondary.

Copay or copayment: A fixed dollar amount required for certain covered services or supplies, such as prescriptions or for certain services under the vision plan, or for certain provider visits if you are enrolled in an Accountable Care Plan, the Select Network Plan, an HMO or the eComm PPO Plan.

Copay assistance: When discounts, coupons, pharmacy discount programs or similar arrangements are provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug discount/coupons provided to pharmacies when you fill a prescription). See [The medical plan](#) and [The pharmacy benefit](#) chapters for details.

Covered expenses: Charges for procedures, supplies, equipment or services covered under the Associates' Medical Plan that are:

- Medically necessary
- Not in excess of the maximum allowable charge
- Not excluded under the Plan, and
- Not otherwise in excess of Plan limits.

Custodial care: Services that are given merely as “care” in a facility or home to maintain a person’s present state of health, which cannot reasonably be expected to significantly improve.

Disability or disabled: Under all coverage options available under the long-term disability (LTD) and truck driver LTD plans, “disability” means that, due to a covered injury or sickness during the benefit waiting period and for the next 24 months of disability, you are unable to perform the material and substantial duties of your own occupation (or, under the truck driver LTD plan, you lose medical certification in accordance with the Federal Motor Carrier Safety Regulations). After 24 months of benefit payments, “disability” means that you are unable to perform the material and substantial duties of any occupation.

In determining whether you are disabled, Lincoln (formerly Liberty) will not consider employment factors, including but not limited to: interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing or loss of professional or occupational license or certification for reasons other than a covered injury or sickness.

To qualify for LTD benefits:

- You must be unable to return to work after the initial benefit waiting period of disability.
- You must continue to be under the appropriate care of a qualified doctor (qualified doctors include legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses).
- Lincoln (formerly Liberty) must receive and approve certification with accompanying medical documentation of a disability from your qualified doctor before benefits are considered for payment.

With respect to short-term disability coverage, see also “total disability.”

Eligibility waiting period: The time between an associate’s hire date and the date the associate is eligible to enroll for benefits.

Eligible dependents: Limited to (and where properly enrolled for coverage, as described in the [Eligibility and enrollment](#) chapter):

- Your spouse, as long as you are not legally separated
- Your domestic partner (or “partner”), as long as you and your domestic partner:
 - Are in an ongoing, exclusive and committed relationship similar to marriage and have been for at least 12 months and intend to continue indefinitely
 - Are not married to each other or anyone else
 - Meet the age for marriage in your home state and are mentally competent to consent to contract
 - Are not related in a manner that would bar a legal marriage in the state in which you live, and
 - Are not in the relationship solely for the purpose of obtaining benefits coverage.
- Any other person to whom you are joined in a legal relationship recognized as creating some or all of the rights of marriage in the state or country in which the relationship was created (also referred to as “partner”)
- Your dependent children through the end of the month in which the child reaches age 26 (or older, if incapable of self-support) who are:
 - Your natural children
 - Your adopted children or children placed with you for adoption
 - Your stepchildren
 - Your foster children
 - The children of your partner, provided your relationship qualifies under the definition of spouse/partner, or
 - Someone for whom you have legal custody or legal guardianship, provided he or she is living as a member of your household and you provide more than half of his or her support.

If a court order requires you to provide medical, dental or vision coverage for children, the children must meet the Plan’s eligibility requirements for dependent coverage.

Evidence of Insurability: See *Proof of Good Health*.

Experimental and/or investigational: Medical procedures, supplies, equipment or services that are defined as experimental and/or investigational according to protocols established by the Third Party Administrators.

Explanation of benefits (EOB): A document sent to Plan participants explaining how a claim was paid or applied.

Extended treatment plan: A plan of care that is consistent with the American Psychiatric Association's standard principles of treatment and is in place of confinement in a hospital or institution. The plan must be in writing and signed by a physician.

Health care advisor: For associates who enroll in the Associates' Medical Plan, a resource who serves as a single point of contact for all inquiries and communication with your Third Party Administrator. Your health care advisor can answer questions about your health care benefits and claims, help you find providers and coordinate care.

Health Reimbursement Account (HRA): An "account" to which the company allocates a specific sum of money to help pay your eligible medical expenses before you have to pay toward the costs of covered medical expenses (except prescriptions). If you choose the HRA High Plan, Walmart will contribute \$500 if you select associate-only coverage, or \$1,000 if you cover your dependents. If you choose the HRA Plan, Walmart will contribute \$300 if you select associate-only coverage, or \$600 if you cover your dependents. Your HRA balance may not exceed your network annual deductible for the plan that you are enrolled in. The new Plan year allocation may only be used for the cost of medical goods or services incurred within that Plan year.

Health Savings Account: A tax-advantaged custodial account you can open with HealthEquity, if you are enrolled in the HSA Plan, which can be used to pay for qualified medical expenses (as defined by the IRS), tax-free. Walmart will match your contributions dollar-for-dollar up to \$350 if you select associate-only coverage, or \$700 if you cover your dependents.

HIPAA: Health Insurance Portability and Accountability Act of 1996, which protects the privacy of personal health information.

Hospital: An institution where sick or injured individuals are given medical or surgical care. The hospital must be a licensed and legally operated acute care general facility that provides:

- Room and board and nursing services for all patients on a 24-hour basis, with a staff of one or more doctors available at all times, and
- On-premise facilities for diagnosis, therapy and major surgery.

A hospital is an institution that is not primarily a nursing home, rest home, convalescent home, institution for treating substance abuse or custodial care institution.

Initial enrollment period: The first time you are eligible to enroll for benefits under the Plan. Initial enrollment periods may vary by job classification. See the charts in the [Eligibility and enrollment](#) chapter.

Leave of absence: Provides associates with needed time away from work while maintaining eligibility for benefits and continuity of employment. To accommodate situations that necessitate absence from work, the company provides three types of leave:

- Family and Medical Leave Act (FMLA)
- Personal, and
- Military.

The decision to grant a request for leave shall be based on applicable laws, the nature of the request, the effect on work requirements and consistency with the policy guidelines and procedures.

Materials copay: Under the vision plan, the copay charged for covered lenses and/or frames, as distinct from the copay charged for eye examinations. See [The vision plan](#) chapter for details.

Maximum allowable charge (MAC): Under the medical plan, applies to both covered in-network and covered out-of-network services. MAC is the maximum amount the Plan will cover or pay for any health care services, drugs, medical devices, equipment, supplies or benefits covered by the Plan. For details, see [The medical plan](#) chapter.

Maximum plan allowance (MPA): Under the dental plan, applies to both covered in-network and covered out-of-network dental services. The MPA is the maximum amount the Plan will cover or pay for dental services covered by the Plan. For details, see [The dental plan](#) chapter.

Medically necessary or medical necessity: Procedures, supplies, equipment or services that are determined by the Plan to be:

- Appropriate for the symptoms, diagnosis or treatment of a medical condition
- Provided for the diagnosis or direct care and treatment of the medical condition
- Within the standards of good medical practice within the organized medical community
- Not primarily for the convenience of the patient or the patient's doctor or other provider, and
- The most appropriate procedure, supply, equipment or service that can be safely provided, which means:
 - There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications for the patient with the particular medical condition being treated, than other possible alternatives

- Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable, and
- For hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

Each Third Party Administrator (TPA) follows its own policies and procedures determining whether a procedure, supply, equipment or service is medically necessary; the policies and procedures may vary by TPA. Your Plan benefits are subject to the terms of such policies. For details, see [The medical plan](#) chapter.

