WHAT'S INSIDE

• Medical Plan
• Pharmacy Benefit
• Dental Plan
• Vision Plan
• Life Insurance and Disability Plans
• Associate Stock Purchase Plan
• Walmart 401(k) Plan
• Resources For Living®

...and much more!

Effective January 1, 2015
Information made easy

Your 2015 Associate Benefits Book makes it easy for you to quickly get the information you need about your Walmart benefits. Got a question about your Walmart benefits? When you download the 2015 Associate Benefits Book PDF from the WIRE or WalmartOne.com, getting the answer is as easy as two clicks and a word search. To find the information you need, simply launch the PDF with Adobe® Reader® and:

• Click “edit” on the top toolbar
• Click “search”
• Type the words or phrase that describe the information you’re looking for, such as “preventive” or “vesting,” and click “search.”

You’ll get instant results!

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This 2015 Associate Benefits Book includes the Summary Plan Descriptions (SPDs) for the Associates’ Health and Welfare Plan (the Plan) and the Walmart 401(k) Plan. Please take time to review each SPD to understand your benefits.

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, Benefits Customer Service, 508 SW 8th Street, Bentonville, AR 72716-3500.

Atención Asociados Hispanos: Este folleto contiene un resumen en inglés de los derechos y beneficios para todos los asociados bajo el plan de beneficios de Walmart. Si Ud tiene dificultades para entender cualquier parte de este folleto puede dirigirse a la siguiente dirección: Benefits Customer Service, 508 SW 8th Street, Bentonville, AR 72716-3500.

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 está disponible en Español. Si usted desea una copia en Español, favor de ver su Representante de Personal.
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 231 in the Legal information chapter for more details.
What you need to know about eligibility and enrollment

- You can enroll 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 impact your initial enrollment period. If you are an associate in Hawaii, your eligibility and benefits information is explained in the Eligibility and benefits for associates in Hawaii chapter.
- Enrollment in certain benefits (such as life insurance benefits) after your initial enrollment period affects your participation in those benefits.
- Medical, dental, vision, critical illness insurance, accident insurance, and accidental death and dismemberment (AD&D) coverage cannot be changed except during annual enrollment, unless you have a status change event.
- If you are participating in the short-term disability plan and have an approved claim, your premiums may be deducted out of your disability 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 2015 Associate Benefits Book. The Plan is sponsored by Wal-Mart Stores, Inc.

If you are an associate in Hawaii, please refer to the Eligibility and benefits for associates in Hawaii chapter for additional information regarding benefits eligibility.

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.

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. 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.

Part-time associates are subject to the annual benefits eligibility check process described below, with the exception of part-time hourly pharmacists hired prior to February 1, 2012. The annual benefits eligibility check determines your eligibility for 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 Initial enrollment eligibility check and the Annual benefits eligibility check sections below.

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 and 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 benefits eligibility check process described below. The annual benefits eligibility check determines your eligibility for 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 Initial enrollment eligibility check and the Annual benefits eligibility check sections below.

Benefits eligibility checks for part-time hourly and temporary associates

Initial enrollment eligibility check

Initial eligibility for part-time/temporary benefits (also known as being “newly eligible”) 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.

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 greater than 13 weeks, you will become eligible for benefits. Specifically, benefits 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
Eligibility and enrollment

7 day of the second calendar month following your one-year anniversary date). For example, if you are hired on April 15, 2015, the company will average the hours you work beginning April 15, 2015, through April 14, 2016. 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, 2016.

Initial 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 2017.

ANNUAL BENEFITS ELIGIBILITY CHECK

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. The annual benefits eligibility check will be administered prior to each calendar year’s annual enrollment period.

The measurement period for the annual benefits 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 2014 (for the 2015 calendar year) will review the associate’s hours worked from October 5, 2013, through October 3, 2014. If you meet your appropriate average weekly hours requirement (24 or 30 hours) over the 52-week period, you will be eligible to enroll in benefits during the annual enrollment period for coverage during 2015.

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

IF YOU TAKE TIME OFF OR HAVE A BREAK IN SERVICE

Unpaid time off: If you take any type of unpaid time off, 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, Family and Medical Leave Act (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 you return from a break in service 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. For example, if you are eligible and enroll in benefits 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).

If your break is greater than 30 days but less than 13 weeks, you will have 60 days after resuming employment to decrease or drop the coverage in which you were automatically re-enrolled.

If you return to employment after 30 days and before 13 weeks, you will be 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.

If you return from a break in service after 13 or more weeks: If you terminate employment and are rehired 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.

IF YOU MEET THE ANNUAL BENEFITS ELIGIBILITY CHECK

If you are a part-time or temporary associate who is currently eligible for benefits and subject to the annual benefits eligibility check requirement, and you meet the annual benefits eligibility check in October, you will:

• Receive annual enrollment materials;
• Remain eligible for medical, vision, critical illness and accident insurance in the current year;
• Remain eligible for medical, vision, critical illness and accident insurance in the year following the annual check; and
• Have your eligibility reviewed each year to determine eligibility for the following year.
If you are a part-time hourly or temporary associate who is currently eligible for benefits and subject to the annual benefits eligibility check requirement, but you do not meet the annual benefits eligibility check in October, you will:

- Maintain your current level of benefits coverage for the remainder of the current year (for example, through December 31, 2015), unless you are in your initial coverage period, in which case you will be considered eligible for your current level of benefits through the end of the second calendar year following your date of hire;
- Receive a letter that will explain your options under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue your medical and vision coverage, and your options through Allstate to maintain your critical illness and accident insurance coverage;
- Not be eligible for benefits coverage under Walmart’s plans for the following year (for example, 2016) unless your job classification changes and you meet the eligibility requirements based on your new classification;
- Have your eligibility for benefits reviewed each year (for example, 2016) to determine your eligibility for benefits for the following year (for example, 2017).

HAWAII ASSOCIATES

If you are a part-time hourly 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.

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 may still receive Resources For Living and business travel accident insurance benefits.

SPECIAL ELIGIBILITY RULES FOR CERTAIN INSURED BENEFITS

HMO plans are available for some facilities. The policies for the HMO plans may have different eligibility requirements and waiting periods than those described in this chapter. You may obtain an explanation of these differences by calling Benefits Customer Service at 800-421-1362. The Plan will apply the eligibility requirements described in this chapter unless you contact Benefits Customer Service and request to have a different eligibility provision in the policy applied to you. For example, state law may require an insurance policy to include different eligibility provisions relating to dependents, such as allowing coverage for a dependent child after age 26.

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, life, disability and any other benefit available to United States associates under the Plan. These localized associates and applicable dependents will no longer 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 paid at 80 percent of covered expenses and processed as network claims, subject to applicable limitations and exclusions under the Plan. The localized associate or their eligible 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;
• 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 under the Plan, including HMOs).

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.

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:
  – Live together in an ongoing, exclusive and committed relationship similar to marriage and have been for at least 12 months and intend to continue sharing a household 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;
  – 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 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 an HMO and your dependent lives in an area that is outside the service area of the HMO, you may still enroll your dependent, but he or she would not have access to an HMO plan provider in the HMO’s geographic area and may only have emergency coverage. If you are unsure if your dependent lives outside the HMO service area, call the HMO at the number listed in their plan material to find out.

You may change coverage plans for both you and your dependent(s) during annual enrollment or if you have a status change event (you and your 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, if all of the following conditions are met:

• The child is physically or mentally incapable of self-support;
• The child is covered as an eligible dependent under a Walmart-sponsored medical and dental plan, critical illness insurance, accident insurance, AD&D and/or optional dependent life insurance prior to his or her 26th birthday; and
• The child’s doctor provides written medical evidence of the child’s disability and inability to provide self-support.
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 associate may be either a covered associate or a covered dependent under the Plan, 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 under the Plan, including HMOs);
- 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 above.

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 Benefits Customer Service 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. 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 Benefits Customer Service.

When you enroll for benefits

Once you have completed any applicable eligibility waiting period, you can enroll for benefits as follows (for more information, refer to the charts that appear later in this chapter to find the one 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 (which could be before or after January 1 of the following year).
- If you choose to enroll in short-term disability, Short-Term Disability Plus or long-term disability during annual enrollment, you will have a one-year wait from the date you enroll. If an end-of-year pay period covers both the prior and new year, your deductions, if applicable, will reflect the deduction amount for the prior year through December 31 and the new deduction amount for the new year, prorated for the number of days covered from January 1 until the end of the pay period.
- 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 are an associate in Hawaii, your eligibility and benefits information is described in the Eligibility and benefits for associates in Hawaii chapter.
Eligibility and enrollment

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;
- Dental;
- Vision;
- Critical illness insurance;
- Accident insurance; and
- Accidental death and dismemberment (AD&D).

Note that some HMOs have different eligibility requirements. See The medical plan chapter for more information.

If you are eligible and do not enroll during your initial enrollment period, you may still enroll for the following benefits during the year by going online through the WIRE or WalmartOne.com. However, if you do not enroll in the benefits listed below during your initial enrollment period, your benefits may be reduced, you may have an additional waiting period, or you may be required to provide Proof of Good Health, depending on the benefit:

- Optional associate life insurance;
- Optional dependent life insurance;
- Short-term disability;
- Short-Term Disability Plus;
- Long-term disability; and
- Truck driver long-term disability.

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 or WalmartOne.com. If you believe there is an error regarding which benefits you enrolled in, you should immediately contact Benefits Customer Service at 800-421-1362.

YOUR PLAN ID CARD

When you enroll in an HRA plan or the HSA Plan, you will receive a plan ID card at your home address. If your Third Party Administrator (TPA) is BlueAdvantage of Arkansas or Aetna, 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 in the medical plan 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 identification (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 or WalmartOne.com. If your dependent is age 18 or over, they will need to contact Benefits Customer Service 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 or WalmartOne.com or you have tried to make contact with Benefits Customer Service on the final day of your initial enrollment, 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 ASSOCIATE’S 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 and on the WIRE during annual enrollment. This includes the eligible dependents you
have elected to cover, unless you change your prior elections. You may call Benefits Customer Service 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.

IMPORTANT
If you are a first-time enrollee, you must actively complete an online enrollment session at WalmartOne.com or on the WIRE 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 actively-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, Short-Term Disability Plus and/or long-term disability, those coverages will not begin until you have returned to work. No enrollment is required for Resources For Living 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.

Some insurance plans, such as optional life insurance policies, provide a “guaranteed issue” amount only if you enroll when you are first eligible for coverage. “Guaranteed issue” is the maximum amount of insurance that can be issued without the need to submit Proof of Good Health.

ACTIVE-WORK OR ACTIVELY-AT-WORK
For medical, dental, vision, critical illness insurance, accident insurance, AD&D and Resources For Living coverage, actively-at-work or active-work means you are on active status and have reported to 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 disability, actively-at-work or active 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. 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, Short-Term Disability Plus and long-term disability 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.

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 Changing your benefits during the year: status change events section 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 CA*), field Logistics, field supervisor positions in stores and clubs; excludes vision center managers

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<thead>
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<th>Plan</th>
<th>Enrollment Periods and Effective Dates</th>
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| Medical                             | Initial enrollment period:  
Between the date of your first paycheck and the day prior to your effective date, as described immediately below.  
When coverage is effective:  
The first day of the calendar month during which your 89th day of continuous full-time employment falls.  
For critical illness insurance:  
If you enroll during your initial enrollment period, your coverage will be effective on the first day of the calendar month during which your 89th day of continuous full-time employment falls. During your initial enrollment period only, you may elect any amount of coverage offered by the Plan without having to provide Proof of Good Health. All amounts elected outside of your initial enrollment period require Proof of Good Health, which will be available electronically when you complete an online enrollment session. If you do not complete the electronic Proof of Good Health questionnaire, you will have 60 days from the date you enroll for coverage to complete a paper form sent to you by Allstate. |
| HMO Plans                           |                                        |
| Vision                              |                                        |
| Dental (enrollment is for two full calendar years) |                                        |
| AD&D                                |                                        |
| Critical illness insurance          |                                        |
| Accident insurance                  |                                        |
| 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. |
| Business travel accident insurance  | Automatically enrolled on your date of hire. |
| Resources For Living                |                                        |
| Optional associate life insurance   | Initial enrollment period:  
Between the date of your first paycheck and the day prior to your effective date, as described immediately below.  
When coverage is effective:  
For optional associate and dependent life insurance, 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. 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 or on your benefits eligibility date, whichever is later.  
For short-term disability, Short-Term Disability Plus and long-term disability, see the disability chapters for more information on coverage effective dates.  
For optional associate life or optional dependent life insurance:  
You may enroll or drop coverage at any time during the year; however, Proof of Good Health will be required to increase any coverage above your guaranteed issue amount outside of your initial enrollment period.  
For STD, STD Plus and LTD:  
You may enroll at any time during the year, but if you enroll at any time other than your initial enrollment period, you will have a one-year wait and a reduction in benefits. |
| Optional dependent life insurance   |                                        |
| Short-term disability              |                                        |
| Short-Term Disability Plus         |                                        |
| Long-term disability               |                                        |

*California pharmacists are eligible for the benefits listed in the chart for management associates.

**NOTE:** Some benefits require you to meet the definition of active-work or actively-at-work. See the Active-work or actively-at-work section in this chapter for more information.
<table>
<thead>
<tr>
<th>Plan</th>
<th>Enrollment Periods and Effective Dates</th>
</tr>
</thead>
</table>
| • Medical  
• HMO Plans  
• Vision  
• Dental (enrollment is for two full calendar years)  
• AD&D  
• Critical illness insurance  
• Accident insurance | **Initial enrollment period:** 
Between the date of your first paycheck and prior to your 60th day after your date of hire.  
**When coverage is effective:** 
Your date of hire.  
**For critical illness insurance:** 
If you enroll during your initial enrollment period, your coverage will be effective on your date of hire. During your initial enrollment period only, you may elect any amount of coverage offered by the Plan without having to provide Proof of Good Health. All amounts elected outside of your initial enrollment period require Proof of Good Health, which will be available electronically when you complete an online enrollment session. If you do not complete the electronic Proof of Good Health questionnaire, you will have 60 days from the date you enroll for coverage to complete a paper form sent to you by Allstate. |
| • Company-paid life insurance | Automatically enrolled on your date of hire. |
| • Business travel accident insurance  
• Resources For Living | Automatically enrolled on your date of hire. |
| • Optional associate life insurance  
• Optional dependent life insurance  
• Short-term disability (Not available in California and Rhode Island; different coverage is available in Hawaii, New Jersey and New York)  
• Short-Term Disability Plus (Not available in California and Rhode Island)  
• Long-term disability | **Initial enrollment period:** 
Between the date of your first paycheck and prior to your 60th day after your date of hire.  
**When coverage is effective:** 
For optional associate and dependent life insurance, 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. 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 or on your benefits eligibility date, whichever is later.  
For short-term disability, Short-Term Disability Plus and long-term disability, see the disability chapters for more information on coverage effective dates.  
**For optional associate life or optional dependent life insurance:** 
You may enroll or drop coverage at any time during the year; however, Proof of Good Health will be required to increase any coverage above your guaranteed issue amount outside of your initial enrollment period.  
**For STD, STD Plus and LTD:** 
You may enroll at any time during the year, but if you enroll at any time other than your initial enrollment period, you will have a one-year wait and a reduction in benefits. |

**NOTE:** Some benefits require you to meet the definition of active-work or actively-at-work. See the [Active-work or actively-at-work](#) section in this chapter for more information.
### PART-TIME HOURLY AND TEMPORARY ASSOCIATES*

<table>
<thead>
<tr>
<th>Plan</th>
<th>Enrollment Periods and Effective Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical</td>
<td><strong>Initial enrollment period:</strong> Between your 52-week anniversary date and the first day of the second calendar month following your 52-week anniversary date.</td>
</tr>
<tr>
<td>• HMO Plans</td>
<td></td>
</tr>
<tr>
<td>• Vision</td>
<td></td>
</tr>
<tr>
<td><strong>When coverage is effective:</strong></td>
<td>The first day of the second calendar month following your 52-week anniversary date.*</td>
</tr>
<tr>
<td>• Critical illness insurance</td>
<td><strong>For critical illness insurance:</strong> If you enroll during your initial enrollment period, your coverage will be effective on the first day of the second calendar month following your 52-week anniversary date. During your initial enrollment period only, you may elect any amount of coverage offered by the Plan without having to provide Proof of Good Health. All amounts elected outside of your initial enrollment period require Proof of Good Health, which will be available electronically when you complete an online enrollment session. If you do not complete the electronic Proof of Good Health questionnaire, you will have 60 days from the date you enroll for coverage to complete a paper form sent to you by Allstate. Temporary Hawaii associates are not eligible for critical illness insurance and accident insurance.</td>
</tr>
<tr>
<td>• Accident insurance</td>
<td></td>
</tr>
<tr>
<td>• Business travel accident insurance</td>
<td>Automatically enrolled on your date of hire.</td>
</tr>
<tr>
<td>• Resources For Living</td>
<td></td>
</tr>
</tbody>
</table>

*Part-time hourly associates and temporary associates must work the required number of hours and pass the initial and annual benefits eligibility checks (part-time hourly pharmacists hired before February 1, 2012, are exempt from this requirement). See [Associate eligibility](#) earlier in this chapter.

**NOTE:** Part-time hourly and temporary associates may only cover their eligible dependent children and may not cover their spouses/partners. Dental, AD&D, optional associate life, optional dependent life, company-paid life and disability coverage are not available to part-time hourly and temporary associates.

### PART-TIME TRUCK DRIVERS

<table>
<thead>
<tr>
<th>Plan</th>
<th>Enrollment Periods and Effective Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical</td>
<td><strong>Initial enrollment period:</strong> Between the date of your first paycheck and the day prior to your effective date, as described immediately below.</td>
</tr>
<tr>
<td>• HMO Plans</td>
<td></td>
</tr>
<tr>
<td>• Vision</td>
<td></td>
</tr>
<tr>
<td><strong>When coverage is effective:</strong></td>
<td>The first day of the calendar month during which your 89th day of continuous employment falls.</td>
</tr>
<tr>
<td>• Critical illness insurance</td>
<td><strong>For critical illness insurance:</strong> If you enroll during your initial enrollment period, your coverage will be effective on the first day of the calendar month during which your 89th day of continuous employment falls. During your initial enrollment period only, you may elect any amount of coverage offered by the Plan without having to provide Proof of Good Health. All amounts elected outside of your initial enrollment period require Proof of Good Health, which will be available electronically when you complete an online enrollment session. If you do not complete the electronic Proof of Good Health questionnaire, you will have 60 days from the date you enroll for coverage to complete a paper form sent to you by Allstate.</td>
</tr>
<tr>
<td>• Accident insurance</td>
<td></td>
</tr>
<tr>
<td>• Business travel accident insurance</td>
<td>Automatically enrolled on your date of hire.</td>
</tr>
<tr>
<td>• Resources For Living</td>
<td></td>
</tr>
</tbody>
</table>

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. Dental, AD&D, optional associate life, optional dependent life, company-paid life and disability coverage are not available to part-time truck drivers.
## ASSOCIATES WHO DO NOT WORK THE REQUIRED NUMBER OF HOURS FOR BENEFITS ELIGIBILITY

<table>
<thead>
<tr>
<th>Plan</th>
<th>Enrollment Periods and Effective Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Business travel accident insurance</td>
<td>Automatically enrolled on your date of hire.</td>
</tr>
<tr>
<td>• Resources For Living</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Plan</th>
<th>Enrollment Periods and Effective Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical</td>
<td>Initial enrollment period:</td>
</tr>
<tr>
<td>• HMO Plans</td>
<td>Between the date of your first paycheck and prior to your 60th day after your date of hire.</td>
</tr>
<tr>
<td>• Vision</td>
<td>When coverage is effective:</td>
</tr>
<tr>
<td>• Dental (enrollment is for two full calendar years)</td>
<td>Your date of hire.</td>
</tr>
<tr>
<td>• AD&amp;D</td>
<td>For critical illness insurance:</td>
</tr>
<tr>
<td>• Critical illness insurance</td>
<td>If you enroll during your initial enrollment period only, you may elect any amount of coverage offered by the Plan without having to provide Proof of Good Health.</td>
</tr>
<tr>
<td>• Accident insurance</td>
<td>All amounts elected outside of your initial enrollment period require Proof of Good Health, which will be available electronically when you complete an online enrollment session. If you do not complete the electronic Proof of Good Health questionnaire, you will have 60 days from the date you enroll for coverage to complete a paper form sent to you by Allstate.</td>
</tr>
<tr>
<td>• Company-paid life insurance</td>
<td>Automatically enrolled on your date of hire.</td>
</tr>
<tr>
<td>• Business travel accident insurance</td>
<td>Automatically enrolled on your date of hire.</td>
</tr>
<tr>
<td>• Resources For Living</td>
<td></td>
</tr>
<tr>
<td>• Optional associate life insurance</td>
<td>Initial enrollment period:</td>
</tr>
<tr>
<td>• Optional dependent life insurance</td>
<td>Between the date of your first paycheck and prior to your 60th day after your date of hire.</td>
</tr>
<tr>
<td>• Long-term disability</td>
<td>When coverage is effective:</td>
</tr>
<tr>
<td>• Truck driver long-term disability</td>
<td>For optional associate and dependent life insurance, 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. 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 or on your benefits eligibility date, whichever is later.</td>
</tr>
<tr>
<td></td>
<td>For optional associate life or optional dependent life insurance: You may enroll or drop coverage at any time during the year; however, Proof of Good Health will be required to increase any coverage above your guaranteed issue amount outside of your initial enrollment period.</td>
</tr>
<tr>
<td></td>
<td>For LTD: You may enroll at any time during the year, but if you enroll at any time other than your initial enrollment period, you will have a one-year wait and a reduction in benefits.</td>
</tr>
<tr>
<td></td>
<td>For Truck Driver LTD: You may enroll at any time during the year, but if you enroll at any time other than your initial enrollment period, you will be required to provide Evidence of Insurability. You will have a reduction in benefits for one year from 50% of average monthly wage to 40% of average monthly wage.</td>
</tr>
</tbody>
</table>

Short-term disability and Short-Term Disability Plus are not available to management associates, management trainees, full-time truck drivers and California pharmacists.

