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

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Network: $1,750 individual/ $3,500 family Out-of-Network: $3,500 individual/ $7,000 family Charges for balance billing, healthcare this plan does not cover, services at out-of-network Walmart Care Clinic or Walmart Health, medical copayments, pharmacy copayment/coinsurance, charges for out-of-network preventive care, and amounts the plan pays at 100% do not count toward the deductible.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. The employer contribution to the HRA is $250/Associate or $500/Family per year. If you have HRA funds from a prior year that rollover, the rollover combined with the new year allocation cannot exceed the in-network deductible; your rollover will be reduced by the amount exceeding the in-network deductible limit.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Deductible is waived for: Doctor on Demand, certain services that are included in the Centers of Excellence programs (except bariatric surgery), eligible pharmacy charges, certain preventive care services and certain in-network office visits.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Network: $6,850 individual/ $13,700 family Out-of-Network: Unlimited</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, penalties for failure to obtain preauthorization for services, health care this plan doesn’t cover, out-of-network coinsurance, services at out-of-network Walmart Care Clinic or Walmart Health, and amounts the plan pays at 100%.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at www.One.Walmart.com/Benefits.
## Important Questions and Answers

### Will you pay less if you use a network provider?

Yes. See [www.One.Walmart.com/Benefits](http://www.One.Walmart.com/Benefits) or call 1-800-421-1362 for a list of network providers.

This plan uses a provider network. You will pay the least if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).

Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

### Do you need a referral to see a specialist?

No.

You can see the specialist you choose without a referral.

---

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization may be required. *See the “Preauthorization” section in the SPD. Special rules, including lower copayments and a waived deductible, may apply to services received at an in-network Walmart Care Clinic and Walmart Health or via video visit. *See the “Walmart Care Clinic and Walmart Health” section of the SPD. Video visits have a $4 copayment and are covered only when provided through the Doctor on Demand service.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>50% coinsurance, deductible doesn't apply</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then determine what your plan will pay. *See the “Preventive care program” section in the SPD for covered preventive services and applicable limitations.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>There is no charge for preventive services received from a network provider. *See the “Preventive care program” section in the SPD for covered preventive services.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>Use of an Alternate Network Provider will be covered with 25% coinsurance. Preauthorization may be required. PET scans are reimbursed as a diagnostic test. *See the “Preauthorization” and “Alternate Provider Networks” section in the SPD.</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see the Summary Plan Description (SPD) at [www.One.Walmart.com/Benefits](http://www.One.Walmart.com/Benefits).*
<table>
<thead>
<tr>
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<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$4 copay (30-days); $8 copay (31-60 days); $12 copay (61-90 days)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>25% coinsurance 30-day supply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred brand drugs</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>20% coinsurance 30-day supply</td>
<td>Not covered</td>
<td>Preauthorization may be required. *See the “Preauthorization” section in the SPD.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$300 copay/visit, plus remaining annual deductible; coinsurance does not apply for emergency services.</td>
<td>$300 copay/visit, plus remaining annual deductible; coinsurance does not apply for emergency services; 50% coinsurance for non-emergency services</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Network Provider</strong> (You will pay the least)</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td></td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>Urgent care</td>
<td></td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td></td>
<td><strong>Facility fee</strong> (e.g., hospital room)</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Physician/surgeon fees</strong></td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need mental health,</td>
<td></td>
<td><strong>Outpatient services</strong></td>
<td><strong>Preauthorization</strong> may be required. *See the “Preauthorization” section in the SPD. For heart surgery, dialysis/ESRD medical record review, spine, hip or knee replacement evaluation or surgery; breast, lung, blood, prostate, and colorectal cancer review; and organ and tissue transplants, coverage may be 100%, deductible waived, through the Centers of Excellence (COE) Program. When not performed through the COE Program, spine and weight loss surgeries and organ and tissue transplants are not covered, even if performed by a network provider, unless an exception applies. When not performed through the COE Program, a hip or knee replacement is subject to the out-of-network deductible and there is a 50% coinsurance, even if performed by a network provider, unless an exception applies. *See the “Centers of Excellence” section in the SPD.</td>
</tr>
<tr>
<td>behavioral health, or substance</td>
<td></td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>abuse services</td>
<td></td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td></td>
<td><strong>Office visits</strong></td>
<td><strong>Preauthorization</strong> may be required. *See the “Preauthorization” section in the SPD.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventive care: No charge; All other services: 25% coinsurance</td>
<td>Preventive care: 50% coinsurance, deductible doesn’t apply; All other services: 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Childbirth/delivery professional services</strong></td>
<td>Preauthorization may be required for stays exceeding standard length of stay for maternity. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Childbirth</strong></td>
<td>Preauthorization may be required for stays exceeding standard length of stay for maternity. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>

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<tr>
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<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>delivery facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at [www.One.Walmart.com/Benefits](http://www.One.Walmart.com/Benefits).
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<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s glasses</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
</tr>
<tr>
<td>Chiropractic Care</td>
</tr>
<tr>
<td>Dental Care</td>
</tr>
</tbody>
</table>

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

- Bariatric Surgery (gastric bypass and gastric sleeve surgery only)
- Cosmetic surgery (limited to conditions that are considered reconstructive)
- Infertility treatment (limited to diagnosis and correction of an underlying condition of infertility)
- Long-term care – up to 60 days/disability period
- Non-emergency care when traveling outside the U.S. (as provided by international business medical insurance policy)
- Private-duty nursing (limited to 100 visits per calendar, billed through a home health agency, and must be provided by a licensed or registered nurse)
- Routine eye care (limited to services and limitations that are identified under the “Preventive care program” section of the SPD)
- Routine foot care (nonsurgical foot care limited to 3 visits per calendar year)

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

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

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

**Does this plan provide Minimum Essential Coverage? Yes**
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-421-1362.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-421-1362.
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-800-421-1362.

*For more information about limitations and exceptions, see the Summary Plan Description (SPD) at www.One.Walmart.com/Benefits.*
## About these Coverage Examples:

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

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

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

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

**Total Example Cost:** $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn’t covered</td>
<td>$1,750</td>
<td>$20</td>
<td>$2,700</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60

**The total Peg would pay is:** $4,530

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

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

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

**Total Example Cost:** $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn’t covered</td>
<td>$1,750</td>
<td>$600</td>
<td>$900</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60

**The total Joe would pay is:** $3,310

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

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

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

**Total Example Cost:** $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn’t covered</td>
<td>$1,600</td>
<td>$300</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Mia would pay is:** $1,900

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

* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at [www.One.Walmart.com/Benefits](http://www.One.Walmart.com/Benefits).
Valued Plan Participant

THE ASSOCIATES’ HEALTH AND WELFARE PLAN (AHWP) RESPECTS THE DIGNITY OF EACH INDIVIDUAL WHO PARTICIPATES IN THE PLAN.

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

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

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](https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf)
- **Email:** OCRCompliant@hhs.gov

Interpreter Services are available at no cost. **800-421-1362**

Português (Brasil)
Servicios de intérprete están disponibles gratis. 1-800-421-1362.

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

Français
Des services d’interprètes sont disponibles sans frais. 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 Thống Dịch có sẵn miễn phí. 1-800-421-1362.