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 People Services 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: $1,750 individual/$3,500 family; Out-of-Network: $3,500 individual/ $7,000 family. The following items don't apply to the deductible: Premiums, charges for balance billing, healthcare this plan does not cover, copayments, pharmacy coinsurance, 3rd party prescription drug assistance, out-of-network preventive care, and coinsurance for COE hip/knee replacement without an exception.	Generally, you must pay all 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 allocation to the HRA is $250/individual or $500/family per year. If you have HRA funds from a prior year that roll over, the rollover combined with the new year allocation cannot exceed the network deductible; your rollover will be reduced by the amount exceeding the network deductible.
Are there services covered before you meet your deductible?	Yes. Deductible is waived for eligible preventive care, virtual care through Doctor On Demand and other AMP virtual care network providers, eligible prescription drugs, and COE programs (except weight loss surgery and family building).	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 must meet their own out-of-pocket limit until the overall family out–of–pocket limit has been met.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums; balance-billing charges; health care this plan doesn't cover; penalties for failure to obtain preauthorization; out-of-network coinsurance; out-of-network preventive care; hip/knee replacement coinsurance outside COE without a network exception; coinsurance when an available AMP alternate network provider for imaging services is used without a network exception, coinsurance when an available Blue Select network provider is not used; and 3rd party prescription drug assistance.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.IncludedHealth.com/Walmart or call 1-800-941-1384 for a list of 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, unless otherwise noted

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

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

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	Limitations, Exceptions, & Other Important Information
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	No charge for routine in-office diagnostic tests on same day as network provider visit or certain at-home labs with Quest Diagnostics.
	Imaging (CT/PET scans, MRIs)	CT/MRIs: 25% coinsurance for alternate network provider; 50% coinsurance for other network providers; PET scans: 25% coinsurance	50% coinsurance	PET scans reimbursed as diagnostic test. CT/MRIs: If no AMP network provider available, TPA network services paid as AMP network provider. If services provided by TPA network provider when AMP network provider available, coinsurance will not apply to out-of-pocket limit without network exception. *See "Provider networks," "TPA network providers," and "AMP network providers" sections in SPD. Pre-authorization may be required. *See "Prior authorization" section in 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 (formulary) drugs	Anti-inflammatory: preferred tier $0 copayment; non-preferred tier: $25 copayment. All others: $4 copayment (1-30 days); $8 copayment (31-60 days); $12 copayment (61-90 days)	Not covered	Non-formulary drugs not covered. Anti-inflammatory drugs on formulary are two tiered: preferred and nonpreferred. Must use Walmart/Sam's Club pharmacy/Walmart Home Delivery Pharmacy for "maintenance drugs" and Walmart Specialty Pharmacy for specialty drugs. Eligible fertility drugs covered only through COE program for family building. High-cost generic drugs not covered when a therapeutically equivalent, lower-cost generic drug is available. Preferred brand (formulary) and non-preferred brand drugs in excess of 30-day supply must be purchased through Walmart Home Delivery Pharmacy. Prices shown for preferred brand (formulary) and non-preferred brand drugs and specialty drugs are for up to a 30-day supply. Deductible does not apply to prescription drugs.
	Preferred brand (formulary) drugs	Anti-inflammatory: preferred tier: $0 copayment; non-preferred tier: $100 copayment. All others: Greater of $50 or 25% coinsurance	Not covered	
	Non-preferred (non-formulary) brand drugs	Not covered	Not covered	
	Specialty drugs (formulary)	Anti-inflammatory: preferred tier: $0 copayment; non-preferred tier: $250 copayment. All others: Greater of $50 or 20% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	Fertility benefits covered only under the COE and limited to a $20,000 max lifetime benefit. COE services may be paid at 0% coinsurance and before deductible if COE facility is used. But see limitations for COE benefits in "Centers of Excellence" section of the SPD. Preauthorization may be required. *See "Prior authorization" section in the SPD.
	Physician/ surgeon fees	25% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	
If you need immediate medical attention	Emergency room care	$300 copayment /visit in addition to any remaining deductible.	$300 copayment /visit and remaining deductible; Non-emergency services also subject to 50% coinsurance	Copayment still applies after the deductible is met. If you are admitted to the hospital as an inpatient directly from the emergency room or pass away prior to admission the copayment is waived.
	Emergency medical transportation	Air ambulance: 25% coinsurance; Ground ambulance: $300 copayment /service in addition to any remaining deductible.	Air ambulance: 25% coinsurance; Ground ambulance: $300 copayment /service and remaining deductible.	Coverage limited to nearest hospital/treatment facility capable of providing care, only if transportation is medically necessary. Ground ambulance: Copayment applies after deductible is met. If you are admitted to the hospital you were taken to as an inpatient or pass away prior to admission the copayment is waived. *See "When limited benefits apply to the AMP" and "Emergency, ground and air ambulance" sections in the SPD.
	Urgent care	25% coinsurance	50% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	COE services may be paid at 0% coinsurance and before deductible is met if COE facility is used. But see limitations for COE in "Centers of Excellence" section of the SPD. Preauthorization may be required. *See "Prior authorization" section in the SPD.
	Physician/ surgeon fees	25% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	50% coinsurance	$0 copayment for Doctor On Demand virtual visits and deductible doesn't apply to provider charges. In-person and telehealth facility charges are subject to deductible and coinsurance. Preauthorization may be required. *See "Prior authorization" section in SPD
	Inpatient services	25% coinsurance	50% coinsurance	