**NOTE:** Some benefits require you to meet the definition of active-work or actively-at-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 within that pay period. If a pay period covers both the prior and new year, 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, your deductions pay for coverage for the previous two weeks. Deductions are based on biweekly (every other week) 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 Benefits Customer Service 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 may be made on an after-tax basis.

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), dental and vision coverage that relate to your partner, or your partner’s children, 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

If you and/or a covered spouse/partner do not use tobacco and are considered to be “tobacco free,” or if you and/or a covered spouse/partner use tobacco and you will enroll in and complete a quit-tobacco program of your choice between the time of annual enrollment and December 31, 2015; 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. Then you can receive lower tobacco-free rates for medical/prescription drug coverage, optional associate life insurance, optional dependent life insurance for a spouse and/or critical illness insurance.

“Tobacco-free” means that you (and/or your covered spouse/partner) do not use tobacco in any form — cigarettes, e-cigarettes, cigars, pipes, snuff, or chewing tobacco.

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, Short-Term Disability Plus and Resources For Living coverage while you are on an FMLA or personal 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 Benefits Customer Service at 800-421-1362 to pay your premiums during your leave. If you cancel your coverage during your FMLA or personal leave and return to work, you may contact Benefits Customer Service 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 Benefits Customer Service 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**

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);
- Short-Term Disability Plus.

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 Benefits Customer Service 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:

**Benefits Customer Service**

P.O. Box 1039
Department 3001
Lowell, AR 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 by calling 800-421-1362 and selecting the debit or credit card payment option, using either Visa, MasterCard or Discover credit cards.
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., vacation, incentive, etc.), will have the full amount of premiums deducted. Payment arrangements can also be made by notifying Benefits Customer Service 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 Short-term disability, Short-Term Disability Plus, Long-term disability and Truck driver long-term disability chapters 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

Your ability to change your benefit coverage at any time other than during the annual enrollment period partially depends on whether the benefit is paid for with pretax dollars or after tax dollars, among other guidelines.

• After-tax benefits can be added or dropped at any time. After-tax benefits are optional associate life insurance, optional dependent life insurance, short-term disability, Short-Term Disability Plus, long-term disability and truck driver long-term disability.

• Pretax benefits (and benefits provided to partners and partners’ children) generally can only be changed during annual enrollment unless you have a status change event. Pretax benefits are the Associates’ Medical Plan, HMO plans, dental, vision, AD&D, critical illness insurance and accident insurance.

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 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 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’s/partner’s change in coverage.
  – If the associate’s hours are reduced such that the associate works an average of less than 30 hours per week and has intent to enroll in another plan offering minimum essential coverage, the associate may drop coverage.

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 dependent(s) had COBRA coverage and that COBRA coverage has ended (nonpayment of premiums is not sufficient for this purpose); or
  – You and/or your spouse/partner and 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.
• A change may be allowed if the lifetime maximum for all medical benefits under another plan has been met.
• 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, accident insurance, or critical illness insurance within 60 days of the loss of coverage.
• 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 Qualified Medical Child Support Order — See 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, your spouse/partner, or your eligible dependents are enrolled in the Associates’ Medical Plan, an HMO 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 or Medicaid), you cannot drop the Associates’ Medical Plan, an HMO 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. Coverage will be effective on the date you enroll in the Plan.
ADDITIONAL CIRCUMSTANCES IN WHICH YOU MAY CHANGE YOUR BENEFITS

In addition to the circumstances under which you may change your benefits listed above, 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 Benefits Customer Service 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 have a status change event that affects your spouse’s eligibility, you can only drop or add 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 or other eligible dependent due to a status change event, they will be subject to the same Plan limitations that apply to you at that time, if any (for example, limits concerning transplant coverage). If you change from an HRA plan to the HSA Plan, or from the HSA Plan to an HRA plan, or from an HMO to either the HSA Plan or an HRA plan 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. If you change from one of the two HRA plans to the other 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 either of the two HRA plans to the HSA Plan or an HMO or to no coverage, 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, the associate and dependent will be subject to the same Plan limitations that apply to whichever of them has been continuously covered on the Plan for the longer period of time. This condition applies to benefits that have a one-year waiting period.

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 (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). However, 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 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 Benefits Customer Service 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 at work or on WalmartOne.com for status changes due to:

- Marriage;
- 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;
- Birth;
- Divorce or legal separation;
- Termination of domestic partnership;
- Termination of legal relationship with a person other than a spouse or domestic partner;
- Gain or loss of coverage by your eligible spouse/partner; or
- Special enrollment period.

For all other types of status changes, call Benefits Customer Service at 800-421-1362.

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, Short-Term Disability Plus, long-term disability or truck driver long-term disability; see the respective chapters for effective date information.

If you do not notify Benefits Customer Service 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 Benefits Customer Service 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 he or she does not notify Benefits Customer Service 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 hired as a part-time hourly or temporary associate and your classification is changed to full-time, you will be eligible for full-time benefits within 90 days of the effective date of the classification change or upon satisfying the waiting period requirement for full-time hourly associates, whichever happens first, provided that you enroll on a timely basis.

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, critical illness insurance and accident insurance. You and your family members will no longer be eligible for dental, life, AD&D 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 dependent(s) 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

<table>
<thead>
<tr>
<th>If Your Transition Occurs</th>
<th>Date Coverage Is Effective</th>
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</table>
| And you have been continuously employed for more than 52 weeks and were eligible for coverage under the Plan as a part-time hourly or temporary associate immediately prior to your transition | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.  
• Your coverage will either be effective the first day of the pay period in which your transition occurs or the date of your call into Benefits Customer Service to enroll, depending on your choice. Remember, premiums will be deducted from your paycheck retroactive to your effective date once you enroll.  
• You will be eligible to enroll in dental, AD&D, optional associate and dependent life insurance, and disability 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; however, Proof of Good Health will be required for all amounts after your initial enrollment period has ended.  
• If you are currently enrolled in medical, vision, critical illness and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family. If you are not currently enrolled in medical, vision, critical illness and/or accident insurance, you will only be able to enroll in associate + spouse/partner or associate + family until the next annual enrollment period or with a valid status change event. (As a part-time hourly associate, you were eligible for associate-only and associate + child(ren) coverage; therefore, you are not eligible to select from these coverage levels.) |

| And you have been continuously employed for more than 52 weeks and were not eligible for coverage under the Plan as a part-time hourly associate immediately prior to your transition | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.  
• Your coverage will either be effective the first day of the pay period in which your transition occurs or the date of your call into Benefits Customer Service to enroll, depending on your choice. Remember, premiums will be deducted from your paycheck retroactive to your effective date once you enroll.  
• You will be eligible to enroll in medical, vision, dental, critical illness, accident insurance, AD&D, optional associate and dependent life insurance, and disability 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; however, Proof of Good Health will be required for all amounts after your initial enrollment period has ended. |

(Continued on the next page)
PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION (Continued)

<table>
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<tr>
<th>If Your Transition Occurs</th>
<th>Date Coverage Is Effective</th>
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| And you have been continuously employed for more than 90 days but less than 52 weeks | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.  
  • Your coverage will either be effective the first day of the pay period your transition occurs or the date of your call into Benefits Customer Service to enroll, depending on your choice. Remember, premiums will be deducted from your paycheck retroactive to your effective date once you enroll.  
  • You will be eligible to enroll in medical, dental, vision, AD&D, optional associate and dependent life insurance, disability, 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; however, Proof of Good Health will be required for all amounts after your initial enrollment period has ended. |
| And you have been continuously employed for less than 90 days   | • 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 the first day of the calendar month during which your 89th day of continuous employment falls or the date you call into Benefits Customer Service to enroll, if you call to enroll during the 60-day period, but after the first day of the calendar month during which your 89th day of continuous employment falls.  
  • Premiums may be deducted from your paycheck retroactive 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, disability, 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; however, Proof of Good Health will be required for all amounts after your initial enrollment period has ended. |
## PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO MANAGEMENT

<table>
<thead>
<tr>
<th>If Your Transition Occurs</th>
<th>Date Coverage Is Effective</th>
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| And you have been continuously employed for more than 52 weeks and were eligible for coverage under the Plan as a part-time hourly associate immediately prior to your transition | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.  
  • Your coverage will either be effective the first day of the pay period in which your transition occurs or the date of your call into Benefits Customer Service to enroll, depending on your choice. Remember premiums will be deducted from your paycheck retroactive to your effective date once you enroll.  
  • You will be eligible to enroll in dental, AD&D, optional associate and dependent life insurance, and long-term disability insurance (short-term disability is not required for management associates). 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; however, Proof of Good Health will be required for all amounts after your initial enrollment period has ended.  
  • If you are currently enrolled in medical, vision, critical illness and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family. If you are not currently enrolled in medical, vision, critical illness and/or accident insurance, you will only be able to enroll in associate + spouse/partner or associate + family until the next annual enrollment period or with a valid status change event. (As a part-time hourly associate, you were eligible for associate-only and associate + child(ren) coverage; therefore, you are not eligible to select from these coverage levels.) |
| And you have been continuously employed for more than 52 weeks and were not eligible for coverage under the Plan as a part-time hourly associate immediately prior to your transition | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.  
  • Your coverage will either be effective the first day of the pay period in which your transition occurs or the date of your call into Benefits Customer Service to enroll, depending on your choice. Remember, premiums will be deducted from your paycheck retroactive to your effective date once you enroll.  
  • You will be eligible to enroll in medical, dental, vision, critical illness, accident insurance, AD&D, optional associate and dependent life insurance and disability 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; however, Proof of Good Health will be required for all amounts after your initial enrollment period has ended. |
| And you have been continuously employed for less than 52 weeks                            | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.  
  • Your coverage will either be effective the first day of the pay period in which your transition occurs or the date of your call into Benefits Customer Service to enroll, depending on your choice. Remember, premiums will be deducted from your paycheck retroactive to your effective date once you enroll.  
  • You will be eligible to enroll in medical, vision, dental, AD&D, optional associate and dependent life insurance and disability, 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; however, Proof of Good Health will be required for all amounts after your initial enrollment period has ended. |
### FULL-TIME HOURLY ASSOCIATES TRANSFERRING TO MANAGEMENT

<table>
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<tr>
<th>If Your Transition Occurs</th>
<th>Date Coverage Is Effective</th>
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<tbody>
<tr>
<td>And you have been continuously employed for 90 days or more</td>
<td>• No changes will take place to the benefits plans in which you are currently enrolled unless you are enrolled in short-term disability and Short-Term Disability Plus. They will be canceled on the first day of the pay period in which your transition occurs.</td>
</tr>
</tbody>
</table>
| And you have been continuously employed for less than 90 days  | • You will have 60 days to enroll from the first day of the pay period in which your transition occurs.  
  • Your coverage will either be effective the first day of the pay period in which your transition occurs or the date of your call into Benefits Customer Service to enroll, depending on your choice. Remember, premiums will be deducted from your paycheck retroactive to your effective date once you enroll.  
  • 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; however, Proof of Good Health will be required to increase any coverage above your guaranteed issue amount outside of your initial enrollment period. |

### FULL-TIME HOURLY VISION CENTER MANAGERS AND WALMART.COM FUNCTIONAL NON-EXEMPT ASSOCIATES TRANSFERRING TO MANAGEMENT

<table>
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<th>Date Coverage Is Effective</th>
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<tbody>
<tr>
<td>No changes will take place to the benefits plans in which you are currently enrolled unless you are enrolled in short-term disability and Short-Term Disability Plus. They will be canceled on the first day of the pay period in which your transition occurs.</td>
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### MANAGEMENT ASSOCIATES TRANSFERRING TO FULL-TIME HOURLY

<table>
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<tr>
<th>Date Coverage Is Effective</th>
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<tbody>
<tr>
<td>• Optional associate life insurance amounts selected over $200,000 will be reduced to $200,000.</td>
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</table>
  • You will automatically be defaulted into short-term disability and Short-Term Disability Plus on the first day of the pay period in which your transition occurs (except in California, Rhode Island, Hawaii, New York and New Jersey, where state-mandated short-term disability laws apply). If you don’t want short-term disability and Short-Term Disability Plus, you can cancel at any time by completing an online enrollment session on the WIRE or WalmartOne.com, or by calling Benefits Customer Service at 800-421-1362. |
### FULL-TIME HOURLY ASSOCIATES TRANSFERRING TO PART-TIME HOURLY OR TEMPORARY

<table>
<thead>
<tr>
<th>If Your Transition Occurs</th>
<th>Date Coverage Is Effective</th>
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</table>
| And you have met your eligibility waiting period and were eligible for coverage under the Plan immediately prior to your transition | • If you are enrolled in medical, vision, 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.  
  • All other coverage (dental, AD&D, life and disability) will be canceled effective the first day of the pay period after your transition occurs. You may be able to convert your and your dependent’s life insurance, critical illness and/or accident insurance to an individual policy. |
| But you have NOT met your eligibility waiting period | • If you have worked the required 30 average hours per week, you will be eligible to enroll in medical, critical illness and accident insurance on the first day of the second month following your 52-week employment anniversary. (Part-time hourly and temporary field Logistics and pharmacists have different hours-per-week requirements, which are detailed in the Associate eligibility section earlier in this chapter.) See the respective chapters in this Summary Plan Description for more information.  
  • You can select associate only or associate + child(ren) coverage. Associate + spouse/partner and associate + family are not available to part-time associates.  
  • Your coverage will be effective on your 366th day of continuous employment. |

### MANAGEMENT ASSOCIATES TRANSFERRING TO PART-TIME HOURLY OR TEMPORARY

<table>
<thead>
<tr>
<th>Date Coverage Is Effective</th>
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<tbody>
<tr>
<td>• If you are enrolled in medical or vision coverage, your coverage type will automatically adjust 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.</td>
</tr>
<tr>
<td>• Your critical illness and accident insurance will automatically adjust 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. (Part-time associates are not eligible for associate + spouse/partner or associate + family coverage levels.)</td>
</tr>
<tr>
<td>• Optional associate life insurance amounts selected over $200,000 will be reduced to $200,000.</td>
</tr>
<tr>
<td>• All other coverage (dental, AD&amp;D, life and disability) will be canceled effective the first day of the pay period after your transition occurs. You may be able to convert your and your dependent’s life insurance, critical illness and/or accident insurance to an individual policy.</td>
</tr>
</tbody>
</table>

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 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. If you are eligible for the medical, dental and/or vision plan and did not elect coverage before the order was received, you will be enrolled in the 2015 default HRA Plan with associate + child(ren) coverage at the tobacco rate, unless the QMCSO specifies otherwise. If you are in the state of Hawaii, the default plan is Health Plan Hawaii (HMSA).

If you were enrolled for coverage before the order was received, your child will be added under your existing coverage. If you are enrolled in an HMO plan, 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 returned to the child support agency. The Plan will request that a new order be sent within 60 days prior to you satisfying your initial waiting period.

When the Third Party Administrator is administering coverage for a court-ordered dependent, information regarding the court-ordered dependent will only be shared 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 child's 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 child’s 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, under federal law governing pretax benefits, 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

WHERE CAN I FIND?

Eligibility waiting period for medical coverage for management associates and management trainees 32
Eligibility waiting period for medical coverage for full-time hourly, part-time hourly and temporary Hawaii associates 32
Status change events for management, full-time hourly, part-time hourly and temporary Hawaii associates 32
Paying premiums during a leave of absence for Hawaii associates 32
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 is not an option for associates in Hawaii. Other than the eligibility and benefit differences described in this chapter, the information in this 2015 Associate Benefits Book applies to you.

RESOURCES FOR HAWAII ASSOCIATES

<table>
<thead>
<tr>
<th>Find What You Need</th>
<th>Online</th>
<th>Other Resources</th>
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</thead>
<tbody>
<tr>
<td>Health Plan Hawaii (HMSA)</td>
<td>Go to hmsa.com</td>
<td>808-948-6372</td>
</tr>
<tr>
<td>Kaiser Foundation Health Plan</td>
<td>Go to kaiserpermanente.org</td>
<td>800-966-5955</td>
</tr>
<tr>
<td>Enroll in Walmart benefits</td>
<td>Go to the WIRE or WalmartOne.com</td>
<td>Call Benefits Customer Service at 800-421-1362</td>
</tr>
<tr>
<td>Report a claim under the state-mandated disability insurance program</td>
<td>Go to WalmartOne.com or directly to MyLibertyConnection.com</td>
<td>Call Liberty at 800-492-5678</td>
</tr>
<tr>
<td>Notify Benefits Customer Service within 60 days of a status change event, such as a dependent losing eligibility under the Plan</td>
<td>Go to the WIRE or WalmartOne.com</td>
<td>Call Benefits Customer Service at 800-421-1362</td>
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</table>

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.
- All associates in Hawaii are eligible to enroll a spouse/partner in the medical and vision plans. You must meet applicable eligibility requirements described in this chapter and must not be legally separated.
Eligibility waiting period for medical coverage for management associates and management trainees

Medical coverage for management associates and management trainees will become effective on their date of hire.

Eligibility waiting period for medical coverage for full-time hourly, part-time hourly and temporary Hawaii associates

Medical coverage for 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 will become effective as of the earlier of:

- 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 (you can enroll any time after the date of your first paycheck and prior to that date).

Full-time hourly associates in Hawaii follow the eligibility guidelines as described in the Eligibility and enrollment chapter for dental, vision, company-paid life insurance, optional associate and dependent life insurance, critical illness insurance, accident insurance, AD&D, business travel accident insurance, Short-Term Disability Plus and long-term disability.

Part-time hourly and temporary associates in Hawaii follow the eligibility guidelines described in the Eligibility and enrollment chapter, with the following exception: the requirements described in the sections titled Initial enrollment eligibility check and Annual benefits eligibility check do not apply to part-time hourly and temporary associates in Hawaii. Note that temporary associates in Hawaii are not eligible for critical illness and accident insurance.

