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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $2,750 individual/ $5,500 family Out-of-Network: $5,500 individual/ $11,000 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.	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. If you have an HRA balance and move into the Walmart Premier Plan, the HRA balance may be used for certain qualified medical expenses. *Please refer to the SPD for more information regarding when HRA rollover dollars may be used under the Premier Plan.
Are there services covered before you meet your deductible?	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 in-network office visits.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $6,850 individual/ $13,700 family Out-of-Network: Unlimited	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.
What is not included in the out-of-pocket limit?	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%.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

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

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See 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.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least for a network provider)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay office visit, deductible doesn't apply	50% coinsurance	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. 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.
	Specialist visit	$75 copay office visit; deductible doesn't apply	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% coinsurance, deductible doesn't apply	
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	There is no charge for in-office services or preventive services received from a network provider. *See the "Preventive care program" section in the SPD for covered preventive services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least for a network provider)	Out-of-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	50% coinsurance	50% coinsurance	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.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.OptumRx.com/Walmart	Generic drugs	$4 copay (30-days); $8 copay (31-60 days); $12 copay (61-90 days)	Not covered	If you work within 5 miles of a Walmart or Sam's Club pharmacy, only drugs purchased at Walmart or Sam's Club are covered, unless an exception applies. If you work more than 5 miles from a Walmart or Sam's Club pharmacy, a 30-day supply of generic drugs purchased at a pharmacy in the OptumRx network will be covered at the same rate. If you work more than 5 miles from a Walmart or Sam's Club pharmacy, generic drugs exceeding a 30-day supply must be purchased at a Walmart or Sam's Club pharmacy or through mail-order. *See "The Pharmacy Benefit" section in the SPD for exceptions. Mail-order prescription drugs will be covered only when purchased through Walmart/Sam's Club or OptumRx mail-order pharmacy regardless of work location. Supplies of preferred brand drugs of more than 30 days must be purchased by mail-order.
	Preferred brand drugs	Greater of $50 or 25% coinsurance 30-day supply	Not covered	
	Non-Preferred brand drugs	Not covered	Not covered	Non-Preferred brand drugs are not covered.
	Specialty drugs	Greater of $50 or 20% coinsurance 30-day supply	Not covered	Preauthorization may be required. *See the "Preauthorization" section in the SPD.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" section in the SPD.
	Physician/ surgeon fees	25% coinsurance	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" section in the SPD.
If you need immediate medical attention	Emergency room care	$300 copay/visit, plus remaining annual deductible; coinsurance does not apply for emergency services.	$300 copay/visit, plus remaining annual deductible; coinsurance does not apply for emergency services; 50% coinsurance for	If you are admitted to the hospital directly from the emergency room, the copayment is waived.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least for a network provider)	Out-of-Network Provider (You will pay the most)	
			non-emergency services	
	Emergency medical transportation	25% coinsurance	25% coinsurance	Coverage is limited to the nearest hospital or 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. Non-emergency transport not covered, except if pre-authorized.
	Urgent care	Office visits: $75 copayment/visit, deductible doesn't apply; All other urgent care: 25% coinsurance	50% coinsurance	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	Preauthorization 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.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $35 copay, deductible doesn't apply; Other services: 25% coinsurance	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" section in the SPD.
	Inpatient services	25% coinsurance	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" section in the SPD.
	Office visits	Preventive care: No charge; All other	Preventive care: 50% coinsurance,	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least for a network provider)	Out-of-Network Provider (You will pay the most)	
If you are pregnant		services: $35 copay/visit; deductible doesn't apply	deductible doesn't apply All other services: 50% coinsurance	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.
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" section in the SPD. Home health care is limited to 100 visits per calendar year. Other limitations may apply. *See the "When Limited Benefits Apply to the Associates' Medical Plan" section in the SPD.
	Rehabilitation services	25% coinsurance	50% coinsurance	Rehabilitation services are limited as follows: Physical therapy limited to 20 visits/year. Occupational therapy limited to 20 visits/year. Speech therapy limited to 60 visits/year. Certain other inpatient rehabilitation services are limited to 120 days per condition. Preauthorization may be required. *See the "When Limited Benefits Apply to the Associates' Medical Plan" and "Preauthorization" sections in the SPD.
	Habilitation services	25% coinsurance	50% coinsurance	Habilitation services are limited to Applied Behavior Analysis therapy. Preauthorization may be required. *See the "Preauthorization" section in the SPD.
	Skilled nursing care	25% coinsurance	50% coinsurance	Skilled nursing care facilities are limited to 60 days per disability period. Preauthorization may be required. *See the "When Limited Benefits Apply to the Associates' Medical Plan" and "Preauthorization" sections in the SPD.
If you need help	Durable medical equipment	25% coinsurance	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" section in the SPD. Orthopedic shoes when prescribed by a Physician are limited to one pair per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least for a network provider)	Out-of-Network Provider (You will pay the most)	
recovering or have other special health needs	Hospice services	25% coinsurance	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" section in the SPD. Hospice services are limited to 365 days per illness.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	Limited to screening that qualifies as preventive services. *See the "Preventive care program" section in the SPD for covered preventive services and applicable limitations.
	Children's glasses	Not covered	Not covered	Glasses are limited when a certain medical diagnosis applies or from eye injury. * See the "When Limited Benefits Apply to the Associates' Medical Plan" section in the SPD.
	Children's dental check-up	Not covered	Not covered	Dental check-ups are not covered under medical benefits; however, there may be additional other coverage under a separate dental plan.

Excluded Services & Other Covered Services:

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

Acupuncture	Glasses	Routine Eye Care
Chiropractic Care	Hearing Aids	Weight loss programs
Dental Care	Non-Preferred Brand Drugs	

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

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

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 file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this plan provide Minimum Essential Coverage? Yes
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.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-421-1362.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-421-1362.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-421-1362.

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

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	$2,750
■ Specialist copayment	$75
■ 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:

Cost Sharing	
Deductibles	$2,750
Copayments	$90
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,400**

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

■ The plan's overall deductible	$2,750
■ Specialist copayment	$75
■ 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:

Cost Sharing	
Deductibles	$2,220
Copayments	$600
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,780**

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

■ The plan's overall deductible	$2,750
■ Specialist copayment	$75
■ 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:

Cost Sharing	
Deductibles	$1,500
Copayments	$400
Coinsurance	$0
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.

Valued Plan Participant

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

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

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

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

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

汉语普通话
翻译服务免费提供。1-800-421-1362.

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

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

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

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

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

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

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 avalable at no cost. **800-421-1362**

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

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

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

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

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

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

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

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