Network providers: Health care providers that have a written agreement with Third Party Administrators to provide services at discounted rates.

Non-network providers: Health care providers that do not have a written agreement with Third Party Administrators to provide services at discounted rates.

Out-of-network benefits: Payment for covered expenses that are provided by a non-network provider and do not meet the criteria outlined under [When network benefits are paid for out-of-network expenses](#) in [The medical plan](#) chapter. (Out-of-network benefits are not provided under the Accountable Care Plans or the Select Network Plan, except in cases of emergency, as defined by the Third Party Administrator.)

Out-of-pocket maximum: The most you will pay each year for eligible network services, including prescriptions.

Partially disabled or partial disability: Under all coverage options available under the long-term disability (LTD) and truck driver LTD plans, “partially disabled” means that, as a result of sickness or injury, you are able to:

- Perform one or more, but not all, of the material and substantial duties of your own or any occupation on a full-time or part-time basis, or
- Perform all of the material and substantial duties of your own occupation on a part-time basis, and
- Earn between 20% and 80% of your indexed pre-disability earnings.

Preauthorization or prior authorization: A notification that may be required as a condition to coverage for certain services by network providers. For more information about services requiring prior authorization, see the [Preauthorization](#) and [Centers of Excellence](#) sections of [The medical plan](#) chapter. Additional details are available by contacting the applicable administrator.

Premium: The amount you pay for the benefits you choose, generally out of each paycheck.

Prenotification: A notification voluntarily made by enrollees/providers to advise Third Party Administrators of any upcoming hospital admissions or outpatient services. As described in the [Prenotification](#) section of [The medical plan](#) chapter, responses by Third Party Administrators to prenotification inquiries are not binding on the Associates’ Medical Plan.

Proof of Good Health or “Evidence of Insurability”: Evidence of your health condition, which includes completing a questionnaire regarding your medical history and possibly having a medical exam. The Proof of Good Health questionnaire is made available when you enroll.

Qualified medical expense: An expense that meets the definition of medical expenses under Internal Revenue Code Sec. 213(d). Examples are provided in IRS Publication 502, *Medical and Dental Expenses*.

Qualified Medical Child Support Order (QMCSO): A final court or administrative order requiring an associate to carry health care coverage for eligible dependents under the Plan, usually following a divorce or child custody proceeding.

Residential treatment facility: A facility offering 24-hour residential programs that are usually short-term in nature and provide intensive supervision and highly structured activities through a written individual treatment plan to persons undergoing an acute demonstrable psychiatric crisis of moderate to severe proportions. The facility must be licensed by the state as a psychiatric residential treatment facility and accredited by the Joint Commission, the nonprofit organization that accredits United States health care programs and organizations.

Specialty drug: Specialty drugs are those pharmaceuticals that target and treat specific chronic or genetic conditions. Specialty drugs include biopharmaceuticals (bioengineered proteins), blood-derived products and complex molecules. They are available in oral, injectable or infused forms. The list of covered specialty drugs is available at [WalmartOne.com](#).

Spouse/partner: Where properly enrolled for coverage, as described in the [Eligibility and enrollment](#) chapter:

- Your spouse, as long as you are not legally separated
- Your domestic partner (or “partner”), as long as you and your domestic partner:
 - Are in an ongoing, exclusive and committed relationship similar to marriage and have been for at least 12 months and intend to continue indefinitely
 - Are not married to each other or anyone else
 - Meet the age for marriage in your home state and are mentally competent to consent to contract

- Are not related in a manner that would bar a legal marriage in the state in which you live, and
 - Are not in the relationship solely for the purpose of obtaining benefits coverage.
- Any other person to whom you are joined in a legal relationship recognized as creating some or all of the rights of marriage in the state or country in which the relationship was created (also referred to as “partner”).

Status change event: An event that allows you to make changes to your coverage outside of the initial enrollment period or annual enrollment period, and in accordance with federal law. These events are listed in the [Eligibility and enrollment](#) chapter.

Third Party Administrator (TPA): A third party that makes claims and internal appeals determinations under the Plan, pursuant to a contractual arrangement with the Plan. Third Party Administrators process your claims and internal appeals with respect to the Plan’s self-funded medical benefits. Third Party Administrators do not insure any benefits under the Plan.

Total disability or totally disabled: Under the short-term disability plans, “total disability” means that you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy. Benefits will be payable during a loss of license only while you are disabled or pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. The determination of whether you are disabled will be made by Sedgwick or Lincoln (formerly Liberty), as applicable, on the basis of objective medical evidence. Objective medical evidence consists of facts and findings, including but not limited to, X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician; and you must be under the continuous care of a qualified doctor and following the course of treatment prescribed. Loss of license in and of itself is not sufficient for meeting the definition of disability.

Walmart: Wal-Mart Stores, Inc. and its participating subsidiaries.

Your own occupation: Under the long-term disability and truck driver long-term disability plans, the occupation that you were performing at Walmart at the time your disability began. “Any occupation” refers to an occupation that you are or can become reasonably fitted for by training, education, experience, age, and physical and mental capacity.

2019 Summary of Material Modifications to the Associates' Health and Welfare Plan

The 2018 *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 2019. Instead, you should review your 2018 *Associate Benefits Book*, along with this SMM. The current summary plan description for the Plan is comprised of the original printing of the 2018 *Associates Benefits Book* and this SMM dated January 1, 2019.

The revisions and page numbers listed below refer to the initial printing of the 2018 *Associate Benefits Book* and the electronic version distributed during the 2018 online Annual Enrollment session. Unless otherwise indicated, the revisions listed below will be effective as of January 1, 2019. Coverage will continue to be subject to the Plan's otherwise applicable eligibility terms, exclusions, limitations, and cost-sharing as described in the 2018 *Associate Benefits Book*.

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 pages 289-290 for more details.

Eligibility and Enrollment

(Pages 4-37 of the 2018 *Associate Benefits Book*)

- Page 6 – The Associates' Health and Welfare Plan Sponsor:** Effective February 1, 2018, the name of the Plan Sponsor changed to Walmart Inc.
- Page 6 – Part-Time Hourly Associate Eligibility:** Effective August 1, 2018, part-time nurse practitioners must work an average of at least 24 hours per week to be eligible to enroll in medical benefits, rather than an average of at least 30 hours per week.
- Page 19 – Paying for Your Benefits:** Effective January 1, 2019, the following is added to the end of the section titled "Paying for your benefits" on page 19 of the 2018 *Associate Benefits Book*: and **Page 20 – Paying for Benefits While on a Leave of Absence:** Effective January 1, 2019, the following replaces the text in the section titled "PAYING FOR BENEFITS WHILE ON A LEAVE OF ABSENCE" on page 20 of the 2018 *Associate Benefits Book*:

To continue coverage while you are on a leave of absence, or if your Walmart paycheck is not enough to pay the full premium deductions due, for any reason, the unpaid portion of the premium for any of the following benefits must be paid, on an after-tax basis, in full to continue coverage for the that benefit:

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

When you pay your premium, you are paying for coverage for the previous pay period. Benefit claims will only be paid if premiums for that benefit have been paid in full as of the date the benefit claim is incurred. Thus, if you have not paid the full amount of premiums due with respect to any benefit for any payroll period, you may experience an interruption in the payment of claims. You can avoid an interruption in the payment of claims for that benefit by paying an additional amount equal to the unpaid portion of any premium that is past due. For more information, call People Services at 800-421-1362.