Status change events for management, full-time hourly, part-time hourly and temporary Hawaii associates

Management and 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 walmart.com functional non-exempt associates) and part-time hourly and temporary associates in Hawaii have the same status change event guidelines as described in the Eligibility and enrollment chapter.

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. The only premium due while you are on a 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).

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.
The medical plan

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### ASSOCIATES’ MEDICAL PLAN RESOURCES

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<th>Other Resources</th>
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| Third Party Administrator                               | Go to WalmartOne.com or blueadvantagearkansas.com | Health care advisor: 866-823-3790       | BlueAdvantage Administrators of Arkansas  
| BlueAdvantage Administrators of Arkansas                |                               |                                         | P.O. Box 1460  
| Aetna                                                   | aetna.com                      | Health care advisor: 855-548-2387       | Aetna  
| UnitedHealthcare                                        | myuhc.com                      | Health care advisor: 888-285-9255       | UnitedHealthcare  
|                                                          |                               |                                         | P.O. Box 30555  
|                                                          |                               |                                         | Salt Lake City, UT 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 Benefits Customer Service 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 the Walmart Care Clinic             | WalmartCareClinic.com         | Call Benefits Customer Service at 800-421-1362 |                                                                                                          |
| Castlight Health: For help finding medical care based on cost and quality 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 |                                                                                                          |
| For guidance from the Life with Baby program if you’re pregnant or thinking of becoming pregnant |                               | Call your health care advisor at the number on your plan ID card |                                                                                                          |
| Request a paper copy of this 2015 Associate Benefits Book |                               | Call Benefits Customer Service at 800-421-1362 |                                                                                                          |
What you need to know about medical benefits

• Under the Associates’ Medical Plan, you have the option to choose medical coverage under either of two HRA plans or the HSA Plan. This chapter describes how these plans function. 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 the HRA or HSA options, 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 amount of money the company allocates to help pay your eligible medical expenses before you have to pay for care out of your own pocket (your HRA can be used to pay for all eligible care except for prescription drugs). This chapter describes how company-provided dollars in your HRA can help pay for eligible medical expenses.

• Your HRA balance may not exceed your network annual deductible for the plan you are enrolled in.

• The HSA Plan allows you to open a Health Savings Account where you can save money through payroll deductions to pay for eligible medical expenses (as defined by the IRS), and Walmart will match your contributions up to predetermined limits. For more information about a Health Savings Account, see the Health Savings Account chapter.

• The HRA plans and the HSA 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.

• 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 Walmart medical plans

The following chart shows the coverage tiers offered by the Associates’ Medical Plan and some of the basic provisions of the Plan. The sections that follow explain how the medical plans work and what the terms mean.

<table>
<thead>
<tr>
<th></th>
<th>HRA HIGH PLAN</th>
<th>HRA PLAN</th>
<th>HSA PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Annual deductible</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate only</td>
<td>$1,750</td>
<td>$3,500</td>
<td>$2,750</td>
</tr>
<tr>
<td>Associate + dependent(s)</td>
<td>$3,500</td>
<td>$7,000</td>
<td>$5,500</td>
</tr>
<tr>
<td><em>Applies for all services except as noted</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Walmart-provided dollars</strong></td>
<td>$500</td>
<td>$1,000</td>
<td>$250</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual out-of-pocket maximum</strong></td>
<td>$5,000</td>
<td>None</td>
<td>$5,000</td>
</tr>
<tr>
<td>Associate only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate + dependent(s)</td>
<td>$10,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eligible preventive care</strong></td>
<td>100%</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>No deductible</td>
<td>No deductible</td>
<td>No deductible</td>
</tr>
<tr>
<td><strong>Doctor visits and diagnostic tests</strong></td>
<td>75%</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>After deductible</td>
<td>After deductible</td>
<td>After deductible</td>
</tr>
<tr>
<td><strong>Hospitalization</strong></td>
<td>75%</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>After deductible</td>
<td>After deductible</td>
<td>After deductible</td>
</tr>
<tr>
<td><strong>Centers of Excellence</strong></td>
<td>100%</td>
<td>N/A</td>
<td>100%</td>
</tr>
<tr>
<td>Spine and heart surgery; hip and knee joint replacement; breast, lung and colorectal cancer review</td>
<td>No deductible</td>
<td>N/A</td>
<td>No deductible</td>
</tr>
<tr>
<td><strong>Transplant</strong> (Mayo Clinic only; excludes kidney, cornea and intestinal transplant)</td>
<td>75%</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>Behavioral health</strong> (Inpatient and outpatient)</td>
<td>75%</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>After deductible</td>
<td>After deductible</td>
<td>After deductible</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>See The pharmacy benefit chapter for details about your prescription drug coverage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Walmart Care Clinic</strong></td>
<td>See the Walmart Care Clinic section of this chapter for details.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Benefit levels differ for behavioral health services in areas served by Aetna. For more information, see the Aetna Custom Performance Network chart later in this chapter.*
HRA FOR MIDYEAR ENROLLMENTS

If you enroll midyear in an HRA plan (or change from HRA to HRA High or from associate-only to associate + dependents), Walmart will allocate a prorated amount to your HRA (although your annual deductible and out-of-pocket maximums 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 HRA High to HRA or from associate + dependents to associate-only. If you drop HRA coverage, your HRA balance will be forfeited.

HEALTH SAVINGS ACCOUNT MATCHING CONTRIBUTIONS

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 the matching limit described in the chart above. Your and Walmart’s combined contributions to your Health Savings Account cannot exceed the 2015 annual limit (as determined by the IRS) of $3,350 for individual coverage or $6,650 for family coverage.

HMO plans

In addition to the plans offered under the Associates’ Medical Plan, HMO plans are available in some locations. 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 to be resolved.

In addition, HMO plans may have different eligibility requirements than the Associates’ Medical Plan. For example, state law may require an insurance policy (such as an HMO) to include different eligibility provisions relating to dependents or waiting periods. You may obtain a description of these differences in the HMOs offered by Walmart by calling Benefits Customer Service at 800-421-1362. The Plan will apply the eligibility requirements outlined in the Eligibility and enrollment chapter, unless you contact Benefits Customer Service and request that a different eligibility provision in an HMO policy be applied.

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 three different Third Party Administrators (TPAs) to handle administration of the Associates’ Medical Plan: BlueAdvantage Administrators of Arkansas, Aetna Life Insurance Company (Aetna) and UnitedHealthcare (UHC). Your work location 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 charge discounted rates to Plan participants. See Your provider network later in this chapter for further details.

HOW THE HRA PLANS PAY BENEFITS

The HRA Plan and HRA High 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 pay for 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 that you are enrolled in. 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 2015, you would be able to use those funds for services rendered in 2015 but not for services rendered prior to 2015 (such as a provider expense that you incurred in 2014 but that was not processed by the TPA until 2015). The HRA rollover balance can be utilized for any service date for which the associate was continuously enrolled in an HRA plan.
If you leave the company, cancel your coverage, lose eligibility or change from one of the HRA plans to the HSA Plan or an HMO, 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.

**HOW THE HRA PLANS’ ANNUAL DEDUCTIBLES WORK**

Your annual deductible is the amount you are responsible for paying each year (Jan. 1–Dec. 31) before the Plan begins paying a portion of your covered expenses. Note that 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. 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 plans, you must meet separate annual deductibles for services provided by network providers and non-network providers. See the **Your provider network** chapter 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 chart 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 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.

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 copays/coinsurance
- Non-network providers’ charges that are above the maximum allowable charge
- Charges for services provided at a Walmart Care Clinic
- Charges excluded by the Plan
- Charges for out-of-network preventive services.

**HOW COINSURANCE AND YOUR OUT-OF-POCKET MAXIMUM WORK UNDER THE HRA PLANS**

For the HRA plans, 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 (except for emergency care, as defined by Third Party Administrators), 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 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 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
- Pharmacy copays/coinsurance.

Your network 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.

---

**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.
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:

- Your coinsurance, including charges for preventive services, when using non-network providers
- Non-network providers’ charges that are above the maximum allowable charge
- Charges for services provided at a Walmart Care Clinic
- Funds you may receive from drug manufacturers or state assistance programs (where permitted by law) to assist you in purchasing prescription drugs
- 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 $5,000. 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 $10,000. In these instances, the out-of-pocket maximum can be met by one or any combination of covered family members, but the plans will not begin to pay 100% of covered charges for any covered person until the entire family out-of-pocket maximum has been met. (Associates in certain locations who have Aetna as their Third Party Administrator have access to Aetna’s Custom Performance Network, which has different out-of-pocket maximums for medical coverage from the ones referred to above. See Custom Performance Network through Aetna later in this chapter for more information.)

HOW THE HSA PLAN ANNUAL DEDUCTIBLES WORK

Like the HRA plans, 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 (Jan. 1–Dec. 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 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 a Walmart Care Clinic
- Charges excluded by the Plan
- Charges for preventive services.
HOW YOUR COVERAGE WORKS UNDER THE HRA PLANS AND THE HSA PLAN

<table>
<thead>
<tr>
<th></th>
<th>HRA High Plan and HRA Plan</th>
<th>HSA Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paying from your account</td>
<td>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 you are enrolled in.</td>
<td>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.</td>
</tr>
<tr>
<td>Meeting your annual deductible</td>
<td>After your HRA is used up, you pay covered medical expenses out of your own pocket until your annual deductible is met.</td>
<td>You pay expenses out of your own pocket or from your Health Savings Account until your annual deductible is met.</td>
</tr>
<tr>
<td>The Plan pays a percentage of covered expenses</td>
<td>After your network annual deductible is met, the Plan pays 75% of your covered network expenses and you pay 25%. 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.</td>
<td>After your network annual deductible is met, the Plan pays 75% of your covered network expenses and you pay 25%. 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.</td>
</tr>
<tr>
<td>The Plan pays 100% of covered network services after you meet your out-of-pocket maximum</td>
<td>After you have met your out-of-pocket maximum for the year, 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.)</td>
<td>After you have met your out-of-pocket maximum for the year, 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.)</td>
</tr>
</tbody>
</table>

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 Third Party Administrators), 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.

The expenses you pay that apply toward your network 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
- Pharmacy charges before your network annual deductible is met.

Your network out-of-pocket maximum may be met by any combination of covered medical services.
Expenses that don’t count toward the annual out-of-pocket maximum. The following expenses are not applied toward the annual out-of-pocket maximum:

- Your coinsurance, including charges for preventive services, when using non-network providers
- Non-network providers’ charges that are above the maximum allowable charge
- Charges for service provided at a Walmart Care Clinic
- Funds you may receive from drug manufacturers or state assistance programs (where permitted by law) to assist you in purchasing prescription drugs
- 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 $6,450. 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 $12,900. In these instances, the out-of-pocket maximum can be met by one or any combination of covered family members, but the Plan will not begin to pay 100% of covered charges for any covered person until the entire family annual out-of-pocket maximum has been met. (Associates in certain locations who have Aetna as their Third Party Administrator have access to Aetna’s Custom Performance Network, which has different out-of-pocket maximums for medical coverage from the ones referred to above. See Custom Performance Network through Aetna later in this chapter for more information.)

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) applies to both covered in-network and covered out-of-network services. MAC means 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 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:

**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.

**BlueAdvantage Administrators of Arkanasas:** 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 and 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 and BlueAdvantage Administrators of Arkansas 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 TPA.

You and your health care provider may access the coverage policies of Aetna at aetna.com, of UnitedHealthcare at myuhc.com and of BlueAdvantage Administrators of Arkansas at blueadvantagearkansas.com.

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, participants in the Associates’ Medical Plan have their benefits administered by one of the following Third Party Administrators (TPAs):

• BlueAdvantage Administrators of Arkansas
• Aetna
• UnitedHealthcare.

The Plan has contracted with each TPA to provide a network of 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 TPA for covered expenses as payment in full (this is the maximum allowable charge for in-network services), subject to the annual deductible and coinsurance amounts applicable to the coverage you have chosen. An out-of-network provider may charge you for the amount over and above what the Plan allows for covered expenses (that is, for amounts above the maximum allowable charge).

After you have met your applicable annual deductible, the Plan will pay 75% of covered expenses if you use a network provider and 50% of the maximum allowable charge if you use a non-network provider. You are responsible for paying all remaining amounts (i.e., your 50% share of the maximum allowable charge if you use a non-network provider plus any amount above the maximum allowable charge). Network providers do not charge more than the maximum allowable charge amount for covered expenses. Online provider directories are available on WalmartOne.com or the WIRE.
If your doctor leaves the network, your benefit will generally be treated as an out-of-network benefit, and 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 doctor who is in the network.

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 TPAs 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. You may contact your TPA 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;
• 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);
• 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; or
• 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.
• 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 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.

If your TPA 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
• 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.

**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:

- GA: Blue Open Access POS
- NH: BlueChoice Open Access POS
- WI: Blue Preferred POS
- MO: Blue Preferred POS
- MD, Northern VA, DC: BlueChoice Advantage Open Access
- NJ: Horizon Managed Care Network
- TN: Network S
- FL: NetworkBLUE
- KC, MO: Preferred-Care Blue.

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 the back of 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:

- 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 the following locations will have access to HPHC Insurance Company, an affiliate of Harvard Pilgrim Health Care:

- Massachusetts
- Maine
- New Hampshire.
CUSTOM PERFORMANCE NETWORK THROUGH AETNA

Associates who have Aetna as their Third Party Administrator will have access to Aetna’s Custom Performance Network of providers if they work in any of the following locations:

- Boise, Idaho
- Chicago, Illinois
- Dallas, Texas
- Houston, Texas
- San Antonio, Texas

Aetna’s Custom Performance Network includes doctors and providers specially selected based on quality and performance criteria. Associates in these areas who choose to receive care from providers in the Custom Performance Network will be provided with a greater level of benefits under the Plan, in the form of lower annual deductibles and lower coinsurance for medical services. The chart below shows a comparison of benefits under the Custom Performance Network (CPN) and the benefits available in Aetna’s broader network.

### AETNA CUSTOM PERFORMANCE NETWORK

<table>
<thead>
<tr>
<th></th>
<th>HRA HIGH PLAN</th>
<th>HRA PLAN</th>
<th>HSA PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aetna</td>
<td>Aetna CPN</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Annual deductible</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate only</td>
<td>$1,750</td>
<td>$1,250</td>
<td>$3,500</td>
</tr>
<tr>
<td>Associate + dependent(s)</td>
<td>$3,500</td>
<td>$2,500</td>
<td>$7,000</td>
</tr>
<tr>
<td>Applies for all services except as noted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual out-of-pocket maximum</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate only</td>
<td>$5,000</td>
<td>$3,000</td>
<td>None</td>
</tr>
<tr>
<td>Associate + dependent(s)</td>
<td>$10,000</td>
<td>$6,000</td>
<td>None</td>
</tr>
<tr>
<td>The CPN’s lower out-of-pocket maximum applies to all network charges except prescription drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eligible preventive care</strong></td>
<td>100% No deductible</td>
<td>50% No deductible</td>
<td>100% No deductible</td>
</tr>
<tr>
<td><strong>Doctor visits and diagnostic tests</strong></td>
<td>75% After deductible</td>
<td>90% After deductible</td>
<td>50% After deductible</td>
</tr>
<tr>
<td><strong>Hospitalization</strong></td>
<td>75% After deductible</td>
<td>90% After deductible</td>
<td>50% After deductible</td>
</tr>
<tr>
<td><strong>Centers of Excellence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spine and heart surgery; hip and knee joint replacement; breast, lung and colorectal cancer review</td>
<td>100% No deductible</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Transplant</strong> (Mayo Clinic only; excludes kidney, cornea and intestinal transplant)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency care</strong></td>
<td>75% After deductible</td>
<td>75% After deductible</td>
<td>75%* After deductible</td>
</tr>
<tr>
<td>*Non-emergency care from out-of-network providers will be covered at 50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral health</strong> (Inpatient and outpatient)</td>
<td>90% After deductible</td>
<td>90% After deductible</td>
<td>50% After deductible</td>
</tr>
</tbody>
</table>

NOTE: The Custom Performance Network has no impact on Walmart-provided dollars for the HRA plans or HSA matching contributions.
Preventive care program

Associates enrolled in one of the HRA plans or the HSA Plan will have 100% coverage for the cost of eligible preventive care services when network providers are used. When a non-network provider is used, the Plan reduces the benefit to 50%, and coinsurance amounts will not apply 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. 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 to answer questions regarding available preventive care services.

Covered services include those listed below. 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, a 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)
• 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
• Diet counseling for adults at higher risk for chronic disease
• Hepatitis C screening for individuals at high risk
• HIV screening for all adults at higher risk
• Immunization vaccines for adults — doses, recommended ages and recommended populations vary:
  – 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: http://www.cdc.gov/vaccines/schedules.

• Lung cancer screening for certain adults age 55–80 with 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

• Anemia screening on a routine basis for pregnant women
• Bacteriuria urinary tract or other infection screening for pregnant women
• BRCA counseling about genetic testing for women at higher risk
• 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
• 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
• **Folic acid** supplements for women who may become pregnant (prescription required)

• **Gestational diabetes** screening for women 24–28 weeks pregnant and those at high risk of developing gestational diabetes

• **Gonorrhea** screening for all women at higher risk

• **Hepatitis B** screening for pregnant women at their first prenatal visit

• **Human immunodeficiency virus (HIV)** screening and counseling for sexually active women

• **Human papillomavirus (HPV) DNA test:** high-risk HPV DNA testing every three years for women with normal cytology results who are 30 or older

• **Osteoporosis** screening for women over age 60, 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**

• **Autism** screening for children at 18 and 24 months

• **Behavioral** assessments for children of all ages

• **Blood pressure** screening for children of all ages

• **Cervical dysplasia** screening for sexually active females

• **Congenital hypothyroidism** 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 (prescription required)

• **Gonorrhea** preventive medication for the eyes of all newborns

• **Hearing** screening for all children

• **Height, weight and body mass index** measurements for children

• **Hematocrit or hemoglobin** screening for children

• **Hemoglobinopathies** or sickle cell screening for newborns

• **HIV** screening for adolescents at higher risk

• **Immunization** vaccines for children from birth to age 18 — doses, recommended ages and recommended populations vary:
  – Diphtheria, tetanus, pertussis
  – 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](http://cdc.gov/vaccines/schedules).

• **Iron** supplements for children ages 6 to 12 months at risk for anemia (prescription required)

• **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

• **Sexually transmitted infection (STI)** prevention counseling and screening for adolescents at higher risk

• **Skin cancer** counseling for young adults to age 24

• **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 Walmart and Sam’s Club facilities.

• 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 go to
The medical plan

Be 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.

Behavioral Health and Substance Abuse Program

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

For participants with coverage administered by BlueAdvantage Administrators of Arkansas or UnitedHealthcare, covered network services are paid at 75% after you’ve met your annual deductible. For participants with coverage administered by Aetna, covered network services are paid at 90% after you’ve met your annual deductible. For all participants, 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.

Coverage is provided for:

- Outpatient services
- Inpatient services where the participant receives covered services 24 hours a day in a hospital
- Partial hospitalization program services where the participant receives covered services six to eight hours a day, five to seven days per week
- Intensive outpatient program services where the participant receives covered services lasting two to four hours a 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 choose 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.

Note: Non-emergency VADs (ventricular assist devices) may require a review by the Third Party Administrator.

Preauthorization

Two of the Plan’s Third Party Administrators, Aetna and UnitedHealthcare, require that their network providers obtain prior authorization of certain services. The types of services subject to the prior authorization requirement include, but are not limited to:

- Inpatient admissions (to hospital, hospice and other facilities)
- Maternity inpatient stays that exceed the Third Party Administrator’s standard length of stay
- Home health care
- Outpatient surgery, radiology services, dialysis
- Non-emergency ambulance (air or ground)
- Reconstructive procedures that may be considered cosmetic
- BRCA genetic testing
- Mental health or substance abuse services (inpatient and some outpatient)
- Rehabilitation services (physical therapy, occupational therapy, speech therapy)
- Certain prosthetic devices and durable medical equipment
- Spinal procedures.