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

Excluded Services & Other Covered Services:

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

- Acupuncture
- Chiropractic care
- Dental care (Adult)
- Glasses
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric surgery (gastric bypass, gastric sleeve and duodenal switch surgery only)
- Cosmetic Surgery (limited to conditions that are considered reconstructive)
- Hearing aids (limited to external hearing aids)
- Infertility treatment (limited to the diagnosis & treatment of underlying medical condition or COE family building services)
- Long-term care - 60 days/disability period
- Non-Emergency Care when traveling Outside the U.S. (as provided by international business medical insurance policy)
- Private-duty nursing (limited to 100 visits per calendar, billed through a home health agency, and must be provided by a licensed or registered nurse)
- Routine eye care (limited to services and limitations that are identified under the "Preventive Care" section of the SPD)
- Routine foot care (nonsurgical foot care limited to 3 visits per calendar year)

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Walmart People Services, Attn: Internal Appeals, Mail Stop 3610, 806 Excellence Drive, Bentonville, AR 72716-3610. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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

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

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-421-1362.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-421-1362.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-421-1362.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-421-1362 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-421-1362.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-421-1362.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-421-1362.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 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	$1,750
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,750
Copayments	$100
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,520**

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

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

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

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

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

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

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

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

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

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

A few more things...

Here are some important legal documents that let you know about your rights as a Plan participant.

You should also share these notices with any family members who are covered under your Plan. If they live in a different household, you can ask for these notices to be sent to a different address. You and your family members can also ask for a free paper copy of these notices by calling People Services at **1-800-421-1362**.

Valued Plan Participant

The Associates' Health and Welfare Plan (AHWP) respects the dignity of each individual who participates in the Plan.

The Associates' Health and Welfare Plan (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.

To learn about or use our grievance process, contact People Services at **1-800-421-1362**
To file a complaint of discrimination, contact the U.S. Department of Health and Human Services, Office of Civil Rights:

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

Interpreter Services are available at no cost. **1-800-421-1362**

عربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
رقم هاتف الصم والبكم: 1-800-421-1362.

[illegible] (Burmese)
သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-800-421-1362. သုိ႔ ေခၚဆိုပါ။

漢語廣東話 (Cantonese)
請指出您的語言。翻譯服務免費提供1-800-421-1362.

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-421-1362. تماس بگیرید.

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. 1-800-421-1362.

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-421-1362.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-421-1362. まで、お電話にてご連絡ください。

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-421-1362. 번으로 전화해 주십시오.

汉语普通话 (Mandarin)
请指出您的语言 翻译服务免费提供 1-800-421-1362.

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-421-1362.

Română (Romanian)
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la -1-800-421-1362.

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-421-1362.

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-421-1362. 'ਤੇ ਕਾਲ ਕਰੋ।

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-421-1362.

Soomaali (Somali)
Tilmaan luuqadaada. Adeegyada turjubaanka, lacag la'aan ayaa laguugu siinayaa. 1-800-421-1362.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-421-1362.

Kiswahili (Swahili)
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-421-1362.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-421-1362.

Availability of Summary of Health Information
As an associate, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare options.

The SBC is available on One.Walmart.com/SBC. A paper copy is also available, free of charge, by calling 1-800-421-1362.

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

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

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

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