Premiums may be paid by check or money order. Be sure to include your name, insurance ID (found on your Plan ID card) and facility number on the payment to ensure proper credit. If you have HMO coverage, include your WIN (Walmart ID) number. Please allow 10-14 days for processing. Make the check or money order payable to the Associates' Health and Welfare Trust and mail to:

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

You may also pay by debit card or with a Visa, MasterCard or Discover credit card by calling 800-421-1362 and saying "make a payment."

If you owe any premiums for benefits under the Plan, any check issued by the company (e.g., paid time off, incentive, etc.), will have the full amount of premiums that are currently due, deducted. Payment arrangements can also be made by notifying People Services at 800-421-1362. Generally, payments to continue your coverage can only be accepted from you, a family member, including a partner, or a health care provider.

If your coverage is canceled, please see the applicable benefit section for information about reinstating coverage.

The Medical Plan

(Pages 44-85 of the 2018 *Associate Benefits Book*)

- Page 45 – Remove Castlight Health from Medical Plan Resource Chart:** Effective January 1, 2019, remove Castlight Health from the list of Plan resources.
- Page 47 – Nationally Available Medical Plan Options – Telehealth Video Visits:** Effective January 1, 2019, Telehealth video visits (through Doctor on Demand) for participants enrolled in the HRA High Plan and HRA Plan options will have a \$4 copay. Participants enrolled in the HSA Plan option will pay 100% of the full visit cost until the deductible is met, and after the deductible is met, the participant will have a \$4 copay.
- Pages 49-53 – Accountable Care Plan and Select Network Plan Options – Telehealth Video Visits:** Effective January 1, 2019, Telehealth video visits (Doctor on Demand) participants will pay a \$4 copay.
- Page 50 – New Accountable Care Plans (Memorial Hermann and Ochsner ACPs):** Effective January 1, 2019, the Memorial Hermann Accountable Care Plan will be available to associates who work at designated facilities in the Houston, Texas area and the Ochsner Accountable Care Plan will be available to associates who work at designated facilities in the New Orleans and Baton Rouge, Louisiana areas. These Accountable Care Plan options will be subject to the same coverage provisions and be administered by the same Third-Party Administrator as the other Accountable Care Plan options listed in the chart on page 50 of the 2018 *Associate Benefits Book*.
- Page 64 – Medica Choice Network No Longer an Additional Network through UnitedHealthcare:** Effective January 1, 2019, the Medica Choice Network described on page 64 of the 2018 *Associate Benefits Book* is no longer available.
- Page 64 – Additional Special Provider Network:** Effective January 1, 2019, an additional special provider network will be available under the HRA High Plan, HRA Plan and HSA Plan options administered by BlueAdvantage Administrators of Arkansas, UnitedHealthcare and Aetna. The following is added to the section titled "Special provider networks" on page 64 of the 2018 *Associate Benefits Book*:

ADVANCED IMAGING

Participants in certain locations nationwide who participate in the HRA High Plan, HRA Plan or HSA Plan options, will have access to an alternate network of providers for advanced imaging services (i.e., MRI and CAT scans). An alternate network is essentially a network within a network, a subgroup of providers within the Plan's larger network in a particular service area. In locations in which an alternate network operates, participants will need to see an alternate network provider in order to receive network terms under the Plan for advanced imaging services — i.e., network annual deductibles and network level coinsurance.

If you seek eligible services from a medical provider who is within an area served by the alternate network but who is not a provider within the alternate network, those eligible services may be treated as out of network and covered accordingly.

For additional information about the alternate advanced imaging network, call your health care advisor at the number on your Plan ID card.

- Pages 65-66 – Preventive Care Program:** Effective January 1, 2019, Vitamin D is removed from the list of available preventive services for adults.

Effective January 1, 2019, the Plan will provide 100% preventive care coverage for screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.
- Page 69 – Grand Rounds Replaces Castlight:** Effective January 1, 2019, Grand Rounds will replace Castlight and offer a personalized tool for searching medical services online.

Grand Rounds

Grand Rounds is a personalized tool that lets you search for doctors and medical services online and view quality information and which providers charge a fair price. Participants and dependents age 13 and over who are enrolled in the Plan are eligible to register with Grand Rounds, with the exception of participants in an Accountable Care Plan option. You can register at grandrounds.com/walmart, by mobile app or by calling Grand Rounds at 1-800-941-1384. Registered users can return to the application at any time to access Grand Rounds. There is no cost to you to use the Grand Rounds tool. However, any medical claims incurred as a result of this tool will be subject to normal Plan rules.

With Grand Rounds you can:

- Compare nearby doctors based on quality
- See a fair cost indicator for providers
- Review your Plan details, including your progress toward meeting your deductible and out of pocket maximum

NOTE: If you are enrolled in one of the Accountable Care Plan options, contact your health care advisor at the number on your Plan ID card to obtain information on network doctors and Plan details. You can also find information on network providers on WalmartOne.com.

- Page 70 – Telehealth Video Visits Through Doctor On Demand™:** Effective January 1, 2019, Doctor On Demand will submit claims for services directly to covered participants' Third Party Administrators. For participants in the HSA Plan option, services provided through Doctor On Demand are subject to the same coverage terms as conventional doctor visits only until the deductible is met. For more information about services and technical requirements, visit DoctorOnDemand.com/walmart or call 800-997-6196.
- Page 71 – Centers of Excellence:** Effective January 1, 2019, a reference to the "Cancer Benefit Center of Excellence" will include prostate cancer and blood cancer (including myeloma, lymphoma and leukemia). For a list of Center of Excellence facilities for each of these conditions or benefits, contact the administrator for the applicable Center of Excellence benefit, as described in the 2018 *Associate Benefits Book* or see WalmartOne.com/COE.

Effective January 1, 2019, replace the chart on page 71 with the following:

Centers of Excellence	Centers of Excellence Providers	Your Medical Plan Network	Out-of-Network* <i>Out-of-network benefits not available under Accountable Care Plans and Select Network Plan (unless an emergency as defined by the Third Party Administrator)</i>
Heart surgery Cancer medical record review (onsite travel if recommended by the Center of Excellence provider) Eligible cancer types are: •Breast •Colorectal •Lung •Prostate •Blood (including myeloma, lymphoma and leukemia)	100% No deductible*	75% After deductible	50% After deductible
Hip and knee replacement	100% No deductible*	50% After deductible <i>(Subject to out-of-network deductible for HRA Plan, HRA High Plan and HSA Plan; network deductible for Accountable Care Plan and Select Network Plan)</i>	50% After deductible
Spine surgery	100% No deductible*	No coverage**	No coverage**
Transplant (Mayo Clinic only. Excludes kidney, cornea and intestinal transplant)	100% No deductible*	No coverage**	No coverage**
Weight loss surgery (Gastric bypass and gastric sleeve)	75% After deductible	No coverage**	No coverage**

*Due to federal tax law, participants in the HSA Plan must meet their annual deductible before 100% benefits can be provided.