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Please note that the prior authorization requirements may vary based on your 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. If your Third Party Administrator approves the preauthorization, 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 Third Party Administrator denies the request for preauthorization, 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 will be asked to 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. 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

Through your medical insurance, you will have the benefit of care management services, including your own personal nurse care manager. These services are provided to all associates and dependents enrolled in the Associates’ Medical Plan and 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 working with your Third Party Administrator 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;
- You are participating in the Life with Baby Maternity Program.

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 physical therapy, skilled nursing and inpatient rehabilitation 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 circumstances, 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 with your special needs. To reach your nurse care manager, call the phone number on your plan ID card.
QUIT TOBACCO PROGRAM

Tobacco use is the number one 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 the free Quit Tobacco program for associates and their covered dependents ages 18 and older who are enrolled in Walmart’s HRA plans or the HSA Plan. The program uses treatment methods to give you personal support and help you quit for good.

When you enroll in the program, you can choose any or all of these services:

- **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 the Quit Tobacco program, associates should call 866-577-7169.

If you are enrolled in an HMO, contact your provider to learn what free quit-tobacco programs are offered through your plan.

All Walmart associates can use the Quit Tobacco tool, which can be found at the Quit Tobacco link at WalmartOne.com. The program offers you online tools, tips and an opportunity to communicate with an online quit specialist. You can join a community of others who are trying to quit or have successfully quit and get the support you need to help you stay on track and reach your goal.

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.

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. Enroll by calling your health care advisor at the phone number on your plan ID card. Ask for the Life with Baby Maternity Program; once enrolled, you’ll be able to talk confidentially to a registered nurse. The program assists with preconception, pregnancy, delivery (including three lactation visits) and child development. Enroll in Life with Baby and 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

Castlight is a free, 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 an HRA plan or the HSA Plan are eligible to use Castlight.

As a new user, start using Castlight by registering at Mycastlight.com/walmart, by free 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.

With Castlight you can:

- Compare nearby doctors, medical facilities and health care services based on the price you’ll pay and quality of care
- 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.

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 co-payment per visit for participants in the HRA Plan or the HRA High Plan, regardless of residency or work location. Due to IRS rules governing eligible expenses under health plans with Health Savings Accounts, associates enrolled in the HSA Plan option are required to pay the posted retail price of $40 per visit 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 are not covered under the Plan and are available for clearly posted prices in addition to the visit charge.

Certain preventive services available at the Walmart Care Clinic are covered under the HRA plans or the HSA 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 in one of the HRA plans or the HSA Plan).
Any additional out-of-pocket costs you incur are not reimbursable under the Plan, and the clinic will not file insurance claims with any of the Plan’s Third Party Administrators. Out-of-pocket spending in the clinic will not be credited against your deductible or out-of-pocket maximum, regardless of your health plan option. Nonpreventive services provided by the clinic are not covered expenses under the Associates’ Medical Plan. Walmart-provided HRA funds may not be used toward the cost of services provided in the clinic. For more information, please visit WalmartCareClinic.com.

Centers of Excellence

Associates and dependents enrolled in one of the HRA plans or the HSA Plan may be eligible to receive 100% coverage for the following non-emergency services at one of Walmart’s Centers of Excellence facilities:

• 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); and
• Medical record review by a Center of Excellence facility for certain types of cancer (all ages) to determine if an on-site evaluation would be beneficial.

Claims for eligible services performed at one of the medical centers included in the program 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.

To participate in the Centers of Excellence program:

• The participant and designated caregiver must agree to abide by program 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 identify the designated caregiver. The caregiver must agree to (and be able to) meet caregiver requirements;
• The participant must provide the physician with contact information for a local physician who has agreed to manage follow-up care after the participant returns home from the medical center; and

• Centers of Excellence services must be preauthorized by the administrator of the program in order to be covered under the Plan. The administrator of the heart, spine, and hip and knee replacement services is Health Design Plus. The administrator of the cancer services is HealthSCOPE Benefits. 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.

Travel, lodging and a daily allowance will be provided for the recipient and a caregiver and must be scheduled through the Centers of Excellence program. Payment is subject to otherwise applicable limits.

If your doctor recommends a cardiac, spine, hip replacement or knee replacement surgery, or if you have been diagnosed with cancer (currently limited to breast, lung and colorectal cancers) and would like to participate in this program, call your health care advisor at the phone number on the your plan ID card.

NOTE: Cardiac, spine, hip replacement or knee replacement surgeries and treatment for cancer provided at facilities other than one of the medical centers included in the Centers of Excellence program, or services prior to arrival or subsequent to discharge from a Walmart Centers of Excellence medical center through coordination and approval by the program administrator, will be subject to regular coverage terms under the Associates’ Medical Plan, as described in Administration of the Associates’ Medical Plan earlier in this chapter. In addition, services performed at a Centers of Excellence medical center that are not eligible services under the Centers of Excellence program will be subject to regular coverage terms under the Associates’ Medical Plan.

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 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 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
- Birth control pills
- 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
- Female sterilization.

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, 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 below 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 for use in the home;
- 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 durable medical equipment 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 durable medical equipment 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 for the following:

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

Orthopedic shoes prescribed by a doctor are limited to two shoes per calendar year.

**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.

**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 recommended by one of the following three drug compendia, and not recommended against by one or more of the same three compendia (appropriate to the date of service):

- American Hospital Formulary Service (AHFS) Drug Information;
- Clinical Pharmacology Online; or
- National Comprehensive Cancer Network (NCCN), category 1 (the recommendation is based on high-level evidence and there is uniform NCCN consensus); category 2A (the recommendation is based on lower-level evidence and there is uniform NCCN consensus); or category 2B (the recommendation is based on lower-level evidence and there is non-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 recommended under one of the following two 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.

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, gums and the chemotherapy.
• Non-dental cutting procedures in the oral cavity
• Medical complications that are the result of a dental procedure
• 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 four
  – Between the age of four 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)
    • 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.

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.

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 prosthetcian 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:

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

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 correction of vision, are not covered, except for vision screening for children covered under preventive care guidelines.

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
- 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 six.

Coverage for transplants and lung volume reduction surgery (LVRS)
To be eligible for transplants and lung volume reduction benefits, participants must be enrolled in the Associates’ Medical Plan or an HMO offered through the Plan for at least 12 months. The 12-month waiting period will be waived for localized associates and their covered dependents. No period of time that you are enrolled in critical illness or accident insurance will count toward the 12-month waiting period.

If your doctor recommends a transplant, please call Benefits Customer Service at 800-421-1362.

GUIDELINES FOR COVERED TRANSPLANTS AND LVRS
All transplants (except kidney, cornea and intestinal) and LVRS

- All 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 transplant-related VADs — ventricular assist devices), lung, pancreas, simultaneous kidney/pancreas, multiple organ, 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 Health Design Plus and are covered at 100% with no annual deductible. However, if you are enrolled in the HSA Plan,
The Independent Review Panel will be made up of
appeals at a facility other than Mayo, as described in the
Claims and
will be decided under the special rules for transplant claims
days of the initial denial of the transplant by Mayo. Your claim
Your claim must be received by the Plan within 120 calendar
days of the initial denial of the transplant by Mayo. Your claim
will be decided under the special rules for transplant claims
must be received by the Plan within 120 calendar
days of the initial denial of the transplant by Mayo. Your claim
will be decided under the special rules for transplant claims

• 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, 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).

• 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 Benefits Customer Service at 800-421-1362.

Appeals for organ transplants at facilities other than Mayo Clinic

• You may file a claim with an Independent Review Panel of the Plan under the special rules if:
  - There is significant risk that travel to Mayo 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. Your claim will be decided under the special rules for transplant claims at a facility other than Mayo, as described in the Claims and appeals chapter.

• The Independent Review Panel will be made up of individuals appointed by the Plan’s Administrative Committee and will not include any employee of Walmart, Mayo Clinic or a Third Party Administrator of the Plan. The Independent Review Panel 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 Panel determines that the transplant and related course of treatment are medically necessary, the Independent Review Panel will reverse Mayo Clinic’s determination and approve the transplant. The Independent Review Panel then will provide you with a list of approved facilities for the transplant.

• Claims will be covered at 75% for network providers after the annual deductible has been met.

• 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.

• 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.

Kidney, cornea and intestinal transplants

• Kidney, cornea and intestinal transplants can be performed at the facility of your choice.

• Claims will be covered at 75% for network providers after the annual deductible has been met.

• 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.

• No travel, lodging or daily allowance will be provided for these transplants (even if performed at Mayo Clinic).
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, an evaluation by Mayo Clinic.
- Claims will be covered at 75% for network providers after the annual deductible has been met.
- 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.
- Travel, lodging and a daily allowance will be provided only if the transplant is performed at Mayo Clinic.

MORE ABOUT TRANSPLANTS AND LVRS COVERAGE

- 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.
- The Associates’ Medical Plan does not coordinate benefits with respect to transplant and LVRS benefits, other than coordination with Medicare, or as otherwise required by law. If any portion of a transplant or LVRS benefit could have been paid by another health plan, had the individual followed the terms of that plan, the Associates’ Medical Plan will not pay any amount of the transplant or LVRS benefit claim.

TRANSPLANT DONOR EXPENSES

- Eligible transplant donor expenses 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.
- Covered donor charges will be paid at the same benefit level as the recipient according to the transplant guidelines previously stated, up to 90 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.
- Eligible transplant donor expenses are covered when the donor is located through an organ donor registry.

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. 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 (e.g., homeopathy, naturopathy, acupuncture, hypnosis, massage therapy, etc.).

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.

Autopsy

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 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: Any services performed by a chiropractor.

Copays and/or discounts, deductibles and/or coinsurance

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. 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.

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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 (e.g., homeopathy, naturopathy, acupuncture, hypnosis, massage therapy, etc.).

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.

Autopsy

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 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: Any services performed by a chiropractor.

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). This also includes early intensive behavior intervention (which includes but is not limited to applied behavior analysis, Lovaas therapy, Early Start Denver Model, Floortime, pivotal response therapy and verbal behavior therapy for autism spectrum disorder and any other conditions).

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. Please refer to the transplant section for transplant services.

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 newborns, 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
- In-vitro fertilization, GIFT, ZIFT, IVC, gamete intracyopreservation, 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
- 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, snog seats, recreational items, home improvements and home appliances, spas, wigs and knee braces for sports.
Phone, video conference and online consultations

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).

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.

Transgender treatment/sex therapy: Care, services or treatment for noncongenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, sexual reassignment surgery, cosmetic procedures, medical or psychiatric treatment or other treatment of sexual dysfunction, including prescription medication and sex therapy.

Travel and lodging, except as specified under transplant benefits and Centers of Excellence benefits

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.

Weight loss treatment: Charges including but not limited to medications, diet supplements, gastric bypass, gastric restrictive or stapling procedures, or small bowel surgery to limit resorption, even if the participant has other health conditions that might be helped by the reduction of weight or by a surgical procedure.

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.

Claims will be determined under the time frames and requirements outlined in the Claims and appeals chapter.

Please see the your plan ID card or the inside back cover of this book 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 you use a non-network provider, payment may be made directly to you, and you will be responsible for your 50% share of the maximum allowable charge, plus any amount over and above the maximum allowable charge. Payment may also be made to a non-network provider that accepts assignments. 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, except as required by state Medicaid law or required under a Qualified Medical Child Support Order.

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 trusted plans, union welfare plans, employer organization plans or employee benefit organization plans;
- Any coverage under governmental plans, such as Medicare, 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 only pay 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**

<table>
<thead>
<tr>
<th></th>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
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<tbody>
<tr>
<td>If another plan pays primary at:</td>
<td>80%</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>And the AMP’s payment is:</td>
<td>75%</td>
<td>100%</td>
<td>75%</td>
</tr>
<tr>
<td>The AMP’s total benefit is:</td>
<td>0%</td>
<td>20%</td>
<td>75%</td>
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**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. If there is no coordination of benefits provision, the plan that has covered the plan participant the longest period of time is primary.
- 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 an HRA plan or the HSA 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 enrolled in Medicare prior to the COBRA effective date, 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**

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-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 meet the actively-at-work requirement. For more information, contact Benefits Customer Service 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 actively-at-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 or drop coverage and re-enroll**

If you return to work for the company or re-enroll within 13 weeks, you will automatically be re-enrolled for the same coverage you had prior to leaving the company (or the most similar plans 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 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.

**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
- 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. For additional information, please call 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).
## WHERE CAN I FIND?

- The pharmacy benefit for HRA and HSA Plan participants: 66
- How the pharmacy benefit works: 66
- What is not covered by the pharmacy benefit: 69
- Pharmacy discounts for prescriptions not covered: 70
- Filing a pharmacy benefit claim: 70
- Privacy and security: 70
The pharmacy benefit

The pharmacy benefit is an important part of your benefits package. Prescription drugs play a critical role in treating illnesses and can help you and your eligible dependents maintain good health. If you are enrolled in the HRA plans or the HSA Plan, you can purchase prescription drugs from network retail or mail-order pharmacies and take advantage of discounted network prices. You pay $4 for a 30-day supply (retail) of eligible generic drugs if you purchase them from a Walmart or Sam’s Club pharmacy under the HRA plans and the HSA Plan. If you purchase prescription drugs from a pharmacy in the Express Scripts® network, you pay $12 for a 30-day supply (retail) of eligible generic drugs. Note that if you are enrolled in the HSA Plan, you and your covered dependents must generally meet the network annual deductible under your medical plan before the pharmacy plan pays benefits.

<table>
<thead>
<tr>
<th>Find What You Need</th>
<th>Online</th>
<th>Other Resources</th>
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<tr>
<td>• Find a Walmart, Sam’s Club or Express Scripts network pharmacy</td>
<td>Go to the WIRE, WalmartOne.com or Express-Scripts.com/walmart</td>
<td>Call Express Scripts at 800-887-6194</td>
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<tr>
<td>• Get the list of covered brand-name drugs</td>
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<tr>
<td>• Get the list of medications that require the collection of additional information</td>
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What you need to know about the pharmacy benefit

• The pharmacy benefit applies to the HRA plans and the HSA Plan. Associates enrolled in an HMO plan receive pharmacy benefits through their HMO.

• In order for benefits to be paid, you must use a Walmart or Sam’s Club pharmacy or an Express Scripts network pharmacy.

• Your pharmacy copays will be lower if you have your prescriptions filled at a Walmart or Sam’s Club pharmacy than if you use an Express Scripts network pharmacy (although exceptions will be made when no Walmart or Sam’s Club pharmacy is located within five miles of an associate’s work location).

• Specialty drugs must be purchased from a Walmart Specialty or Accredro Specialty pharmacy (a subsidiary of Express Scripts) in order for benefits to be paid under the Plan.
The pharmacy benefit for HRA and HSA Plan participants
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 or Express Scripts network pharmacy. Remember, you must use a Walmart/Sam’s Club pharmacy or Express Scripts network pharmacy or no benefits will be paid. Visit 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.

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, or you may call Express Scripts at 800-887-6194. If you don’t see your drug listed, please call Express Scripts to see if it is on the formulary.

- As a participant in one of the HRA plans, 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 cannot be used to purchase prescriptions.
- As an HSA Plan participant, 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.
- You will save money when you fill your prescriptions at a Walmart or Sam’s Club pharmacy, as detailed in the Pharmacy benefits chart. Note that exceptions will be made for associates who work more than five miles from a Walmart or Sam’s Club pharmacy. All associates so situated will have access to the same copays available at a Walmart or Sam’s Club pharmacy when they purchase prescriptions from an Express Scripts network pharmacy.

For all HRA and HSA Plan participants, once you reach the annual out-of-pocket maximum applicable to your coverage, 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 later in this chapter for details about copays and coinsurance under the HRA plans and the HSA Plan.

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 only those 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.

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.

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...
The pharmacy benefit 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).

**THE HRA PLANS’ PHARMACY BENEFIT**

Participants in one of the HRA plans can purchase eligible prescriptions by paying the copays listed in the chart below. Your copays will be applied toward your medical plan’s annual out-of-pocket maximum. Once your out-of-pocket maximum is met, eligible prescriptions will be paid at 100%. Remember, your HRA dollars may not be used to purchase prescriptions. You will be required to pay pharmacy copays out of your own pocket.

**THE HSA PLAN PHARMACY BENEFIT**

HSA Plan participants pay the full retail/mail-order price for prescriptions until the medical plan’s network annual deductible is met. Once you have met your network annual deductible, you pay the copays shown in the chart below. Your copays will be applied toward your medical plan’s annual out-of-pocket maximum. Once your out-of-pocket maximum is met, eligible prescriptions will be paid at 100%.

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.

**IF YOU HAVE COVERAGE UNDER THE AETNA CUSTOM PERFORMANCE NETWORK**

Associates who have Aetna as their Third Party Administrator and work in certain locations have access to Aetna’s Custom Performance Network (CPN). The CPN has lower annual out-of-pocket maximums for in-network medical coverage than the out-of-pocket maximums that generally apply under the Associates’ Medical Plan. Please note that the CPN’s lower out-of-pocket maximums do not apply to prescription drugs; if you have access to the CPN, you will continue to pay your applicable prescription drug costs until you reach the higher annual out-of-pocket maximum. Once that maximum is met, eligible prescriptions will be paid at 100%. These terms apply whether you elect coverage under the HRA plans or the HSA Plan. See **Custom Performance Network through Aetna** in **The medical plan** chapter for details about coverage under the CPN.

### PHARMACY BENEFITS

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<tr>
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<th>HRA Plans</th>
<th>HSA Plan</th>
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<tr>
<td></td>
<td>Walmart / Sam’s Club Pharmacy or Walmart / Express Scripts Network</td>
<td>Express Scripts Network</td>
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<tr>
<td><strong>Generic drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 30-day supply</td>
<td>$4 copay</td>
<td>$12 copay</td>
</tr>
<tr>
<td>31- to 60-day supply</td>
<td>$8 copay</td>
<td>$24 copay</td>
</tr>
<tr>
<td>61- to 90-day supply</td>
<td>$12 copay</td>
<td>$36 copay</td>
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<tr>
<td><strong>Brand-name drugs</strong></td>
<td>Greater of $50 or 25% of allowed cost</td>
<td>Greater of $75 or 30% of allowed cost</td>
</tr>
<tr>
<td><strong>Specialty drugs</strong></td>
<td>Greater of $50 or 20% of allowed cost</td>
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*Covered medications that are on the Express Scripts list of approved preventive medications are not subject to the network annual deductible under the HSA Plan. See **Preventive medications not subject to the HSA Plan’s network annual deductible** earlier in this chapter for details.

**Mail order drugs:**
- Your cost for a 90-day supply in 2015 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 only, through Walmart or Express Scripts Mail Order.
IMPORTANT NOTES ABOUT YOUR PRESCRIPTION DRUG BENEFITS LISTED IN THE CHART ON THE PREVIOUS PAGE

• The allowed cost of prescription drugs is determined by Express Scripts.

• 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, you will receive your prescription drug benefits through your HMO.

• Prescription drug copays count toward the medical 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.

• Funds you may receive from drug manufacturers or state assistance programs (where permitted by law) to assist you in purchasing prescription drugs will not count toward the medical plan’s annual out-of-pocket maximum.

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. 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 in 2015 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 Benefits Customer Service at 800-421-1362 for additional information regarding the mail-order prescription service.

CONTRACEPTIVES FOR WOMEN

The Plan covers all FDA-approved contraceptive methods 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 under the HRA and HSA Plans (and brand-name contraceptives when medically necessary) will be covered at 100%, when prescribed by a physician.

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 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.
The pharmacy benefit

PREVENTIVE OVER-THE-COUNTER MEDICATIONS
If you are enrolled in the Associates' Medical Plan, costs of certain over-the-counter (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 as of the date this Summary Plan Description was prepared. (Please note that the Plan's coverage of OTC preventive care medications may change as additional regulations are issued.) For the covered OTC medications to be paid at 100% by the pharmacy benefit plan, you must purchase them at retail network pharmacies and present your plan ID card and a prescription from your physician at the time of purchase.

Some of the most common preventive OTC medications identified by the United States Preventive Services Task Force (USPSTF) are listed in the chart below. 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.

<table>
<thead>
<tr>
<th>MEDICATIONS THAT REQUIRE PRIOR AUTHORIZATION</th>
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| 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 can still elect to fill the prescription, but you will be responsible for the full retail cost.

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

PREVENTIVE OVER-THE-COUNTER MEDICATIONS
Recommended by the U.S. Preventive Services Task Force (USPSTF)

<table>
<thead>
<tr>
<th>Oral fluoride</th>
<th>By prescription when appropriate for children 6 months to 6 years of age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iron supplementation</td>
<td>By prescription in symptomatic children 6 to 12 months of age</td>
</tr>
<tr>
<td>Folic acid</td>
<td>By prescription for all women planning or capable of pregnancy</td>
</tr>
<tr>
<td>Aspirin</td>
<td>By prescription for men age 45 to 79 and women age 55 to 79</td>
</tr>
<tr>
<td>Vitamin D</td>
<td>By prescription for individuals age 65 and over</td>
</tr>
</tbody>
</table>

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.

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 Food and Drug Administration 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 by non-network pharmacies.

- Prescription drugs with available over-the-counter equivalents.

- 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 use a Walmart or Sam’s Club pharmacy or an Express Scripts 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 through the pharmacy benefit. 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 paid by another health plan or insurance provider, 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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Closing your Health Savings Account  78
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 $300 for individual coverage and up to $600 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.

<table>
<thead>
<tr>
<th>HEALTH SAVINGS ACCOUNT RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Find What You Need</strong></td>
</tr>
<tr>
<td>Establish or change your contribution amount</td>
</tr>
</tbody>
</table>
| Open your Health Savings Account   | Log on to mybenefitwallet.com to complete an electronic signature | Call BenefitWallet Service Center at 800-358-3494  
| Get a list of qualified medical expenses (I.R.C.§ 213(d))  
| Get information on eligibility and tax reporting responsibilities associated with a Health Savings Account | irs.gov | Call BenefitWallet Service Center at 800-358-3494 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 and complete the electronic signature; this will automatically open the account on 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. Your account will not be considered “open” until you have signed the Master Signature Card or submitted an electronic signature and completed any other required steps.
- A welcome kit will be mailed to your home address from BenefitWallet, which provides administration for the HSA custodian, BNY Mellon.
- Upon opening your account, address changes will need to be made through BenefitWallet.
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 or checks you will receive. If the funds are used for non-medical or non-qualified 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 reimbursement under a Health Savings Account, only if they are prescribed by a doctor. (This requirement does not apply to insulin.)
- BNY Mellon, the custodian of the account, has provided these services to Walmart associates since 2006.
- Interest earnings on the balance in your account will not be taxed as long as the funds remain in your account or are spent on qualified medical expenses. In addition, all Health Savings Account withdrawals for qualified medical expenses are tax-free.
- You have investment opportunities for your account balance once that balance reaches a certain amount. Earnings on investments made with Health Savings Account funds will not be taxed as long as the funds remain in the account or are spent on qualified medical expenses. Investments are not guaranteed or FDIC-insured. In addition, all Health Savings Account withdrawals for qualified medical expenses are tax-free.

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 Health Savings Account custodian 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 (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);
- Enrolled in Medicare;
- Enrolled in Medicaid;
- Covered under TRICARE® or have received medical benefits from the U.S. Department of Veterans Affairs during the preceding three months (mere eligibility for Veterans Affairs benefits does not disqualify you from contributing to a Health Savings Account); or
- Claimed as a dependent on another person’s tax return.

If you are enrolled in the critical illness insurance, you’re not eligible for the Organ Transplant Rider due to IRS restrictions on the HSA Plan.

Other restrictions may apply. For further information, please call BenefitWallet Service Center at 800-358-3494.

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 and administered by BenefitWallet on behalf of BNY Mellon.

If you have non-high-deductible health plan coverage through Walmart or any other employer (e.g., your eligible spouse’s/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.
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 BenefitWallet Service Center by phone at 800-358-3494 or online at mybenefitwallet.com.

Opening your Health Savings Account

When you enroll online in the HSA Plan through the WIRE or WalmartOne.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 Opening and changing contribution amount later in this chapter.

You’ll receive a welcome kit at your home address directly from BNY Mellon, 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 effective date in the HSA Plan if you enroll at any other time.

Whether you open your Health Savings Account online or by mail, it’s your responsibility to review the material, sign the signature card to obtain a checkbook, designate a beneficiary for your account and return all forms to your Health Savings Account custodian (unless you have completed all steps required to open your account online, including electronic signature). You will not receive a checkbook until you complete this process. In addition, your debit card will be mailed to you separately. You may open your account online at mybenefitwallet.com by completing an electronic signature.

After your initial enrollment, any address changes will need to be submitted to your Health Savings Account custodian. Updating your address with Walmart will not update it with the custodian.

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 signed the Master Signature Card or submitted an electronic signature and completed any other steps required by your Health Savings Account custodian.

In the event that any payroll withholding and 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, debit card or checkbook), you may call BenefitWallet Service Center at 800-358-3494 or go online to mybenefitwallet.com.

Once Walmart receives confirmation from BenefitWallet 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 BNY Mellon as your Health Savings Account custodian when you enroll. However, you may move your funds to another Health Savings Account custodian (other than BNY Mellon) at any time. If you move your Health Savings Account custodian to a bank other than BNY Mellon, 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.

The company will not pay overdraft fees, excess contribution fees, lost card or replacement check 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 BenefitWallet Service Center at 800-358-3494 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 mybenefitwallet.com.
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 and deposit coupon to your Health Savings Account custodian. These contributions will be made on an after-tax tax basis and are not eligible for the Walmart matching contribution. 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 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 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 annual 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.

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 2015, $3,350 for individual coverage; or
- For 2015, $6,650 for family coverage.

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.

<table>
<thead>
<tr>
<th>Your HSA Plan network annual deductible</th>
<th>Company matching contribution limit — $1 for $1 up to</th>
<th>Maximum annual contribution limit (associate and company contributions combined)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,000 (associate-only coverage)</td>
<td>$300</td>
<td>$3,350</td>
</tr>
<tr>
<td>$6,000 (family coverage)</td>
<td>$600</td>
<td>$6,650</td>
</tr>
</tbody>
</table>
If two associates who are legally married are both eligible to contribute to individual Health Savings Accounts, the contribution limit for 2015 for both accounts combined is based on the maximum amount that can be contributed for a family: $6,650. Note, however, if either of the associates is age 55 or older in 2015, 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 $6,650 (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 2015, 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 BenefitWallet Service Center at 800-358-3494.

**EARNING INTEREST ON YOUR HEALTH SAVINGS ACCOUNT**

The balance in your Health Savings Account earns interest. For interest rate information on your account, contact BenefitWallet Service Center at 800-358-3494 or online at mybenefitwallet.com.

**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 your contribution 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 or WalmartOne.com and click on “Online Enrollment.” If you need help setting up your payroll deductions, please contact Benefits Customer Service at 800-421-1362.

**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 2015, the catch-up contribution limit is $1,000. Please call BenefitWallet Service Center at 800-358-3494 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 2015 for both accounts combined is based on the maximum amount that can be contributed for a family: $6,650. If either you or your spouse is age 55 or older in 2015, 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 $6,650 (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 2015, 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 BenefitWallet Service Center at 800-358-3494 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 mybenefitwallet.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 BenefitWallet.

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 or Health Savings Account custodian 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 mybenefitwallet.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 BenefitWallet Service Center at 800-358-3494 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

<table>
<thead>
<tr>
<th>Find What You Need</th>
<th>Online</th>
<th>Other Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get a listing of Delta Dental PPO and Delta Dental Premier dentists</td>
<td>Go to the WIRE, WalmartOne.com or deltadentalar.com</td>
<td>Call Delta Dental at 800-462-5410 or Benefits Customer Service at 800-421-1362</td>
</tr>
<tr>
<td>Get answers to questions about your dental claims and to contact Delta Dental Customer Service</td>
<td>Go to deltadentalar.com and select “Subscriber” to create your account</td>
<td>Call Delta Dental at 800-462-5410</td>
</tr>
<tr>
<td>Get a claim form if you use a nonparticipating dentist</td>
<td>Go to the WIRE, WalmartOne.com or deltadentalar.com</td>
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</table>

What you need to know about the dental plan

• Dental plan coverage is available to full-time hourly associates (including full-time hourly pharmacists, field Logistics associates and field supervisor positions in stores and clubs, full-time hourly Vision Center managers, and walmart.com functional non-exempt associates), full-time truck drivers, and management associates (including management trainees and California pharmacists), and their eligible dependents.

• Dental plan coverage remains in effect for two full calendar years.

• Major care and orthodontia assistance are 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

As a full-time hourly associate, full-time truck driver or management associate, you are eligible to enroll in the dental plan.

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, 2015, your coverage must remain in effect until December 31, 2017. 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;
- Associate + child(ren); or
- Associate + family.

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 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.

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 participated in the dental plan for 12 months and 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.

---

**Coverage Under the Dental Plan**

Including dental plan benefits that apply to your annual deductible or lifetime maximum

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Delta Dental PPO Dentists</th>
<th>Delta Dental Premier Dentists</th>
<th>Non-Network Dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waived for preventive and diagnostic care and orthodontia care</td>
<td>100% covered; no annual deductible applies</td>
<td>80% covered,* no annual deductible applies</td>
<td>80% covered; no annual deductible applies</td>
</tr>
<tr>
<td>Maximum benefits</td>
<td></td>
<td>$2,500 per covered person per calendar year</td>
<td></td>
</tr>
<tr>
<td>Preventive and diagnostic care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charges (if any) do not count toward annual deductible</td>
<td>100% covered; no annual deductible applies</td>
<td>80% covered,* no annual deductible applies</td>
<td>80% covered; no annual deductible applies</td>
</tr>
<tr>
<td>*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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including fillings, non-surgical periodontics and root canal therapy</td>
<td>80% of maximum plan allowance after annual deductible is met (70% of maximum plan allowance for composite resin fillings in posterior teeth)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major care (12-month wait)</td>
<td></td>
<td>50% of maximum plan allowance after annual deductible is met</td>
<td></td>
</tr>
<tr>
<td>Including surgical periodontics, crowns and dentures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia assistance (12-month wait)</td>
<td></td>
<td>80% of maximum plan allowance up to $1,500 lifetime maximum orthodontia benefit per person; no annual deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

2015 Associate Benefits Book | Questions? Log on to WalmartOne.com or the WIRE, or call Benefits Customer Service at 800-421-1362
NOTE: The 12-month waiting period will be waived for localized associates and their covered dependents.
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 for covered expenses.

MAXIMUM PLAN ALLOWANCE
The maximum plan allowance (MPA) 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 customer service 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, AR 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.

<table>
<thead>
<tr>
<th>IT PAYS TO USE NETWORK DENTISTS</th>
<th>Delta Dental Premier dentists and PPO dentists</th>
<th>Non-network dentists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist often files claim forms for you</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dentist accepts the maximum plan allowance as payment in full, subject to annual deductible and coinsurance amounts</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dentist offers discounted prices for Delta Dental participants</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
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, AR 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’s 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 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 examinations: Benefits are payable as follows:

• Routine oral examination: Two examinations covered during a calendar year
• Comprehensive oral examination: Initial comprehensive oral examination will be payable subject to the routine oral examination time limitations. Subsequent comprehensive oral examinations submitted by the same provider within three years will be processed as routine oral examinations.

Emergency evaluations performed by dentists are not subject to the calendar year restriction.

Sealants or 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.

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: Simple extractions.

Non-surgical periodontics: Provided once in any consecutive 36-month period.

Occlusal guard: Benefits are payable once every five years. Repair and/or rel ine 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

Coverage for major care is available after you complete a 12-month waiting period as a participant in the dental plan. 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: 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.

Implants: Implants and the surgical placement of an implant body are 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.

• Crown benefits are based on the amount payable for predominantly base metal substrates.

• 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, prosthetic 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) and your eligible dependents. Benefits are paid at 80% of the maximum plan allowance, up to a lifetime benefit of $1,500 per person for both network (Delta Dental PPO and Delta Dental Premier) and non-network dentists. Keep in mind that a non-network dentist may bill you for amounts above the maximum plan allowance, while a network dentist agrees to accept the maximum plan allowance as payment in full, subject to the annual deductible (where applicable) and coinsurance amounts.

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

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.
• A denture that replaces another denture or fixed bridge, or a fixed bridge that replaces another fixed bridge, will not be covered until you have been covered under the Plan for 12 consecutive months.
• 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.

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.

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.

Major care: Services listed under the Major care section during the first consecutive 12 months that a participant is covered under the dental plan.

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;
- 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
If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-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 meet the actively-at-work requirement. For more information, contact Benefits Customer Service 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 actively-at-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 or drop coverage and re-enroll
If you return to work for the company or re-enroll 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 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.
The vision plan

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How to use the plan 91
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Breakage and loss of eyewear 91
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If you go on a leave of absence 92
When vision coverage ends 92
If you leave the company and are rehired or drop coverage and re-enroll 92
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.

<table>
<thead>
<tr>
<th>VISION PLAN RESOURCES</th>
<th>Online</th>
<th>Other Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locate a Walmart Vision Center or Sam’s Club Optical provider</td>
<td>Go to the WIRE or WalmartOne.com</td>
<td></td>
</tr>
<tr>
<td>For detailed information about vision plan coverage or to locate a VSP network provider</td>
<td>Go to vsp.com and enter your member number</td>
<td>Call VSP at 866-240-8390</td>
</tr>
<tr>
<td>Get the cost for vision plan coverage</td>
<td>Go to the WIRE or WalmartOne.com</td>
<td>Call Benefits Customer Service at 800-421-1362</td>
</tr>
</tbody>
</table>

What you need to know about the vision plan

- All associates (including part-time hourly and temporary associates who work the required number of hours) 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’ Medical 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 one eye exam every 12 months, lenses every 12 months, and frames once every 24 months or contact lenses every 12 months. 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 for 12 months. 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 noncovered 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
- Progressive multifocal 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
- Frames or contacts that cost more than your allowance.

<table>
<thead>
<tr>
<th></th>
<th>Walmart Vision Center</th>
<th>Sam’s Club Optical</th>
<th>VSP network providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine exam</strong></td>
<td>Plan pays 100% after $10 copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every 12 months</td>
<td></td>
<td></td>
<td><strong>Limitations apply for low-vision testing or supplemental testing for individuals whose vision problems are not correctable with regular lenses.</strong></td>
</tr>
<tr>
<td><strong>Lenses</strong></td>
<td>Plan pays 100% after $10 copay*</td>
<td></td>
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<tr>
<td>Every 12 months</td>
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<tr>
<td>• Single vision</td>
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<tr>
<td>• Lined bifocal</td>
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<tr>
<td>• Lined trifocal</td>
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<td></td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>$130 frame allowance after $10 copay*</td>
<td></td>
<td><strong>Any charges above the frame allowance are the responsibility of the associate.</strong></td>
</tr>
<tr>
<td>Every 24 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contact lenses</strong></td>
<td>$130 contact lens allowance</td>
<td></td>
<td><strong>Plus fitting and evaluation fee paid by the associate. Based on the complexity of the exam; out-of-pocket costs for fitting and evaluation are not to exceed $60.</strong></td>
</tr>
<tr>
<td>In lieu of glasses</td>
<td></td>
<td></td>
<td><strong>Any charges above the contact lens allowance are the responsibility of the associate.</strong></td>
</tr>
<tr>
<td>Every 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

*The frame and lens copay is charged only once when frames and lenses are purchased at the same visit.*
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.

<table>
<thead>
<tr>
<th>STEP 1</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>STEP 2</td>
<td>When you call the provider to make an appointment, identify yourself as a VSP member and give the office the associate’s 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.</td>
</tr>
<tr>
<td>STEP 3</td>
<td>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.</td>
</tr>
</tbody>
</table>

What’s 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 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 laws — 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
  - 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
- 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; you should check with your eyewear provider for specific warrants.

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’s/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.

"Wire" is a service mark of Wal-Mart Network, Inc. and Walmart Services, Inc.
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

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-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 meet the actively-at-work requirement. For more information, contact Benefits Customer Service 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 actively-at-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 24 months) 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 or drop coverage and re-enroll

If you return to work for the company or re-enroll 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 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 have received covered vision services prior to your absence, any applicable benefit frequency limitation under the vision plan (i.e., eyeglass frames every 24 months) will continue to apply after your return.
# COBRA

## WHERE CAN I FIND?

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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, including less-expensive options, through the Health Insurance Marketplace, 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 CONEXIS to administer COBRA. Please familiarize yourself with this one-time coverage continuation opportunity by carefully reading the COBRA notification and noting enrollment deadlines.

### COBRA RESOURCES

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<td>Find What You Need</td>
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<tr>
<td>Contact Benefits Customer Service within 60 calendar days of a divorce, legal separation, annulment, termination of a relationship with a partner (as defined below) or ineligibility of dependent(s)</td>
<td></td>
<td>Call Benefits Customer Service at 800-421-1362 or provide notification in writing to: Walmart Benefits Customer Service 508 SW 8th Street Bentonville, AR 72716-3500</td>
</tr>
<tr>
<td>Contact CONEXIS for questions regarding eligibility, enrollment, premiums and notification of a second qualifying event</td>
<td>Go to mybenefits.conexis.com</td>
<td>Call CONEXIS at 800-570-1863</td>
</tr>
</tbody>
</table>

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, 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 below). 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 Benefits Customer Service 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, annulment, termination of the relationship with your partner (as defined under COBRA qualifying events below) or ineligibility of dependent(s) (for instance, your dependent(s) no longer satisfies the requirements for coverage, such as attainment of age 26).
- If you leave the company or 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.
- To enroll in COBRA within 60 days of the date of the election notice, you must:
  1. Go online at mybenefits.conexis.com to enroll; and
  2. Make your premium payment online at mybenefits.conexis.com or call CONEXIS at 800-570-1863.

If you have any questions or need assistance with enrollment, please call CONEXIS at 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 continuation provisions of the Consolidated Omnibus Budget Reconciliation Act (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 below. You are only able to continue the same medical, dental or vision coverage you had on the day prior to your qualifying event; however, you are able to choose a lesser tier level, if applicable.

If you have HMO coverage at the time of your qualifying event and the state in which you reside has more stringent coverage continuation rules, those state rules will apply. 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, Short-Term Disability Plus, long-term disability, truck driver 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.

**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. 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 your employment ended.

**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, dental or vision 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 below) 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 you ineligible for coverage under the Plan;
- You and your spouse divorce or legally separate, or your marriage is annulled;
- 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:
    - Live in an ongoing, exclusive and committed relationship similar to marriage and have been for at least 12 months and intend to continue sharing a household 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;
    - 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.

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.
• You enroll in Medicare benefits Part D (you must contact Benefits Customer Service by calling 800-421-1362 within 60 days of enrolling in Medicare Part D); or

• Your death.

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 you ineligible for coverage under the Plan;

• You enroll in Medicare benefits Part D (you or your eligible dependent must contact Benefits Customer Service 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

• Your death.

NOTIFICATION

In general, Walmart will notify CONEXIS 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. The notification must be made within 30 days after the qualifying event.

Federal law places responsibility upon you or your eligible dependent(s) to notify Benefits Customer Service within 60 calendar days of a divorce, legal separation, annulment, termination of your partnership (as defined above) or ineligibility of dependent(s). If you or your eligible dependent(s) does not notify Benefits Customer Service, your dependent(s) will not be eligible for COBRA. You or your eligible dependent(s) must also notify CONEXIS 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 timely notice is not provided of a second qualifying event or extension request, COBRA continuation rights will expire on the date that your initial COBRA expires.