See the adjacent **Centers of Excellence text for circumstances when exceptions may apply.

12. Page 72 – Centers of Excellence Administration: Effective January 1, 2019, HealthSCOPE Benefits will be the administrator of all Cancer Center of Excellence programs, including those for prostate and blood cancers.

13. Page 72-73 – Centers of Excellence: Effective January 1, 2019, delete the second NOTE in the right-hand column at the bottom of page 72, including the three bullet points and replace with the following:

NOTE: In cases of hip or knee joint replacement, if you are eligible for Centers of Excellence benefits and you choose to receive treatment in a facility outside the Centers of Excellence program, your treatment will be considered out-of-network, even if the provider is a network provider for other purposes. In such circumstances, the Plan will pay 50% for hip and knee joint replacement, subject to the following limitations:

- If you have coverage under the HRA High Plan, HRA Plan or the HSA Plan and have your procedure performed by a network provider, you will be subject to the out-of-network deductible before benefits are payable.
- If you have coverage under any of the Accountable Care Plan options or the Select Network Plan and have your procedure performed by a network provider, you will be subject to your Plan's annual deductible.
- If you have coverage under any of the Accountable Care Plan options or the Select Network Plan and have your procedure performed by an out-of-network provider, no benefits will be payable (unless it is considered an emergency, as defined by the Third-Party Administrator).

In cases of spine surgery, if you are eligible for Centers of Excellence benefits and you choose to receive treatment in a facility outside the Centers of Excellence program, your treatment will be considered out-of-network, even if the provider is a network provider for other purposes. In such circumstances, no benefits will be payable.

14. Page 73 – Centers of Excellence – Effective January 1, 2019, replace the sections titled "Requests for exceptions to Plan coverage terms for spine surgery and hip and knee replacement: and "Pre-service exception request" with the following:

Requests for exceptions to Plan coverage terms for spine surgery and hip and knee replacement

In cases of spine surgery and hip and knee replacement, you may request an exception to the rules described under the "NOTE", immediately above, which states how the Plan will cover these procedures when they are performed outside the Centers of Excellence program. You may request an exception so that procedures performed by a network provider that is not a Centers of Excellence provider be covered at a coinsurance rate of 75% of the network discounted rate and cost-sharing will be applied to your network deductible and network out-of-pocket maximum. Depending on whether you have already received treatment when you make your request, it will be treated as a pre-service claim or post-service claim (as described below) and decided under special rules for granting exceptions to the Plan's coverage terms for spine surgery and hip and knee replacement under the Centers of Excellence program, as described in the **Claims and appeals** chapter.

Pre-service exception request: If you have not yet received treatment but are considering receiving services from a non-Centers of Excellence provider, you may file a prior authorization request (a pre-service claim) to have spine surgery or hip or knee replacement performed by a provider who is not a Centers of Excellence provider if travel to the Centers of Excellence provider would likely result in loss of life, paralysis or further injury, or if the Centers of Excellence facility does not recommend spine surgery or hip or knee replacement because it is not deemed the appropriate medical course of treatment or you are not an appropriate candidate for surgery. Your request will be considered by Health Design Plus following the procedures described under

Special procedures for approval of exceptions to Plan coverage terms for spine surgery and hip and knee replacement in the **Claims and appeals** chapter. If your request is granted, coverage will be at the otherwise applicable network rate, including any deductibles, coinsurance or limitations. If your request is denied because Health Design Plus determines that travel to a Centers of Excellence provider is safe, based on the documentation received, coverage for hip and knee joint replacement surgery performed at a non-Centers of Excellence facility will be paid at 50% as outlined above and no benefits will be payable in the case of spine surgery performed at a non-Center of Excellence facility, also as outlined above.

Decisions not to move forward with spine surgery or hip or knee replacement by the respective Centers of Excellence providers will not be subject to review under this process if the Centers of Excellence provider's decision is based on a determination that the procedure is not appropriate because you refuse to comply with medical restrictions or requirements, including weight loss, smoking cessation, alcohol cessation, social support or similar factors.

15. Page 73 – Transplants: Effective January 1, 2018, the transplant benefit described in the section titled "TRANSPLANTS" on pages 73-74 of the 2018 *Associate Benefits Book* includes CAR-T cell treatment. To be eligible for Car-T cell treatment under the Centers of Excellence program, participants must be enrolled in the Plan for at least 12 months.

16. Pages 75-76 – Weight Loss Surgery Benefit: Effective January 1, 2019, replace the bullet points under the "WEIGHT LOSS SURGERY BENEFIT" beginning on page 75 with the following:

- Services must be provided by a physician and a facility designated by the Plan
- If you wish to utilize the weight loss surgery benefit you must be enrolled for medical benefits in the Plan for at least 12 months. If you are enrolled in the eComm PPO Plan or an HMO Plan you are not eligible for weight loss surgery benefits, but if you later become covered under one of the Plan options, you time enrolled in the eComm PPO Plan or an HMO will count toward the 12-month waiting period. If you are not enrolled in one of the Plan options, any time enrolled in critical illness insurance or accident insurance will not count toward the 12-month waiting period.
- You must be willing to travel to the facility designated by the Plan at your own expense (travel reimbursement is not provided)
- You must be an associate or an eligible covered spouse/partner of an associate (coverage is not available to dependent children, regardless of age)
- You must be at least 18 years of age
- You must either:
 - ◊ Have a body mass index (BMI) of 35 or greater, with at least one obesity-related comorbid condition, or
 - ◊ Have a BMI of 40 or greater.
- You must agree to comply with all requirements for the duration of the weight loss surgery treatment

17. Page 80 – Speech Therapy: Effective January 1, 2018, speech therapy for a residual speech impairment resulting from congenital and severe developmental speech disorders no longer has an age limit.

The Pharmacy Benefit

(Pages 86-93 of the 2018 *Associate Benefits Book*)

1. Page 91 – Preventive Over-the-Counter Medications: Effective January 1, 2019, Vitamin D is removed from the list of available preventive over-the-counter medications.

2. Page 91 – Castlight Tool No Longer Available: Effective January 1, 2019, the Castlight tool described on page 91 of the 2018 *Associate Benefits Book* is no longer available.

Health Saving Account

(Pages 94-101 of the 2018 *Associate Benefits Book*)

1. Page 98-99 – Annual Contribution Limit: Effective January 1, 2019, the maximum annual contribution that can be made to your Health Savings Account, including both the company's contributions and your contributions (pre-tax and after-tax) is \$3,500 for individual coverage and \$7,000 for family coverage.

The Dental Plan

(Pages 102-109 of the 2018 Associate Benefits Book)

- 1. Page 108 – Limited Benefits:** Effective January 1, 2018, oral surgeon fees for services performed in a hospital setting, for participants not enrolled in the Associates' Medical Plan, will be covered, subject to terms of the dental benefit.