Under the law, you or your eligible dependent is responsible for notifying Benefits Customer Service of your divorce, legal separation, annulment, termination of your relationship with a partner (as such term is defined above), 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 Benefits Customer Service by calling 800-421-1362 or writing to:

Walmart Benefits Customer Service
508 SW 8th Street
Bentonville, AR 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
• Address of the dependent(s) losing coverage (if different from the covered associate’s address).

If you do not contact Benefits Customer Service within the 60-day period, you will lose your right to elect COBRA continuation coverage.

Within 14 days after CONEXIS receives notification that a qualifying event has occurred, they 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 Benefits Customer Service.) To receive COBRA continuation coverage, you must notify CONEXIS within 60 calendar days from the date of the election notice. You can contact CONEXIS by logging on to mybenefits.conexis.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 CONEXIS 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 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 a child is born), you must notify CONEXIS 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 above) or other eligible dependent due to a status change event while on COBRA, they will be subject to the same Plan limitations that apply to you at that time, if any (for example, limits concerning transplant coverage). If you change from an HRA plan to the HSA Plan, or from the HSA Plan to an HRA plan, or from an HMO to either the HSA Plan or an HRA plan 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. If you change from one of the two HRA plans to the other 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 either of the two HRA plans to the HSA Plan or an HMO or to no coverage, 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. You will also receive credit toward any waiting periods.

In the event of a status change, a qualified beneficiary 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 CONEXIS 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.

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**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 must cover the cost of COBRA coverage from the qualifying event through the end of 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 equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.) 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 received 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 initial premium due date. 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, CONEXIS 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:

**CONEXIS**
P.O. Box 14225
Orange, CA 92863-1225

To pay online, log on to mybenefits.conexis.com, or to pay by phone, call 800-570-1863.

If your 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 Duration of COBRA coverage chart below.

<table>
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<tr>
<th>Conditions</th>
<th>Associate</th>
<th>Dependent(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Your employment with the company ends for any reason</td>
<td>18 months</td>
<td>18 months</td>
</tr>
<tr>
<td>• You are no longer eligible due to a reduction in hours, making you ineligible for coverage under the Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Your death</td>
<td>Not applicable</td>
<td>36 months</td>
</tr>
<tr>
<td>• Your marital (or partnership) status changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dependent(s) no longer meets eligibility requirements (e.g., turns age 26)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You enroll in Medicare less than 18 months prior to your termination of employment or reduction in hours</td>
<td>Not applicable</td>
<td>The later of 36 months from the date the associate enrolled in Medicare or 18 months from the qualifying event</td>
</tr>
<tr>
<td>Disability extension is obtained</td>
<td>29 months</td>
<td>29 months</td>
</tr>
<tr>
<td>Second qualifying event — you must notify CONEXIS within 60 days of the second qualifying event</td>
<td>Not applicable</td>
<td>Up to 36 months</td>
</tr>
</tbody>
</table>

If you are entitled to Medicare prior to your COBRA election date, you or your eligible dependent(s) must notify CONEXIS 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 60 calendar days of the qualifying event; and
• You and/or your eligible dependent(s) notifies CONEXIS of the Social Security Administration’s disability determination by submitting a copy of the Social Security Administration Disability Determination award letter to CONEXIS within your initial 18-month COBRA period and within 60 days of the later of:
  – The date of your qualifying event; or
  – The date of your Social Security Administration Disability Determination award letter; or
  – The date on which you and/or your eligible dependent(s) loses coverage under the Plan as a result of the qualifying event.

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 CONEXIS 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 get 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, annulment, termination of a relationship with a partner (as such term is defined above); or
- Your child is no longer eligible for medical, dental or vision coverage (e.g., a dependent turns age 26).

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 CONEXIS of the second qualifying event within 60 calendar days of the date of the event. If CONEXIS 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

Usually, COBRA coverage 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;
- 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;
- You or your eligible dependent(s) becomes covered by Medicare after electing COBRA coverage (only medical may be terminated early);
- 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); or
- You or your eligible dependent(s) submits a fraudulent claim or fraudulent information to the Plan.

If your COBRA coverage is HMO coverage, you may be able to convert your coverage to an individual policy when your COBRA coverage ends. Contact your HMO for details.

FILING AN APPEAL

You have the right to appeal an enrollment or eligibility status decision or a claim denial. For enrollment or eligibility status appeals, see Appealing an enrollment or eligibility status decision in the Claims and appeals chapter for more information. For a claim denial appeal, see Appealing a medical, pharmacy, transplant or dental claim that has been fully or partially denied in the Claims and appeals chapter.
Resources For Living®

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Resources For Living®

Resources For Living (RFL) is a valuable, confidential counseling and wellbeing information service that’s free to all Walmart associates and available from your date of hire. You and your family members can call a professional counselor any time, day or night, 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.

**RESOURCES FOR LIVING RESOURCES**

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<td>Call 800-825-3555</td>
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<td>TDD 800-827-3707 for the hearing impaired</td>
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<tr>
<td>Access articles, tools and resources across a wide range of topics</td>
<td>Go to rfl.com</td>
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<td>Access monthly Healthy Living Tips and webinars on a variety of topics</td>
<td>Go to rfl.com or WalmartOne.com</td>
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**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.
- 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)

RFL is a service dedicated to promoting wellbeing and life success for all Walmart associates and their family members. RFL is available 24 hours a day, 365 days a year at 800-825-3555 (TTY 800-827-3707) to serve as your coach, guide or resource as you navigate life challenges and opportunities to your overall health and wellbeing.

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.

Resources For Living provides a gateway to personalized counseling support, encouragement, guidance and information for all aspects of wellbeing:

- **Emotional/Social**: Develop strategies to strengthen and enrich relationships with your family and friends, tap into your creative potential, manage stress...even stay motivated.
- **Career**: Discover solutions for finding balance between work and life, managing time and commitments, enhancing workplace relationships and more.
- **Financial**: Tap into resources to help you set up a budget, learn about housing and home buying, get tips on managing credit card debt, learn how to save for the future and more.
- **Community**: Get help with finding important resources in your area, such as childcare, eldercare, pet care, housing, schools, adult education and more.
- **Physical**: Learn ways to keep your mind and body healthy, with helpful information on topics such as nutrition, weight management, fitness and overall wellbeing.

RFL WorkLife Services

RFL has expanded its services to help you with practical resources and solutions to address everyday needs such as the following:

- Locating childcare
- Understanding eldercare options and identifying community resources for seniors
- Military family resources
- Learning about money management and overcoming debt
- Learning about adoption resources.

Using RFL's WorkLife Services means more balance in your life by having a specialist do the research and make the phone calls for you. If you're looking for a particular resource or provider of services, RFL will provide you with detailed information on those identified as a match. You'll also receive a follow-up call to make sure your needs are met.

This service is available by calling the same toll-free number: 800-825-3555.

CALLING RFL

Personalized telephone support is available to you and your family members all day, every day by calling 800-825-3555 (TTY 800-827-3707). Services are available in English and Spanish (other languages available upon request) and are provided 24 hours a day, seven days a week. This service is free and calls are confidential, except as required by law.

You also may visit the RFL website, rfl.com, or WalmartOne.com for articles, webinars, tools and resources on a variety of topics to help you live well.
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 Benefits Customer Service at 800-421-1362 or file a claim by writing to the following address:

Benefits Customer Service
508 SW 8th Street
Bentonville, AR 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.
### WHERE CAN I FIND?

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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, 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 during your initial enrollment period.

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What you need to know about critical illness insurance

- All associates (except for temporary Hawaii associates) and their eligible dependents (except for spouses/partners of part-time hourly associates, temporary associates and part-time truck drivers) can enroll in critical illness insurance when they are eligible. If you enroll after your initial enrollment period, you will be required to provide Proof of Good Health.

- 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.
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. During your initial enrollment period, coverage is guaranteed issue up to $20,000, meaning no Proof of Good Health is required.

Coverage amounts are available in $5,000 increments up to a maximum of $20,000 without submitting Proof of Good Health. Once you have enrolled, Proof of Good Health is required for any future increase in coverage.

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 walmart.com functional 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)
- Associate + family.

You are eligible to apply for and enroll in critical illness insurance if you are a:

- Part-time hourly associate
- Temporary associate (outside Hawaii); 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 and whether you (and/or your covered spouse/partner) are eligible for tobacco-free rates.

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 or WalmartOne.com.

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
- 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 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 or WalmartOne.com. 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.

Proof of Good Health for critical illness insurance

Proof of Good Health includes completing an electronic questionnaire regarding your medical history. Based upon your answers, you may be approved immediately for coverage. If you choose not to complete an electronic questionnaire, you will receive a paper form from Allstate Benefits.

In order for your coverage to be effective, you will need to return the form within 60 days from the date of your enrollment. If the form is not received within 60 days, you will not be eligible to enroll until the next annual enrollment or with a valid status change.

Proof of Good Health may be required for the following:

- You enroll after your initial enrollment period for any amount; or
- You increase your coverage after your initial enrollment period.

When your critical illness insurance coverage begins

If you enroll during annual enrollment, your coverage will become effective on the first day of the Plan year related to annual enrollment.

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 indicated above) and before Allstate Benefits approves your coverage, 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, FL 32203-1488

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, 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. See the Claims and appeals chapter for details.

Critical illness benefits

The following benefits are payable at 100% of your coverage election:

- Invasive cancer
- Alzheimer’s disease
- Coronary artery bypass surgery
- End-stage renal failure
- Heart attack
- Stroke
- Advanced Parkinson’s (requires loss of two activities of daily living [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
- Major organ transplant rider.

NOTE: 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)
- 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
  - 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.

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 or WalmartOne.com. You can also call Allstate Benefits at 800-514-9525 for a copy. You can view a brochure online at allstateatwork.com/walmart.

**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
If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-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 meet the actively-at-work requirement. For more information, contact Benefits Customer Service 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 actively-at-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 Continuation of coverage at termination section above.

When coverage ends
Coverage under critical illness insurance for you and/or your dependent 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 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.

Critical illness insurance coverage ends for your covered spouse/partner upon a valid decree of divorce, termination of domestic partnership, termination of legal relationship with a person other than a spouse or domestic partner, your death, or your change of status to a part-time hourly associate, temporary associate or part-time truck driver.

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 or drop coverage and re-enroll
If you return to work for the company or re-enroll 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 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.
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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, 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 the 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.

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What you need to know about accident insurance

- All associates (except for temporary Hawaii associates) and their eligible dependents (except for the spouses/partners of part-time hourly associates, temporary associates and part-time truck drivers) can enroll in accident insurance when they are 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 walmart.com functional non-exempt associates);
- Full-time truck driver; or
- Management associate (including management trainees and California pharmacists).

When applying for accident insurance, you may choose:

- Associate only
- Associate + spouse/partner
- Associate + child(ren)
- Associate + family.

You are eligible to apply for and enroll in accident insurance if you are a:

- Part-time hourly associate;
- Temporary associate (outside Hawaii); or
- Part-time truck driver.

Benefits-eligible part-time hourly associates may choose:

- 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 or WalmartOne.com.

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
- 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 or WalmartOne.com. 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 the first day of the Plan year related to annual enrollment.

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, FL 32203-1488

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.

The following benefits for services that are required 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
• 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

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-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 meet the actively-at-work requirement. For more information, contact Benefits Customer Service 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 actively-at-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

Coverage under accident insurance for you and/or your dependent 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 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.

Accident insurance coverage ends for your covered spouse/partner upon a valid decree of divorce, termination of domestic partnership, termination of legal relationship with a person other than a spouse or domestic partner, your death or your change of status to a part-time hourly associate, temporary associate or part-time truck driver.
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 above.

For more information, please contact Allstate Benefits at 800-514-9525.

If you leave the company and are rehired or drop coverage and re-enroll

If you return to work for the company or re-enroll 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 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.
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, 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

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<tr>
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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 walmart.com functional 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 or WalmartOne.com. 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.

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
- 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 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.

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.

Additional benefits

Benefits are payable under the following circumstances:

- If a dependent child is born alive and dies within 60 days of birth and was 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. 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.

An 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 death 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, 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, PA 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 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: WMTWILL.

NOTE: 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.

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 beneficiary or to your estate.
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 below.

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; or
   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 actively-at-work requirement 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 (or enrolled in the most similar coverage offered under the Plan).

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, 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? In addition to your Walmart-provided life insurance, optional associate life insurance protects your family financially during a difficult time.

### OPTIONAL ASSOCIATE LIFE INSURANCE RESOURCES

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### What you need to know about optional associate life insurance

- All full-time hourly 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 walmart.com functional non-exempt associates) and management associates can enroll in optional associate life insurance.

- 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 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. Therefore, it has no cash value.
Enrolling in optional associate life insurance

All full-time hourly associates and management associates can enroll in optional associate life insurance in addition to the company-paid life insurance provided by Walmart. Your coverage choices for optional associate life insurance depend on whether you are a full-time hourly associate or a management associate, as follows:

If you are a full-time hourly associate, 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 or full-time truck driver.

For all associates (full-time hourly or management), 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.

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.

All associates (full-time hourly or management) can enroll in optional associate life insurance at any time. Proof of Good Health is required 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 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 or WalmartOne.com.

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.

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
- 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 whoever 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 or WalmartOne.com.
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 whoever 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 or WalmartOne.com.

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

If Proof of Good Health is required, your coverage will generally become effective the day that the company receives approval from Prudential.

If you should die before Prudential approves coverage, no optional associate life insurance benefit will be paid to your beneficiary(ies).

If 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.

An 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 death 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, PA 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 beneficiary or to your estate.

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 true 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

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-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 meet the actively-at-work requirement. For more information, contact Benefits Customer Service 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 actively-at-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;
• On the last day of the pay period when your job status changes to part-time;
• Upon failure to pay your premiums;
• 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);
• 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.
**Optional associate life insurance**

**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; or
   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 actively-at-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.

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**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 work to decrease or drop 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. 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, you may enroll for coverage under the time periods and conditions described in the [Eligibility and enrollment](#) chapter. Proof of Good Health will be required.
Optional dependent life insurance

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If you drop or decrease your coverage and re-enroll 134

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, 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.

<table>
<thead>
<tr>
<th>Find What You Need</th>
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<th>Other Resources</th>
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<tbody>
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<td>Get details about continuing your insurance</td>
<td></td>
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</tr>
<tr>
<td>File a claim</td>
<td></td>
<td>Call Prudential at 877-740-2116</td>
</tr>
</tbody>
</table>

What you need to know about optional dependent life insurance

- All full-time hourly 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 walmart.com functional non-exempt associates) and management associates can enroll their spouse/partner and/or children in optional dependent life insurance.
- 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 full-time hourly associates and management associates can enroll their spouse/partner and/or child(ren) in optional dependent life insurance. If your 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:

- Spouse/partner:
  - $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 do not have to provide Proof of Good Health for your child(ren).

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.

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’s/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’s/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’s/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

If Proof of Good Health is required, your spouse’s/partner’s coverage will generally become effective the day that the company receives approval from Prudential.

If your spouse/partner should die before Prudential approves coverage, no optional dependent life insurance will be paid to you.

If Proof of Good Health is not required, your spouse’s/partner’s coverage 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).

Additional benefits are available if a dependent child is born alive and dies within 60 days of birth, or if a dependent child is stillborn. See Additional benefits in the Company-paid life insurance chapter for more information.

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.
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, PA 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 resulted in the death of the insured. Instead, the benefit may go to another eligible beneficiary or to the insured’s estate.

No benefits will be paid to you if your spouse/partner or dependent 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’s/partner’s Proof of Good Health questionnaire. If material facts about your spouse/partner were stated inaccurately, the true 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

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-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 meet the actively-at-work requirement. For more information, contact Benefits Customer Service 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 actively-at-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;
- On the last day of the pay period when your job status changes to part-time;
- 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.

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. Spouse/partner and child coverage is only portable in conjunction with the associate's coverage (exceptions are death of the associate or divorce or termination of domestic partnership or legal relationship).

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 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 decrease or drop 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. 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 request to re-enroll within 30 days, you may re-enroll for the same coverage plan you had 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. Proof of Good Health will be required for spouse/partner coverage plans.
Optional dependent life insurance
Accidental death and dismemberment (AD&D) insurance

WHERE CAN I FIND?

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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, 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.

<table>
<thead>
<tr>
<th>AD&amp;D INSURANCE RESOURCES</th>
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<tbody>
<tr>
<td>Change your beneficiary designation</td>
<td>Go to the WIRE or WalmartOne.com</td>
<td>Beneficiary changes cannot be made over the phone</td>
</tr>
<tr>
<td>Get more details about AD&amp;D insurance</td>
<td>Call Prudential at 877-740-2116</td>
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<td>File a claim</td>
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<td></td>
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</table>

What you need to know about AD&D insurance

- All full-time hourly 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 walmart.com functional non-exempt associates) and management associates can enroll in AD&D.
- 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 full-time hourly associates 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 + family

The coverage amount for your family 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

The amount of your benefit depends on the type of loss. 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 + family 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 or WalmartOne.com. 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.

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
- 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 whoever 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 or WalmartOne.com. 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. Executor or administrator of your estate.
When your AD&D coverage begins

If you enroll during annual enrollment, your coverage will become effective on the first day of the Plan year related to annual enrollment.

If you enroll outside of annual enrollment, your coverage will become effective on the event date 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

The coverage amount you enroll in is the coverage amount that applies to you, the associate. If you enroll in family coverage, your family members’ coverage amount is a percentage of your associate coverage amount. The coverage amount for your family members depends on your family unit. 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 family 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 has not been found within one year of disappearance, stranding, sinking or wrecking of any vehicle in which you were an occupant.
- Loss of both hands, both feet, sight in both eyes, speech, or hearing in both ears: Severance at or above the wrists or ankle joints, or total and permanent loss of sight, speech or hearing that continues for at least 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.
- Quadruplegia: 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

<table>
<thead>
<tr>
<th>Associate coverage amount</th>
<th>If family unit includes spouse/partner only</th>
<th>If family unit includes a spouse/partner and children</th>
<th>If family unit includes children only</th>
</tr>
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<tbody>
<tr>
<td>Associate — 100%</td>
<td>Spouse/partner — 50%</td>
<td>Spouse/partner — 40%</td>
<td>Children — 10%</td>
</tr>
<tr>
<td>$25,000</td>
<td>$12,500</td>
<td>$10,000</td>
<td>$2,500</td>
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<td>$25,000</td>
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<td>$80,000</td>
<td>$20,000</td>
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</tbody>
</table>

*Note: The table provides a sample of the full benefit amount for different coverage amounts and family units. For complete details, please refer to the Eligibility and enrollment chapter.
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 that continues 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 that continues 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 Associate Health and Welfare 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 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. But 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; or
• While operating a land, water or air vehicle, being legally intoxicated or under the influence of any narcotic, unless prescribed and administered on the advice of a 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, PA 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
If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-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 meet the actively-at-work requirement. For more information, contact Benefits Customer Service 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 actively-at-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;
• On the last day of the pay period when your job status changes to part-time;
• 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.

If you leave the company and are rehired
If you return to work 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 decrease or drop 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.
Business travel accident insurance

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Additional business travel accident insurance benefits 145
When business travel accident insurance benefits are not paid 146
When coverage ends 146
If you leave the company and are rehired 146

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 the applicable insurer under this chapter, the terms of the policy will govern. You may obtain a copy of this policy 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 certain types of injury or death. This coverage costs you nothing and is effective on your first day of work.

### BUSINESS TRAVEL ACCIDENT INSURANCE RESOURCES

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<td>Change your beneficiary designation</td>
<td>Go to the WIRE or WalmartOne.com</td>
<td>Beneficiary changes cannot be made over the phone</td>
</tr>
<tr>
<td>Get more details about business travel accident insurance</td>
<td>Call Prudential at 877-740-2116</td>
<td></td>
</tr>
<tr>
<td>File a business travel accident insurance claim</td>
<td>Call Prudential at 877-740-2116</td>
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</table>

### 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 were involved in while traveling on authorized company business.
- Your coverage amount is three times your Base Annual Earnings — maximum of $1 million, minimum of $200,000 (unless otherwise specified). This company-paid insurance is provided through The Prudential Insurance Company of America (Prudential).
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
- 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 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

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, PA 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.

It’s important to update your beneficiary information annually. Keep in mind, proceeds will go to whoever 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 or WalmartOne.com. Any change in beneficiary must be completed and submitted to Walmart before the covered person’s death.
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, 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.
• Uniplegia: Total paralysis of one limb.

Additional business travel accident insurance benefits

Business travel accident insurance provides these additional benefits:

• Seat belt benefit;
• Air bag 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 because of a felonious assault either on or off company premises, 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; or
- Losses resulting from being legally intoxicated or under the influence of any narcotic while operating a land, water or air vehicle (unless the narcotic is prescribed and administered on the advice of a 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.
WHERE CAN I FIND?

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Short-term disability

Pregnancy, a scheduled surgery or an unplanned illness or injury could keep you off the job and off the payroll for an extended period of time. Enrollment in the Walmart short-term disability plan can protect part of your paycheck if you become disabled for more than 14 days. When you can’t work, the Walmart short-term disability plan works for you.

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<thead>
<tr>
<th>Find What You Need</th>
<th>Online</th>
<th>Other Resources</th>
</tr>
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<tbody>
<tr>
<td>Get more details about short-term disability or file a claim within 90 days of the date your disability began</td>
<td>Go to WalmartOne.com</td>
<td>Call Sedgwick/Liberty at 800-492-5678</td>
</tr>
<tr>
<td>If you work in California</td>
<td>Go to edd.ca.gov</td>
<td>Call the state of California at 800-480-3287</td>
</tr>
<tr>
<td>If you work in Hawaii</td>
<td>Go to WalmartOne.com</td>
<td>Call Liberty at 800-492-5678</td>
</tr>
<tr>
<td>If you work in New Jersey</td>
<td>Go to WalmartOne.com</td>
<td>Call Liberty at 800-492-5678</td>
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<tr>
<td>If you work in New York</td>
<td>Go to WalmartOne.com</td>
<td>Call Liberty at 800-492-5678</td>
</tr>
<tr>
<td>If you work in Rhode Island</td>
<td>Go to <a href="http://www.dlt.ri.gov/tdi">www.dlt.ri.gov/tdi</a></td>
<td>Call the state disability carrier at 401-462-8420</td>
</tr>
</tbody>
</table>

What you need to know about short-term disability

- 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 walmart.com functional non-exempt associates) can enroll in short-term disability coverage. Enrollment in short-term disability is required to enroll in long-term disability.

- If you enroll after your initial eligibility period, your short-term disability coverage will not begin until you complete a 12-month waiting period. Once coverage begins, benefits will be reduced during your first five continuous years of coverage.

- While you are disabled, the short-term disability plan replaces 40% or 50% of your income, depending on when you enroll for coverage.

- There is a 90-day deadline from the date your disability begins to file a claim for short-term disability benefits, except in the state of California (which has a 41-day deadline) and Rhode Island. Associates who work in these states should refer to the Filing a claim for short-term disability section for more information.
Enrolling in short-term disability and when coverage is effective

All full-time hourly associates are eligible to enroll in short-term disability coverage. Short-term disability coverage is self-insured. This means there is no insurance company that collects premiums and pays benefits. Instead, participating associates make contributions that are intended to cover all of the costs of the benefits. Contributions are deposited into the Plan’s Trust. Contributions are used to pay benefits and expenses of the Plan. If associate contributions are insufficient to pay short-term disability benefits due, then other Trust assets will be used to pay benefits. If associate contributions exceed the amount necessary to pay benefits for any period, the excess contributions will be treated as assets of the Plan available to pay any Plan benefit or expense.

Short-term disability coverage is administered by Sedgwick Claims Management Services, Inc. (Sedgwick) in all 50 states except California, Hawaii, New Jersey, New York and Rhode Island, which have state-mandated disability plans. Coverage in Hawaii, New York and New Jersey is provided in accordance with the state programs in each of the states and insured by Liberty Life Assurance Company of Boston (Liberty), a Liberty Mutual company. For associates who work in Rhode Island and California, short-term disability coverage is provided and administered by the state. For information on coverage, call the phone number listed in Short-term disability resources at the beginning of this chapter.

You must be enrolled in short-term disability coverage in order to enroll in long-term disability coverage. Short-term disability provides up to 50% of your average weekly wage for up to 26 weeks after a 14-day waiting period if you become totally disabled as defined by the Plan. The maximum weekly benefit under the short-term disability plan is $600. For more information about your average weekly wage, see Your short-term disability benefit later in this chapter.

The date your coverage begins and the amount of your short-term disability benefit depend 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 from the date you enroll before your coverage is effective. You will not pay short-term disability premiums during your 12-month waiting period. Your coverage will become effective on the day you meet the 12-month waiting period.

• If at any time you drop your short-term disability coverage and later decide to re-enroll, you will be treated as a late enrollee with a 12-month waiting period.

Once your coverage is effective, your benefit depends on when you enrolled and the length of time you were covered under the Plan at the time of your total disability. You must be actively-at-work at the time of your total disability.

• If you enrolled during your initial enrollment period:
  – 50% of your average weekly wage up to the maximum benefit.

• If you are a late enrollee:
  – Any disability claim approved during the first five continuous years of coverage will be reduced to 40% of your average weekly wage up to the maximum benefit.
  – Any disability claim approved after five continuous years of coverage will be paid at 50% of your average weekly wage up to the maximum benefit. NOTE: The five-year period of continuous coverage does not include the 12-month waiting period.

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.

If your job classification changes from management to full-time hourly, you will be automatically enrolled for short-term disability and Short-Term Disability Plus coverage as though you had enrolled during your initial enrollment period. If you do not wish to carry this coverage, you have 60 days from the first day of the pay period your transition occurs to notify Benefits Customer Service. Any premiums you paid for the coverage will be refunded.

THE COST OF SHORT-TERM DISABILITY COVERAGE

Your cost for short-term disability, if you work in most states, 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 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.

Your short-term disability costs differ in the following states:

• California
• Hawaii
• New Jersey
• New York
• Rhode Island.
Short-term disability

Coverage during a temporary layoff or leave of absence

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 a temporary layoff or an approved leave of absence, 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 temporary layoff or approved leave of absence began, but would be reinstated if you returned to actively-at-work status within one year.

When you qualify for short-term disability benefits

In order to qualify for short-term disability benefits through the Plan, you must:

- Submit medical evidence provided by a qualified doctor that you are totally disabled as defined by the Plan (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); and

- Receive approval by Sedgwick of your claim.

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.

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:

- You are unable to perform the essential duties of your job for your normal work schedule due to a mental or physical illness or injury, or pregnancy. Failure to meet requirements necessary to maintain a license to perform the duties of your occupation does not mean you are totally disabled. 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; and

- In order to qualify for disability benefits, you must be under the continuous care of a qualified doctor and following the course of treatment prescribed. 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.

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 26 weeks.

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 war or act of war (declared or not), insurrection, rebellions or taking part in a riot or civil disorder;

- Incurred while in the armed services of any country engaged in war or other armed conflict;

- 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; and/or

- Sustained as a result of doing any work for pay or profit.

YOUR SHORT-TERM DISABILITY BENEFIT

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<td>During your initial enrollment period, or as a late enrollee after five years of continuous coverage</td>
<td>50% of your average weekly wage For example, 50% of $400 is a $200 weekly benefit</td>
</tr>
<tr>
<td>As a late enrollee and have been covered for less than five continuous years</td>
<td>40% of your average weekly wage For example, 40% of $400 is a $160 weekly benefit</td>
</tr>
</tbody>
</table>
Filing a claim for short-term disability

For all states except California and Rhode Island, you must submit your short-term disability claim within 90 days of the date your disability begins to assure benefits. Claims for California and Rhode Island must be filed directly with the state, as described below.

Claims for all other states except Hawaii, New Jersey and New York must be submitted to Sedgwick. Claims for Hawaii, New Jersey and New York must be submitted to Liberty within 30 days of the date your disability begins.

If you experience a disabling illness or injury, or are scheduled to begin maternity leave, follow these steps:

**STEP 1**: Notify Sedgwick (or Liberty, as appropriate) as soon as you know you will be absent from work due to an illness or injury. Report your disability online by going to WalmartOne.com, 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 provide medical information, including the following:

- Diagnosis;
- Disability date and expected duration of disability;
- Restrictions and limitations;
- Exam findings and test results; and
- Treatment plan.

You will need to sign a form authorizing your doctor to release this information.

**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.

If you are approved for short-term disability benefits, the benefit will begin after a 14-day waiting period on the 15th calendar day after your total disability begins.

Any illness protection, vacation or personal time pay you have may be used to substitute for the benefit waiting period, but the time used cannot exceed 80 hours.

If you are drawing short-term disability and you are approaching your anniversary date, you can receive a payout of your vacation time the pay period before your anniversary.

Illness protection pay is allowed up to the 15th calendar day of an illness after your claim for short-term disability benefits is approved. You must repay the company for any illness protection, vacation, personal time or other types of benefit hours taken beyond the 14-day benefit waiting period.

You will not accumulate illness protection, vacation, personal time or other types of benefit hours 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 you enrolled for coverage during your initial enrollment period or as a late enrollee (see Enrolling in short-term disability and when coverage is effective earlier in this chapter).

The maximum weekly benefit under the short-term disability plan is $600.

Total gross pay includes:

- Overtime;
- Bonuses;
- Vacation;
- Illness protection (not including any previously paid disability benefits); and
- Personal pay for the 26 pay periods prior to your last day worked.

**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.
- Contact Benefits Customer Service at 800-421-1362.

**Rhode Island associates** — You must:

- File a claim with the state of Rhode Island by calling 401-462-8420.
- Contact Benefits Customer Service at 800-421-1362.

**When short-term disability benefits begin**

If you are approved for short-term disability benefits, the benefit will begin after a 14-day waiting period on the 15th calendar day after your total disability begins.

Any illness protection, vacation or personal time pay you have may be used to substitute for the benefit waiting period, but the time used cannot exceed 80 hours.

If you are drawing short-term disability and you are approaching your anniversary date, you can receive a payout of your vacation time the pay period before your anniversary.

Illness protection pay is allowed up to the 15th calendar day of an illness after your claim for short-term disability benefits is approved. You must repay the company for any illness protection, vacation, personal time or other types of benefit hours taken beyond the 14-day benefit waiting period.

You will not accumulate illness protection, vacation, personal time or other types of benefit hours 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 you enrolled for coverage during your initial enrollment period or as a late enrollee (see Enrolling in short-term disability and when coverage is effective earlier in this chapter).

The maximum weekly benefit under the short-term disability plan is $600.

Total gross pay includes:

- Overtime;
- Bonuses;
- Vacation;
- Illness protection (not including any previously paid disability benefits); and
- Personal pay for the 26 pay periods prior to your last day worked.
Depending on when you enroll, your short-term disability benefit is 40% or 50% of your average weekly wage; for details, refer to the Your short-term disability benefit chart earlier in this chapter.

Your weekly benefit will be reduced by other benefits or income that you (or your family) receive or are eligible to receive. Examples include, but are not limited to, income from the following:

- Any governmental program that provides disability or unemployment benefits as a result of your job with the company;
- Employer-related individual policies;
- No-fault automobile insurance; or
- Lump sum payments or settlements related to the disability.

To obtain additional information about offsets under short-term disability, please call 800-492-5678.

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.

When short-term disability benefits end

Short-term disability 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 proof that you are totally disabled when requested to do so by Sedgwick or by 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 Liberty requires an examination;
- The last day of the maximum period for which benefits are payable (end of 26 weeks);
- The date no further benefits are payable under any provision in the short-term disability plan that limits benefit duration, which would include refusal to work in a similar position offered to you by Walmart that you are medically able and qualified to perform, with a rate of pay 50% or greater of your pre-disability earnings;
- The date of your death; or
- The day after you drop coverage.

The company offers additional disability coverage — Short-Term Disability Plus — that pays your payroll contributions for medical, dental, AD&D, Short-Term Disability Plus, and optional associate and dependent life insurance for up to 56 calendar days while you are disabled and receiving short-term disability benefits. See the Short-Term Disability Plus chapter for more information.

Your short-term disability and long-term disability coverage will not be canceled if you are receiving payments under the Plan. You will not be required to pay short-term disability or 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 premiums will be withheld from those payments.

AVERAGE WEEKLY WAGE

<table>
<thead>
<tr>
<th>Length of employment</th>
<th>How average weekly wage is determined</th>
</tr>
</thead>
</table>
| Employed 12 months or more | Total gross pay ÷ prior 52 weeks  
For example, the average weekly wage for an associate with a total annual gross pay of $20,800 is $400 ($20,800 ÷ 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 $4,800 for 12 weeks of work is $400 ($4,800 ÷ 12) |

Continuing benefit coverage while disabled

If you wish to continue medical, dental, vision, AD&D, Short-Term Disability Plus, 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.
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 actively-at-work requirement.

NOTE: State short-term disability programs may have different end dates.

**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 and become totally disabled again from the same or a related condition that caused the first period of disability, 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 26 weeks.

If you have returned to active full-time work for more than 30 calendar days and then become totally disabled again from the same or a related cause, it will be considered a new disability, and you may be able to receive up to 26 weeks of benefits. A new 14-day benefit waiting period 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 26 weeks of benefits. A new 14-day benefit waiting period will apply.

**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.

**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 to part-time;
- Upon failure to pay your premiums;
- 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);
- When the benefit is no longer offered by the company; or
- The day after you drop your coverage.

**If you leave the company and are rehired**

If you leave the company and return to work for the company on a full-time basis within 30 days, you will automatically be re-enrolled in the same disability benefit plan(s) you had prior to leaving the company (or the most similar coverage offered under the Plan).

If you return to work for the company on a full-time basis after 30 days, you will be considered newly eligible, and you can enroll for coverage once the applicable waiting period is met.

If you return to work within 30 days and did not have disability coverage prior to your termination, you will be considered a late enrollee if you elect disability coverage. See Enrolling in short-term disability and when coverage is effective earlier in this chapter.
Short-Term Disability Plus

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If you leave the company and are rehired 159
Short-Term Disability Plus

Health care insurance is an important financial safety net throughout your life. It becomes even more critical while you’re disabled. Enrollment in the Short-Term Disability Plus program keeps your medical and other specified Plan coverage in force at a time when you need your benefits the most. The Plan pays your premiums for up to 56 calendar days while you are receiving short-term disability benefits (after your 14-day short-term disability waiting period).

<table>
<thead>
<tr>
<th>Find What You Need</th>
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</tr>
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<tbody>
<tr>
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<td>Go to WalmartOne.com</td>
<td>Call Sedgwick at 800-492-5678</td>
</tr>
<tr>
<td>If you work in Hawaii</td>
<td>Go to WalmartOne.com</td>
<td>Call Liberty at 800-492-5678</td>
</tr>
<tr>
<td>If you work in New Jersey</td>
<td>Go to WalmartOne.com</td>
<td>Call Liberty at 800-492-5678</td>
</tr>
<tr>
<td>If you work in New York</td>
<td>Go to WalmartOne.com</td>
<td>Call Liberty at 800-492-5678</td>
</tr>
</tbody>
</table>

What you need to know about Short-Term Disability Plus

- 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 walmart.com functional non-exempt associates) can enroll in Short-Term Disability Plus during their initial enrollment period or at any other time. Late enrollees will have a 12-month waiting period before coverage is effective.

- You must be enrolled in the Walmart short-term disability plan or be covered by a state-mandated plan (Hawaii, New Jersey or New York) in order to enroll in the Short-Term Disability Plus program. Short-Term Disability Plus is not available in California or Rhode Island.

- Short-Term Disability Plus pays your premiums for your company-sponsored medical, dental, optional associate and dependent life insurance and other specified benefits for up to 56 calendar days while you are receiving short-term disability benefits.
Enrolling in Short-Term Disability Plus and when coverage is effective

All full-time hourly associates who have enrolled in the short-term disability plan or who are covered in a state-supplied plan in New York, New Jersey and Hawaii are eligible to enroll in Short-Term Disability Plus. Short-Term Disability Plus coverage is self-insured. This means there is no insurance company that collects premiums and pays benefits. Instead, participating associates make contributions that are intended to cover all of the costs of the benefits. Contributions are deposited into the Plan’s Trust. Contributions are used to pay benefits and expenses of the Plan. If associate contributions are insufficient to pay Short-Term Disability Plus benefits due, then other Trust assets will be used to pay benefits. If associate contributions exceed the amount necessary to pay benefits for any period, the excess contributions will be treated as assets of the Plan available to pay any Plan benefit or expense.

Short-Term Disability Plus is not available in California or Rhode Island. Short-Term Disability Plus coverage is administered by Sedgwick Claims Management Services, Inc. (Sedgwick) except in New York, New Jersey and Hawaii, where coverage is administered by Liberty.

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 as a late enrollee, you are required to finish a 12-month waiting period from the date you enroll before your coverage is effective. You will not pay Short-Term Disability Plus premiums during your 12-month waiting period. Your coverage will become effective on the day you meet the 12-month waiting period.
- If at any time you drop your Short-Term Disability Plus coverage and later decide to re-enroll, you will be treated as a late enrollee with a 12-month waiting period.

If your job classification changes from management to full-time hourly, you will be automatically enrolled for short-term disability and Short-Term Disability Plus coverage as though you had enrolled during your initial enrollment period. If you do not wish to carry this coverage, you have 60 days from the first day of the pay period your transition occurs to notify Benefits Customer Service. Any premiums you paid for the coverage will be refunded.

If you are totally disabled and receiving short-term disability benefits, Short-Term Disability Plus coverage will pay your premiums for your company-sponsored medical (including HMO), dental, optional associate and dependent life insurance, AD&D and Short-Term Disability Plus benefits for up to 56 calendar days after a 14-day waiting period. You are responsible for your premiums during the 14-day waiting period and once Short-Term Disability Plus benefits have been exhausted. Short-Term Disability Plus does not pay premiums for vision insurance, critical illness insurance or accident insurance. See the Eligibility and enrollment chapter for details.

THE COST OF SHORT-TERM DISABILITY PLUS COVERAGE

The cost of Short-Term Disability Plus depends on the level of medical coverage you select; i.e., whether you select associate-only coverage (or no coverage), or if you select coverage for yourself and your eligible dependents.

Coverage during a temporary layoff or leave of absence

Once your Short-Term Disability Plus coverage has begun, if you are not actively-at-work due to an approved leave of absence or a temporary layoff, you will continue to be eligible for Short-Term Disability Plus benefits for 90 days from your last day of work. Your coverage will end on the 91st day. Coverage will reinstate if you return to actively-at-work status within one year.

Your Short-Term Disability Plus benefits

Short-Term Disability Plus benefit amounts are based on the costs of your coverage as of your last day worked before your total disability began. Should any coverage costs increase after your disability begins, you will be responsible for paying the difference in your rates.

You are responsible for your biweekly benefits payments toward the cost of your other coverage, even if there are delays in processing your short-term disability claim.

Sedgwick will calculate your benefit payment amount and send it to the Plan. Your short-term disability benefit payment will be increased by this amount to cover the benefits deductions from your check.

Filing a claim

You do not have to file a claim for Short-Term Disability Plus benefits; a claim is automatically generated by Sedgwick when you file a claim for short-term disability benefits.

In order to receive Short-Term Disability Plus benefits:

- Your short-term disability claim under the Plan must be approved by Sedgwick; or
- You must be receiving short-term disability benefits through a state-mandated disability plan in New York, New Jersey or Hawaii. Short-Term Disability Plus is not available in California and Rhode Island.
When Short-Term Disability Plus benefits begin

The Short-Term Disability Plus program begins paying benefits after a benefit waiting period of 14 calendar days.