Optional Dependent Life Insurance

(Pages 152-157 of the 2018 Associate Benefits Book)

- 1. Page 154 – Enrolling in Optional Dependent Life Insurance:** Effective October 13, 2018, your coverage choices for optional dependent life insurance for spouse/partner include \$150,000 and \$200,000.

Effective October 13, 2018, the coverage choice for optional dependent life insurance for your child listed on page 154 of the 2018 Associate Benefits Book are replaced with the following coverage choices: \$5,000 per child; \$10,000 per child or \$20,000 per child.

- 2. Page 155 – Additional Benefits:** Effective October 13, 2018, additional benefits payable under the circumstances described under the "Additional benefits" section on page 155 increased from \$2,000 to \$5,000.

Short-Term Disability for Hourly Associates

(Pages 170-177 of the 2018 Associate Benefits Book)

- 1. Page 175 – Your Short-Term Disability Benefit:** Effective March 1, 2018, add the following section before the section titled "TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT" on page 175 of the 2018 Associate Benefits Book:

MATERNITY BENEFIT

For full-time hourly associates, except for those who work in CA, HI, NJ and RI, if your disability is due to pregnancy, the short-term disability plan for hourly associates pays a maternity benefit of 100% of your average weekly wage for up to the first nine weeks, after an initial waiting period of seven calendar days. If you remain disabled and are eligible for benefits after the first nine weeks of disability payments, the short-term disability plan will pay up to 50% (basic) or 60% (enhanced) of your average weekly wage, as described in the 2018 Associate Benefits Book, depending on which plan you are enrolled in at the time of your disability, from week 11, up to 25 weeks.

NOTE: If your disability is due to pregnancy, Sedgwick won't require objective medical evidence (as described in the **Short-term disability for hourly associates** chapter of the 2018 Associate Benefits Book) as a condition for approving your disability claim for the short-term disability maternity benefit, unless you begin your leave of absence more than two weeks prior to your estimated date of delivery or you remain disabled after the nine-week maternity benefit. If you begin your leave of absence more than two weeks prior to your estimated date of delivery, objective medical evidence will be required. The maternity benefit will generally begin two weeks before the estimated date of delivery (as determined by a qualified doctor) or the actual date of delivery.

Maternity benefits under the short-term disability plan for full-time hourly associates, except for those who work in CA, HI, NJ and RI, are as described here:

MATERNITY BENEFIT for full-time hourly associates who have been continuously employed with the company for 52 weeks, except for those who work in CA, HI, NJ and RI	
Duration of benefit	Your benefit is:
Up to 9 weeks*	Maternity benefits under the short-term disability plan begin on the 8th calendar day after your eligible disability begins. You may use PTO during your first 7 calendar days of continuous disability. 100% of your average weekly wage after an initial waiting period of 7 calendar days.

* You may also be eligible for additional parental pay equal to 100% of your average weekly wage under Walmart's Parental Pay policy. For additional information, refer to the Parental Pay Policy on the **WIRE**.

Full-time hourly associates who work in CA, HI, NJ and RI generally are not eligible for the Walmart short-term disability plan because these states have state-mandated disability plans with their own eligibility terms. If you work in one of these states, you will be eligible for maternity benefits under the short-term disability plan for hourly associates, subject to the following:

- If your disability is due to pregnancy, and you are eligible for state-mandated short-term disability benefits, the short-term disability plan for hourly associates supplements the state-mandated short-term disability benefits. The short-term disability plan will pay a maternity benefit that will make up the difference between the state-mandated short-term disability benefits and 100% of your average weekly wage up to the first nine weeks, after an initial waiting period of seven calendar days. The short-term disability maternity benefits will end at the end of the nine weeks. However, you may still qualify for continued benefits through your state-mandated short-term disability benefit.

- If your disability is due to pregnancy, and you are not eligible for state-mandated short-term disability benefits, the short-term disability plan pays a maternity benefit of 100% of your average weekly wage up to the first nine weeks, after an initial waiting period of seven calendar days. The short-term disability maternity benefits will end after nine weeks.

NOTE: If your disability is due to pregnancy, Sedgwick won't require objective medical evidence (as described in the Short-term disability for hourly associates chapter of the 2018 Associate Benefits Book) as a condition for approving your disability claim for the short-term disability maternity benefit, unless you begin your leave of absence more than two weeks prior to your estimated date of delivery. If you begin your leave of absence more than two weeks prior to your estimated date of delivery, objective medical evidence will be required.

The maternity benefit will generally begin two weeks before the estimated date of delivery (as determined by a qualified doctor) or the actual date of delivery.

Maternity benefits under the short-term disability plan for associates who work in CA, HI, NJ, or RI are described here:

MATERNITY BENEFIT for full-time hourly associates who have been continuously employed with the company for 52 weeks and who work in CA, HI, NJ, or RI		
Duration of benefit	Your benefit is:	
	If you are eligible for state-mandated short-term disability benefits	If you are not eligible for state-mandated short-term disability benefits
Up to 9 weeks*	State-mandated short-term disability benefits are payable at the applicable state rate; the Walmart short-term disability maternity benefit will make up the difference between the state-mandated benefit and 100% of your average weekly wage after an initial waiting period of 7 calendar days. Maternity benefits under the short-term disability plan begin on the 8th calendar day after your eligible disability begins. You may use PTO during your first 7 calendar days of continuous disability.	100% of your average weekly wage after an initial waiting period of 7 calendar days. Maternity benefits under the short-term disability plan begin on the 8th calendar day after your eligible disability begins. You may use PTO during your first 7 calendar days of continuous disability.

*You may also be eligible for additional parental pay equal to 100% of your average weekly wage under Walmart's Parental Pay policy. For additional information, refer to the Parental Pay Policy on the **WIRE**.

Long-Term Disability for Hourly Associates

(Pages 194-201 of the 2018 Associate Benefits Book)

- 1. Page 195 – What you need to know about long-term disability:** Effective January 1, 2019, LTD benefits are paid bi-monthly, rather than at the end of each 30-day period of disability, as long as you continue to be disabled as defined by the LTD plans.
- 2. Page 196 – Enrollment in Long-Term Disability and When Coverage is Effective:** Effective January 1, 2018, the maximum monthly benefit for the LTD enhanced plan increased from \$15,000 to \$18,000.
- 3. Page 198 – YOUR LTD BENEFIT:** Effective January 1, 2018, the maximum monthly benefit for the LTD enhanced plan increased from \$15,000 to \$18,000.

Effective January 1, 2019, LTD benefits are paid bi-monthly, rather than at the end of each 30-day period of disability, as long as you continue to be disabled as defined by the LTD plans.

Truck Driver Long-Term Disability

(Pages 202-209 of the 2018 Associate Benefits Book)

- 1. Page 203 – What you need to know about truck driver long-term disability:** Effective January 1, 2019, truck driver LTD benefits are paid bi-monthly, rather than at the end of each 30-day period of disability, as long as you continue to be disabled as defined by the truck driver LTD plans.
- 2. Page 204 – Enrollment in Truck Driver LTD and When Coverage is Effective:** Effective January 1, 2018, the maximum monthly benefit for the Truck Driver LTD enhanced plan increased from \$15,000 to \$18,000.
- 3. Page 206 – Your Truck Driver LTD Benefits:** Effective January 1, 2018, the maximum monthly benefit for the Truck Driver LTD enhanced plan increased from \$15,000 to \$18,000.

Effective January 1, 2019, truck driver LTD benefits are paid bi-monthly, rather than at the end of each 30-day period of disability, as long as you continue to be disabled as defined by the truck driver LTD plans.

Claims and Appeals

(Pages 246-263 of the 2018 Associate Benefits Book)

- 1. Page 253 – SPECIAL PROCEDURES FOR APPROVAL OF EXCEPTIONS TO PLAN COVERAGE TERMS FOR SPINE SURGERY AND HIP AND KNEE REPLACEMENT**

Effective January 1, 2019, replace the "Special Procedures for Approval of Exceptions to Plan Coverage Terms for Spine Surgery and Hip and Knee Replacement" section with the following:

As described in The medical plan chapter, spine surgery and hip and knee replacement that are eligible to be performed at a Centers of Excellence facility must be pre-approved by the administrator of the program and performed at a Centers of Excellence facility in order for Centers of Excellence benefits to be payable. You may file a prior authorization request to receive services at a non-Centers of Excellence facility and receive in-network benefits if there is significant risk that travel could result in paralysis or death (a "pre-service" claim) or where a Center of Excellence facility does not recommend spine surgery or hip or knee replacement because it is not deemed the appropriate medical course of treatment or the patient is not an appropriate candidate for surgery (also a "pre-service" claim).

In addition, if you have already received surgical treatment because your circumstances called for immediate surgery, without which you would likely have suffered paralysis or loss of life, or if spine surgery or hip or knee replacement has been provided by a network provider in a course of treatment that began prior to the effective date of this provision, you may request that the services you received at a non-Centers of Excellence facility be covered as in-network services (a "post-service" claim).

Pre-service claims will be considered by Health Design Plus, the administrator of the spine surgery and hip and knee replacement Centers of Excellence, which may approve coverage at the in-network level for spine surgery or hip or knee replacement at a non-Centers of Excellence facility.

Send your written request for a pre-service exception to the Plan's coverage terms for spine surgery or hip or knee replacement to:

Centers of Excellence: Walmart
Attn: Appeals Coordinator
1755 Georgetown
Hudson, Ohio 44236

Health Design Plus will not include any associate of Walmart or the Centers of Excellence facility for spine surgery or hip or knee replacement. Health Design Plus will review any pertinent medical files that were reviewed or generated by the Centers of Excellence facility, as well as any additional materials you submit, and will consider your condition, alternative courses of treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit the surgical procedure would have.

Post-service claims will be considered by an Independent Review Organization appointed by the Plan Administrator, which may approve coverage at the in-network level for the spine surgery or hip or knee replacement at a non-Centers of Excellence facility.

The Independent Review Organization will not include any associate of Walmart, the Centers of Excellence facility for spine surgery or hip or knee replacement, or a Third-Party Administrator of the Plan. The Independent Review Organization will review any pertinent medical files that were reviewed or generated by the Centers of Excellence facility, as well as any additional materials you submit, and will consider your condition, alternative courses of treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit the surgical procedure would have.

Send your written request for a post-service exception to the Plan's coverage terms for spine surgery or hip or knee replacement to:

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500
800-421-1362

If you are filing a pre-service claim for services at a non-Centers of Excellence facility because there is significant risk that travel could result in paralysis or death, you should file as soon as possible. If you are filing a pre-service claim because a Center of Excellence facility determined that the surgery is not an appropriate medical course of treatment, your claim must be received by the Plan within 120 calendar days of the initial denial by the Centers of Excellence facility. If you are filing a post-service claim because you already received surgery elsewhere, as described above, you must file your claim within 120 calendar days of the date of service.

If a pre-service claim is urgent, Health Design Plus will make its determination within 72 hours after receipt of the claim (otherwise, Health Design Plus will make its determination within 15 days of receipt of a pre-service claim). An urgent claim is any claim for medical care or treatment where making a determination under the normal time frame could seriously jeopardize the life, health or ability to regain maximum function, or, in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim. If the urgent claim is determined to be incomplete, you will receive a notice within 24 hours of receipt of the claim, and you will have 48 hours to provide additional information. For non-urgent claims, the deadline to decide the claim may be extended 15 days, and Health Design Plus will send a notice explaining the extension. If the extension is necessary to request additional information, the extension notice will describe the required information and you will be given at least 45 days to submit the information. Health Design Plus will make a determination within 15 days from the date Health Design Plus receives your information, or, if earlier, the deadline to submit your information.

If you file a post-service claim, the Independent Review organization will make its determination within 30 days of receipt of the post-service claim. For post-service claims, the deadline to decide the claim may be extended 15 days, and the Independent Review Organization will send a notice explaining the extension. If the extension is necessary to request additional information, the extension notice will describe the required information and you will be given at least 45 days to submit the information. The Independent Review Organization will make a determination within 15 days from the date the Independent Review Organization receives your information, or, if earlier, the deadline to submit your information.

You will have 180 days to request that an Independent Review Organization conduct an internal review of a denial of a pre-service claim by Health Design Plus or a post-service claim of an Independent Review Organization. The Independent Review Organization will decide a request for urgent review of a pre-service claim within 72 hours after receipt, non-urgent review of a pre-service claim within 30 days after receipt, and review of a post-service claim within 60 days of receipt. You then may appeal a denial of an internal review appeal under the external appeal process described in this section if your claim involves medical judgment.

2. Page 261-262 – Claims Process for Disability Coverage Claims: Effective April 1, 2018 replace the text beginning with "Any adverse benefit determination will be in writing and will include:" in the left-hand column of page 262 and ending with the all of the text in the right-hand column of page 262 with the following:

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 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 description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits
- A description of the review procedures and time limits applicable to such procedures, and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA after you appeal the decision if you receive a written denial on appeal

APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for benefits is denied and you would like to appeal, you must submit a written or oral appeal to Sedgwick or Lincoln (as applicable) within 180 days of the denial.

Your appeal will be conducted without regard to your initial determination by someone other than the party who decided your initial claim or a subordinate of the individual who decided your initial claim. No deference will be afforded to the initial determination. You will have the opportunity to submit written comments, documents or other information in support of your appeal. You have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. The Third Party Administrator, on behalf of the Plan, will provide you with any new or additional evidence or rationale considered in connection with your claim sufficiently in advance of the appeals determination date to give you a reasonable opportunity to respond.

If your claim involves a medical judgment question, the Plan will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the Plan will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

Sedgwick or Lincoln (as applicable) will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if it is determined that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification of the denial that will include:

- The specific reasons for the adverse determination
- Reference to the specific Plan provisions on which the determination was based
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
 - ◊ The views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you;
 - ◊ The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the benefit determination; and
 - ◊ A disability determination regarding you made by the Social Security Administration and presented by you to the Plan;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA (including a description of any contractual limitations period that applies and the calendar date on which the contractual limitations period expires).

Legal Information

(Pages 264-277 of the 2018 Associate Benefits Book)

1. Page 271 – Email for Questions Regarding the HIPAA Notice of Privacy Practices:

Effective January 1, 2018, the address where you can send questions about the HIPAA Notice of Privacy Practices or to exercise one or more of the rights listed in the notice, the email address on page 271 of the 2018 Associate Benefits Book changed to AHWPPrivacy@walmart.com

Changes Affecting Multiple Locations in the 2018 Associate Benefits Book

Effective January 1, 2019, all references to "Liberty" or Liberty Life Assurance Company of Boston" are changed to Lincoln Financial Group or "Lincoln". The phone number remains the same. The address is changed to: Group Benefits Claims Appeal Unit, Lincoln Financial Group, Group - Charlotte, WM, P.O. Box 7216, London, Kentucky 40742-7216. The new portal URL is MyLincolnPortal.com and replaces the current URL MyLibertyConnection.com.
The following sections and page numbers are affected:
ELIGIBILITY AND ENROLLMENT (Pages 4-37 of the 2018 Associate Benefits Book), Page 18
ELIGIBILITY AND BENEFITS FOR ASSOCIATES IN HAWAII (Pages 38-43 of the 2018 Associate Benefits Book), Page 39
SHORT-TERM DISABILITY FOR HOURLY ASSOCIATES (Pages 170-177 of the 2018 Associate Benefits Book), Pages 171-176
LONG-TERM DISABILITY (Pages 194-201 of the 2018 Associate Benefits Book), Pages 194-199, 201
TRUCK DRIVER LONG-TERM DISABILITY (Pages 202-209 of the 2018 Associate Benefits Book), Pages 202-207, 209
CLAIMS AND APPEALS (Pages 246-263 of the 2018 Associate Benefits Book), Pages 261-263
GLOSSARY (Pages 278-283 of the 2018 Associate Benefits Book), Pages 280, 283

Effective January 1, 2019, replace the two paragraphs under the section titled "BREAK IN COVERAGE" in the chapter and the page indicated below in the 2018 Associate Benefits Book with the following two new paragraphs:

If your coverage has been canceled (by your choice, due to nonpayment of the full premium due while you are on leave or nonpayment of the full premium due while you are actively employed) and you return to active work status within one year from cancellation, you will be enrolled for the same coverage (or, if this coverage is not available, the coverage that is most similar to your prior coverage). Your coverage will be effective the first day of the pay period that you return to active work as defined by the Plan. For more information, contact People Services at 800 421 1362.

If your coverage has been canceled (by your choice, due to nonpayment of the full premium due while you are on leave or nonpayment of the full premium due while you are actively employed) and you return to active work status after one year from cancellation, you will be considered newly eligible and you may enroll for coverage within the applicable time period and under the conditions described in the Eligibility and enrollment chapter.

THE MEDICAL PLAN (Pages 44-85 of the 2018 Associate Benefits Book), Page 85
THE DENTAL PLAN (Pages 102-109 of the 2018 Associate Benefits Book), Page 109
THE VISION PLAN (Pages 110-115 of the 2018 Associate Benefits Book), Page 114
CRITICAL ILLNESS INSURANCE (Pages 128-133 of the 2018 Associate Benefits Book), Page 133
ACCIDENT INSURANCE (Pages 134-139 of the 2018 Associate Benefits Book), Page 138
OPTIONAL ASSOCIATE LIFE INSURANCE (Pages 146-151 of the 2018 Associate Benefits Book), Page 150
OPTIONAL DEPENDENT LIFE INSURANCE (Pages 152-157 of the 2018 Associate Benefits Book), Page 155
ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE (Pages 158-163 of the 2018 Associate Benefits Book), Page 163

Please attach this Summary of Material Modifications ("SMM") to your 2018 Associate Benefits Book and retain it for future reference. Among other items, the 2018 Associate Benefits Book and earlier SMM contain 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 2018 Associate Benefits Book or the January 1, 2019 Summary of Material Modifications, 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

Associates' Health & Welfare Plan Legal Notices

See the Notifications insert for the following annual notices the Plan is required to provide to participants:

- Medicare Part D Notice of Creditable Coverage
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- Notice Informing Individuals About Nondiscrimination and Accessibility Requirements
- Women's Health and Cancer Rights Act ("WHCRA")

Medicare and your prescription drug coverage

Please read this notice about Medicare and your prescription drug coverage carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage under the Associates' Health and Welfare Plan (the Plan) and your prescription drug coverage option under Medicare. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

There are important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Some of the Walmart prescription drug plans (as described later in this notice under the heading Which Walmart plans are considered creditable coverage?) are, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and are therefore considered creditable coverage. If you are a participant in one of these plans, you may keep your current coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
- Other Walmart plan options (as described later in this notice under the heading Which Walmart plans are considered non-creditable coverage?) are, on average for all Plan participants, not expected to pay out as much as the standard Medicare prescription drug coverage will pay. If you are a participant in one of these plans, your coverage is non-creditable coverage. This is important because for most people enrolled in these plan options, enrolling in Medicare prescription drug coverage means you will get more help with drug costs than if you had prescription drug coverage exclusively through the Plan. This is also important because it may mean that you pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

If you have non-creditable coverage under the Plan, it may affect how much you pay for Medicare D drug coverage in the future. When you become eligible for Medicare D, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offered by Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

Creditable and Non-Creditable Coverage

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

Which Walmart plans are considered creditable coverage?

Walmart has determined that the following Plans' prescription drug coverages are considered creditable according to Medicare guidelines:

- HRA High Plan
- HRA Plan
- Select Network Plan
- Accountable Care Plan
- HMO Plans
- eComm PPO Plan

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

If you are enrolled in any of the Plans listed above, you can choose to join a Medicare prescription drug plan later without paying extra because you have existing prescription drug coverage that, on average, is as good as Medicare's coverage.

If you are enrolled in Medicare Part D, you are not eligible to enroll in any of the Plans listed above. If your dependent is enrolled in Medicare Part D and you are not, you are eligible to enroll in a Walmart medical or HMO plan, but your dependent would not be eligible for coverage.

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

Which Walmart plans are considered non-creditable coverage?

The following Plan's prescription drug coverage is considered non-creditable according to Medicare guidelines:

- HSA Plan

If your coverage is non-creditable, you might want to consider enrolling in Medicare prescription drug coverage or a Walmart creditable Plan listed above because the coverage you have is, on average for all participants, not expected to pay out as much as the standard Medicare prescription drug coverage will pay.

When can I enroll for Medicare prescription drug coverage?

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

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

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

When will I pay a higher premium (a penalty) to join a Medicare drug plan?

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

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

Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may always be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following Medicare annual enrollment period beginning in October to join.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current coverage under the Associates' Medical Plan (AMP) will be affected. Plan guidelines restrict you from enrolling in the AMP if you are enrolled in Medicare Part D. If your dependent is enrolled in Medicare Part D and you are not, you are able to enroll in the AMP, but your dependent would not be eligible for coverage.

If you decide to join a Medicare drug plan and drop your coverage under the Walmart AMP, be aware that you and your dependents will be able to get your AMP coverage back, but only during annual enrollment or due to a status change event.

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

For more information about Medicare and your prescription drug coverage

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

Additional information available

More detailed information about Medicare plans that offer prescription drug coverage is available through the

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

- Visit medicare.gov
- Call your state health insurance assistance program for personalized help. (See your copy of the "Medicare & You" handbook for its telephone number.)
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

Remember:

Keep this notice. If you enroll in one of the Medicare prescription drug plans, you may need to provide a copy of this notice when you join to show whether or not you have creditable coverage and therefore whether or not you are required to pay a higher premium (a penalty).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, 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 www.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 www.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 an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer 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 www.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, 2018. 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
- Medicaid Eligibility: <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS – Medicaid

- Website: <http://myarhipp.com/>
- Phone: 855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & 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+: Colorado.gov/HCPF/Child-Health-Plan-Plus
- CHP+ Customer Service: 800-359-1991 / State Relay 711

FLORIDA – Medicaid

- Website: <http://flmedicaidprecovery.com/hipp/>
- Phone: 877-357-3268

GEORGIA – Medicaid

- Website: <http://dch.georgia.gov/medicaid>
Click on Health Insurance Premium Payment (HIPP)
- Phone: 404-656-4507

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: <http://www.indianamedicaid.com>
- Phone: 800-403-0864

IOWA – Medicaid

- Website: <http://dhs.iowa.gov/hawk-i>
- Phone: 800-257-8563

KANSAS – Medicaid

- Website: <http://www.kdheks.gov/hcf/>
- Phone: 785-296-3512

KENTUCKY – Medicaid

- Website: <https://chfs.ky.gov>
- Phone: 800-635-2570

LOUISIANA – Medicaid

- Website: <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>
- Phone: 888-695-2447

MAINE – Medicaid

- Website: <http://www.maine.gov/dhhs/ofii/public-assistance/index.html>
- Phone: 800-442-6003
- TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

- Website: <http://www.mass.gov/eohhs/gov/departments/masshealth/>
- Phone: 800-862-4840

MINNESOTA – Medicaid

- Website: <https://mn.gov/dhs/people-we-serve/seniors/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

NEBRASKA – Medicaid

- Website: <http://www.ACCESSNebraska.ne.gov>
- Phone: 855-632-7633
- Lincoln: 402-473-7000
- Omaha: 402-595-1178

NEVADA – Medicaid

- Medicaid Website: <http://dhcfnv.gov>
- Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid

- Website: <https://www.dhhs.nh.gov/ombp/nhhpp/>
- Phone: 603-271-5218
- Hotline: NH Medicaid Service Center at 888-901-4999

NEW JERSEY – Medicaid and CHIP

- Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/mcicaid/>
- 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/mcicaid/
- Phone: 800-541-2831

NORTH CAROLINA – Medicaid

- Website: <https://dma.ncdhhs.gov/>
- Phone: 919-855-4100

NORTH DAKOTA – Medicaid

- Website: <http://www.nd.gov/dhs/services/medicalserv/mcicaid/>
- Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP

- Website: <http://www.insureoklahoma.org>
- Phone: 888-365-3742

OREGON – Medicaid

- Website: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
- Phone: 800-699-9075

PENNSYLVANIA – Medicaid

- Website: <http://www.dhs.pa.gov/provider/medcalassistance/healthinsurancepremiumpaymenthippprogram/index.htm>
- Phone: 800-692-7462

RHODE ISLAND – Medicaid

- Website: <http://www.eohhs.ri.gov/>
- Phone: 855-697-4347

SOUTH CAROLINA – Medicaid

- Website: <https://www.scdhhs.gov>
- Phone: 888-549-0820

SOUTH DAKOTA – Medicaid

- Website: <http://dss.sd.gov>
- Phone: 888-828-0059

TEXAS – Medicaid

- Website: <http://gethipptexas.com/>
- Phone: 800-440-0493

UTAH – Medicaid and CHIP

- Medicaid Website: <https://medicaid.utah.gov/>
- CHIP Website: <http://health.utah.gov/chip>
- Phone: 877-543-7669

VERMONT – Medicaid

- Website: <http://www.greenmountaincare.org/>
- Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP

- Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
- Medicaid Phone: 800-432-5924
- CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
- CHIP Phone: 855-242-8282

WASHINGTON – Medicaid

- Website: <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program>
- Phone: 800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

- Website: <http://mywvhipp.com/>
- Toll-free phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP

- Website: <https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>
- Phone: 800-362-3002

WYOMING – Medicaid

- Website: <https://wyequalitycare.acs-inc.com/>
- Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

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 **800-421-1362**

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

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

Interpreter Services are available at no cost. **800-421-1362**

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

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ආරක්ෂා සේවාවලට අමතරව, අප ඔබගේ භාෂාවට අනුව 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.

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

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

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

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

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

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

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

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

The 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 People Services at 800-421-1362.

For more information

For more information

IF YOU HAVE QUESTIONS ABOUT...	GET ANSWERS HERE
When you're eligible for benefits or how to enroll	<ul style="list-style-type: none"> • WalmartOne.com/Benefits • People Services: 800-421-1362
Benefits, medical claims or care management	<ul style="list-style-type: none"> • WalmartOne.com/Medical • BlueAdvantage Administrators of Arkansas health care advisor: 866-823-3790 • Aetna health care advisor: 855-548-2387 • UnitedHealthcare health care advisor: 888-285-9255 • HealthSCOPE Benefits health care advisor: 800-804-1272
Finding a network provider for medical plans	<ul style="list-style-type: none"> • WalmartOne.com/ProviderNetworks • Aetna health care advisor: 855-548-2387 • BlueAdvantage Administrators of Arkansas health care advisor: 866-823-3790 • UnitedHealthcare health care advisor: 888-285-9255 • HealthSCOPE Benefits health care advisor: 800-804-1272
Pharmacy benefits	<ul style="list-style-type: none"> • WalmartOne.com/Prescriptions • Express Scripts: 800-887-6194
Health Savings Account	<ul style="list-style-type: none"> • WalmartOne.com/HSA • HealthEquity: 866-296-2860
Dental plan	<ul style="list-style-type: none"> • WalmartOne.com/Dental • Delta Dental: 800-462-5410
Vision plan	<ul style="list-style-type: none"> • WalmartOne.com/Vision • VSP: 866-240-8390
Accident insurance Critical illness insurance	<ul style="list-style-type: none"> • WalmartOne.com/Accident • WalmartOne.com/Critical • Allstate Benefits: 800-514-9525
Short-term disability	<ul style="list-style-type: none"> • WalmartOne.com/ShortTermDisability • Sedgwick or Lincoln (formerly Liberty): 800-492-5678
Long-term disability Truck driver long-term disability	<ul style="list-style-type: none"> • WalmartOne.com/LongTermDisability • Lincoln (formerly Liberty): 800-492-5678
Life and accidental death and dismemberment (AD&D) insurance	<ul style="list-style-type: none"> • WalmartOne.com/Life • WalmartOne.com/ADD • Prudential: 877-740-2116
Resources for Living®	<ul style="list-style-type: none"> • WalmartOne.com/RFL • 800-825-3555, 24/7
Walmart 401(k) Plan	<ul style="list-style-type: none"> • WalmartOne.com/401k • Benefits.ml.com • Bank of America Merrill Lynch: 888-968-4015
Associate Stock Purchase Plan	<ul style="list-style-type: none"> • WalmartOne.com/ASPP • Computershare: 800-438-6278 (800-952-9245 for the hearing impaired)