Continuing benefits coverage while disabled

Because the Short-Term Disability Plus program pays your premiums for your company-sponsored medical, dental, optional associate and dependent life insurance, AD&D and Short-Term Disability Plus benefits, your coverages under these plans will remain in force. However, if you are enrolled in vision, accident insurance or critical illness insurance, you must continue to pay your premiums or your coverage may be canceled. 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 are receiving short-term disability benefits, you are not required to pay short-term disability or long-term disability premiums from disability benefits payments. 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 Plus benefits end

The Short-Term Disability Plus program pays your premiums for 56 calendar days after your 14-day benefit waiting period. You are responsible for all your coverage premiums after that time. If you do not pay your premiums, your coverage will be canceled. Benefit payments will end on the earliest of:

- The day you are no longer receiving short-term disability;
- At the end of 56 calendar days for which Short-Term Disability Plus benefits are payable;
- At termination of your employment; or
- The day of your death.

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 on how to appeal a denied claim, see the Claims and appeals chapter.

For information about making payments while on a leave of absence, see the Eligibility and enrollment chapter.

BREAK IN SERVICE

If your coverage has been canceled due to nonpayment of premiums while you are on leave and you return to actively-at-work status within one year of cancellation, you will automatically 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 meet the actively-at-work requirement.

If your coverage has been canceled due to nonpayment of premiums while you are on leave and you return to work on a full-time basis after one year of cancellation, you will be considered newly eligible; you may enroll for short-term disability coverage (and Short-Term Disability Plus) within the applicable time period and under the conditions described in the Eligibility and enrollment chapter.

When coverage ends

Your Short-Term Disability Plus coverage ends:

- At termination of your employment;
- On the last day of the pay period when your job classification changes to part-time;
- Upon failure to pay your premiums;
- 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);
- When the benefit is no longer offered by the company; or
- On the day after you drop coverage.

If you leave the company and are rehired

If you leave the company and return to work for the company on a full-time basis within 30 days, you will automatically be re-enrolled in the same disability benefit plan(s) you had prior to leaving the company (or the most similar coverage offered under the Plan).

If you return to work for the company on a full-time basis after 30 days, you will be considered newly eligible, and you can enroll for coverage once the applicable waiting period is met.

If you return to work within 30 days and did not have disability coverage prior to your termination, you will be considered a late enrollee if you elect disability coverage. See Enrolling in Short-Term Disability Plus and when coverage is effective earlier in this chapter.
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 Liberty Life Assurance Company of Boston (Liberty), a Liberty Mutual company, 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.

<table>
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<tr>
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<td>Go to WalmartOne.com</td>
<td>Call Liberty at 800-492-5678</td>
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What you need to know about long-term disability

• All full-time associates (including full-time hourly pharmacists, field Logistics associates, field supervisor positions in stores and clubs, full-time hourly Vision Center managers and walmart.com functional non-exempt associates) enrolled in the short-term disability plan or participating in California, Hawaii, New Jersey, New York or Rhode Island state-mandated plans, and management associates (including management trainees and California pharmacists) are eligible to enroll in the long-term disability plan.

• If you enroll after your initial eligibility period, your long-term disability coverage will not begin until you complete a 12-month waiting period. Once coverage begins, benefits for disability claims beginning during your first five continuous years of coverage will be reduced.

• The long-term disability plan works with any other benefits you receive while disabled to replace 40% or 50% of your average monthly wage, depending on when you enroll for coverage.

• Long-term disability benefits are paid at the end of each 30-day period of disability.
Enrolling 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 who is enrolled in the short-term disability plan;
• Employed in a state that has a state-mandated short-term disability plan (California, Hawaii, New Jersey, New York and Rhode Island); or
• A management associate.

The long-term disability plan is insured by Liberty and provides up to 50% of your average monthly wage after your waiting period if you become disabled as defined by the Plan. For more information about your waiting period, see When long-term disability benefits begin later in this chapter.

The maximum monthly benefit under the long-term disability plan is $15,000. For more information about your average monthly wage, see Your long-term disability benefit later in this chapter.

The date your coverage begins and the amount of your long-term disability benefit depend 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 from the date you enroll before your coverage is effective. You will not pay long-term disability premiums during your 12-month waiting period. Your coverage will become effective on the day you meet the 12-month waiting period, provided you have been actively-at-work for the previous six-month period.

• If at any time 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.

Once your coverage is effective, your benefit depends on when you enrolled and the length of time you have been covered under the Plan at the time of your disability. You must be actively-at-work at the time of your disability.

• If you enrolled during your initial enrollment period:
  – Your coverage amount will be 50% of your average monthly wage up to the maximum benefit.

• If you are a late enrollee:
  – Any disability beginning during the first five continuous years of coverage will be reduced to 40% of your average monthly wage up to the maximum benefit.
  – Any disability beginning after five continuous years of coverage will be paid at 50% of your average monthly wage up to the maximum benefit. NOTE: The five-year period of continuous coverage does not include the 12-month waiting period.

THE COST OF LONG-TERM DISABILITY COVERAGE

Your cost for long-term disability is based on your biweekly earnings and your age. 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.

Coverage during a temporary layoff or leave of absence

Once your long-term disability coverage is effective and you are eligible to file a claim for benefits, if you are not actively-at-work due to a temporary layoff or an approved leave of absence, you will continue to be eligible for long-term disability benefits for 90 days from your last day of work. Your eligibility for long-term disability benefits would end on the 91st day after your temporary layoff or approved leave of absence began, but would be reinstated if you returned to actively-at-work status within one year.

When you qualify for long-term disability benefits

Under the terms of the long-term disability plan, “disability” means that, due to a covered injury or sickness during the benefit waiting period and for the next 12 months of disability, you are unable to perform the material and substantial duties of your own occupation, and after 12 months of benefit payments, you are unable to perform the material and substantial duties of any occupation.

In determining whether you are disabled, 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 long-term disability 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); and

• 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 long-term disability 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;

• Cosmetic surgery, unless such surgery is in connection with an injury or sickness sustained while the individual is a covered person; or

• A gender change, including, but not limited to, any operation, drug therapy or any other procedure related to a gender change.

No benefit will be payable during any period of incarceration.

PRE-EXISTING CONDITION EXCLUSION

You will not receive long-term disability benefits for any condition, diagnosed or undiagnosed, for which you had received treatment during the 365-day period prior to your effective date unless:

• You have not been treated for the pre-existing condition for more than 365 days while insured; or

• You have been continuously insured on a full-time basis under the long-term disability plan for 730 consecutive days prior to becoming disabled.

When long-term disability benefits begin

If you are approved by Liberty for long-term disability benefits, they will begin after your waiting period:

• For full-time hourly associates: Your waiting period is 26 weeks or the end of your short-term disability benefits — whichever is longer.

• For management associates: Your waiting period is 90 days or the end of your employer-sponsored salary continuation program — whichever is longer.

If you are approved for long-term disability benefits, any illness protection, vacation or personal pay may not be used while receiving long-term disability benefits. If you are drawing long-term disability and you are approaching your anniversary date, you can receive a payout of your vacation time the pay period before your anniversary.

IF YOU RETURN TO WORK DURING YOUR WAITING PERIOD AND BECOME DISABLED AGAIN

• For full-time hourly associates: 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 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.

• For management associates: If you cease to be disabled and return to work for a total of 180 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 180 calendar days while satisfying your benefit waiting period, you must satisfy an entirely new benefit waiting period.

Filing a long-term disability claim

Full-time hourly associates: If you are on an approved short-term disability claim, your claim will be automatically transitioned from Sedgwick to Liberty around the 17th week of disability.

Management associates: If you believe you will need to use your long-term disability benefit, call Liberty at 800-492-5678. To avoid any delay in receiving your benefit, make this call by approximately the 45th day of your salary continuance, or as soon as you know you will need to use your benefit. Liberty will provide you with additional information on how to complete your claim.
Associates receiving workers’ compensation benefits and enrolled for long-term disability insurance may be eligible for disability benefits after their waiting period has expired. Call Liberty at 800-492-5678 to report your long-term disability claim. Management associates should call Liberty by approximately the 45th day after they started receiving workers’ compensation disability benefits. All others should call Liberty by approximately the 90th day after they have started receiving these 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 long-term disability benefit

The amount of your long-term disability benefit is based on:

- Your average monthly wage; and
- Whether you enrolled for coverage during your initial enrollment period or as a late enrollee (see Enrolling in long-term disability and when coverage is effective earlier in this chapter).

### AVERAGE MONTHLY WAGE

<table>
<thead>
<tr>
<th>Length of employment</th>
<th>How average monthly wage is determined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed 12 months or more</td>
<td>Total gross pay ÷ prior 12 months. For example, the average monthly wage for an associate with a total annual gross pay of $20,800 is $1,733.33 ($20,800 ÷ 12).</td>
</tr>
<tr>
<td>Employed less than 12 months</td>
<td>Total gross pay ÷ number of months worked. For example, the average monthly wage for an associate with a total gross pay of $11,900 for seven months of work is $1,700 ($11,900 ÷ 7).</td>
</tr>
</tbody>
</table>

Total gross pay includes:

- Overtime;
- Bonuses;
- Vacation;
- Illness protection (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 long-term disability benefit is shown below:

<table>
<thead>
<tr>
<th>YOUR LONG-TERM DISABILITY BENEFIT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If you enrolled</td>
<td>Your coverage is</td>
</tr>
<tr>
<td>During your initial enrollment period</td>
<td>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*).</td>
</tr>
<tr>
<td>As a late enrollee and have been covered for less than five continuous years</td>
<td>40% 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*).</td>
</tr>
</tbody>
</table>

*See Other benefits or income that reduces long-term disability benefits for more information.

The maximum monthly benefit under the long-term disability plan is $15,000. Your benefit will be no less than $50 for any month that you are eligible to receive long-term disability benefits. The total of your monthly disability payment, plus all earnings, cannot exceed 100% of your average monthly wage prior to your disability.

Long-term disability benefits are paid at the end of each 30-day period of disability, as long as you continue to be disabled as defined by the Plan.

Liberty has the right to recover, and you must repay, any amount that is overpaid to you for long-term disability benefits under this Plan.

### OTHER BENEFITS OR INCOME THAT REDUCES LONG-TERM DISABILITY BENEFITS

Your long-term disability 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 that begins 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; and
- 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 long-term disability benefits are subsequently adjusted by cost-of-living increases, your long-term disability benefit will not be further reduced. Please refer to the policy for a complete list of offsets. You may obtain a copy of the long-term disability policy by calling Liberty at 800-492-5678.

**REDUCTION OF LONG-TERM DISABILITY BENEFIT EXAMPLE**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average monthly wage</td>
<td>$1,800</td>
</tr>
<tr>
<td>Benefit amount (50% of average monthly wage, subject to the $15,000 maximum)</td>
<td>-$900</td>
</tr>
<tr>
<td>Less Social Security disability benefit</td>
<td>-$500</td>
</tr>
<tr>
<td>Less dependent’s Social Security benefits</td>
<td>-$250</td>
</tr>
<tr>
<td>Long-term disability payment (monthly)</td>
<td>$150</td>
</tr>
</tbody>
</table>

**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 long-term disability 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 benefits while you are receiving benefits under the long-term disability plan and your Social Security disability claim is approved retroactively, you must reimburse Liberty for any long-term disability (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 an 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.

The following calculation is used to determine your monthly benefit for a partial disability.

<table>
<thead>
<tr>
<th>DISABLED AND WORKING BENEFIT CALCULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \frac{(A - B) \times C}{A} = D )</td>
</tr>
</tbody>
</table>

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

Your “pre-disability monthly earnings” means your regular monthly rate of pay in effect for the 26 regular pay periods immediately prior to your last day worked, divided by 12. Pre-disability earnings include overtime, bonuses, 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.

**Continuing benefit coverage while disabled**

If you wish to continue medical, dental, vision, AD&D, Short-Term Disability Plus, optional associate and dependent life insurance, critical illness insurance and accident insurance coverage while you are receiving long-term disability benefits, you must make premium payments each pay period. These amounts will not be deducted from your long-term disability benefit payments. 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.

You will not be required to pay short-term disability or long-term disability premiums from any long-term disability benefit payments received. If, however, you receive any other earnings through the Walmart payroll systems while you are receiving long-term disability benefits, your premiums will be withheld from those payments.

Your coverage will not be canceled while you are receiving disability benefits under this policy.
IF YOU DIE WHILE RECEIVING LONG-TERM DISABILITY BENEFITS

Coverage under the long-term disability plan ends upon your death. However, if you die while you are receiving long-term disability benefits, a lump-sum payment of $5,000 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 in equal shares. If you are not survived by a spouse/partner or children, the payment will be made to your estate.

When long-term disability benefits end

Long-term disability 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 job with Walmart where workplace modifications or accommodations are made to allow you to perform your occupation;
- 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.

<table>
<thead>
<tr>
<th>Age when you become totally disabled</th>
<th>Benefits duration (Years of LTD benefits)</th>
<th>Year of birth</th>
<th>Normal retirement age</th>
</tr>
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<tbody>
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<td>Prior to age 62</td>
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IF THE DISABILITY IS DUE TO MENTAL ILLNESS, ALCOHOLISM OR DRUG ADDICTION

To receive long-term disability 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.

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, 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.

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.

When coverage ends

Your long-term disability 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 to part-time;
- Upon failure to pay your premiums;
- On the date you lose eligibility;
- On the 91st 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; or
- On the date of your death.

If you leave the company and are rehired

If you leave the company and return to work for the company on a full-time basis within 30 days, you will automatically be re-enrolled in the same disability benefit plan(s) you had prior to leaving the company (or the most similar coverage offered under the Plan).

If you return to active full-time work for the company after 30 days, you will be considered newly eligible, and you can enroll for long-term disability coverage once the applicable waiting period is met.
WHERE CAN I FIND?

- Enrolling in truck driver long-term disability and when coverage is effective 170
- Coverage during a temporary layoff or leave of absence 170
- When you qualify for truck driver long-term disability benefits 170
- When benefits are not paid 171
- When truck driver long-term disability benefits begin 171
- Filing a truck driver long-term disability claim 171
- Your truck driver long-term disability benefit 172
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- Continuing benefit coverage while disabled 173
- When truck driver long-term disability benefits end 173
- If you return to work and become disabled again 175
- If you go on a leave of absence 175
- When coverage ends 175
- If you leave the company and are rehired 175

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 Liberty Life Assurance Company of Boston (Liberty), a Liberty Mutual company, 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 beyond your salary continuance period, truck driver long-term disability benefits work 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.

What you need to know about truck driver long-term disability

- Full-time truck drivers may choose from two truck driver long-term disability plans: full-duration coverage and five-year coverage.
- The truck driver long-term disability plan works with any other benefits you receive while disabled to replace 40% or 50% of your average monthly wage, depending on when you enroll for coverage.
- If you enroll 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; and if your disability begins during the first 12 months of coverage, your disability benefit will be paid at 40% of your average monthly wage.
- Truck driver long-term disability benefits are paid at the end of each 30-day period of disability.

TRUCK DRIVER LONG-TERM DISABILITY RESOURCES

<table>
<thead>
<tr>
<th>Find What You Need</th>
<th>Online</th>
<th>Other Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get more details about truck driver long-term disability or file a claim</td>
<td>Go to WalmartOne.com</td>
<td>Call Liberty at 800-492-5678</td>
</tr>
</tbody>
</table>
Enrolling in truck driver long-term disability and when coverage is effective

You are eligible to enroll in truck driver long-term disability coverage if you are a full-time truck driver. Truck driver long-term disability offers two coverage plans:

- **Full-duration coverage.** Full-duration coverage pays benefits for the longer of:
  - The period shown in the [Maximum duration of truck driver long-term disability](#) chart (later in this chapter); or
  - The normal retirement age under the Social Security Act shown in the [Social Security normal retirement age](#) chart (later in this chapter).

- **Five-year coverage.** Five-year coverage pays benefits for 60 months unless the longer of the following is less than 60 months. In this case, the monthly benefit will be payable for the shorter period.
  - The period shown in the [Maximum duration of truck driver long-term disability](#) chart (later in this chapter); or
  - The normal retirement age under the Social Security Act shown in the [Social Security normal retirement age](#) chart (later in this chapter).

The truck driver long-term disability plan begins paying benefits after you have been disabled, as defined by the Plan, for a 90-day waiting period. The maximum monthly benefit under the long-term disability plan is $15,000. Truck driver long-term disability coverage is insured by Liberty. Your benefit will be no less than $50 for any month that you are eligible to receive long-term disability benefits.

The date your coverage is effective and the amount of your truck driver long-term disability benefit depend on when you enroll for coverage:

- If you enroll during your initial enrollment period (from the date of your first paycheck through 60 days of your date of hire), your coverage amount will be 50% of your average monthly wage. 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:
  - 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; and
  - Any disability beginning during the first year of coverage will be reduced to 40% of your average monthly wages, up to the maximum benefit.
- If at any time you drop your truck driver long-term disability coverage and later decide to re-enroll, you will be treated as a late enrollee as described above.
- If you enroll in the five-year coverage plan and subsequently decide to enroll in the full-duration coverage plan, you will be required to provide Evidence of Insurability before you can be approved for coverage. As a late enrollee, your coverage will be effective the first day of the pay period after Benefits Customer Service receives approval from Liberty.

**The Cost of Truck Driver Long-Term Disability Coverage**

Your cost for truck driver long-term disability is based on your biweekly earnings. Premiums are deducted from all wages, including bonuses. You will not be required to pay truck driver long-term disability premiums from any truck driver long-term disability benefit payments received. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving truck driver long-term disability benefits, your premiums will be withheld from those payments.

**Coverage during a temporary layoff or leave of absence**

Once your truck driver long-term disability coverage is effective and you are eligible to file a claim for benefits, if you are not actively-at-work due to a temporary layoff or an approved leave of absence, you will continue to be eligible for truck driver long-term disability benefits for 90 days from your last day of work. Your eligibility for truck driver long-term disability benefits would end on the 91st day after your temporary layoff or approved leave of absence began, but would be reinstated if you returned to actively-at-work status within one year.

**When you qualify for truck driver long-term disability benefits**

Under the terms of the truck driver long-term disability plan, “disability” means that, due to an injury or sickness during the benefit waiting period and for the next 12 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 12 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, 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 long-term disability 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); and
- 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, Liberty has the right to re-examine your Proof of Good Health 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 long-term disability 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;
- Cosmetic surgery, unless such surgery is in connection with an injury or sickness sustained while the individual is a covered person; or
- A gender change, including, but not limited to, any operation, drug therapy or any other procedure related to a gender change.

No benefit will be payable during any period of incarceration.

**PRE-EXISTING CONDITION EXCLUSION**

You will not receive truck driver long-term disability benefits for any condition, diagnosed or undiagnosed, for which you had received treatment during the 365-day period prior to your effective date unless:

- You have not been treated for the pre-existing condition for more than 365 continuous days while insured; or
- You have been continuously insured on a full-time basis under the truck driver long-term disability plan for 730 consecutive days prior to becoming disabled.

If you change from the five-year duration coverage to the full-duration coverage, 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, your benefits would be limited to the five-year duration coverage plan.

**When truck driver long-term disability benefits begin**

If you are approved by Liberty for truck driver long-term disability benefits, they will begin after your waiting period, which is the longer of:

- The first 90 consecutive calendar days of any one period of total disability; or
- The end of your company-sponsored salary continuance program, with the exception of benefits required by state law.

If you are approved for truck driver long-term disability benefits, any illness protection, vacation or personal pay may not be used while receiving truck driver long-term disability benefits. If you are drawing truck driver long-term disability and you are approaching your anniversary date, you can receive a payout of your vacation time the pay period before your anniversary.

**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.

**Filing a truck driver long-term disability claim**

If you believe you will need to use your truck driver long-term disability benefit, call Liberty at 800-492-5678. To avoid any delay in receiving your benefit, make this call by approximately the 45th day of your salary continuance, or as soon as you know you will need to use your benefit. Liberty will then provide you with additional information on how to complete 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. See the Claims and appeals chapter for details.

Associates receiving workers’ compensation benefits and enrolled for truck driver long-term disability insurance may be eligible for disability benefits after their waiting period has expired. Call Liberty at 800-492-5678 to report your truck driver long-term disability claim by approximately the 45th day of being on workers’ compensation disability benefits.

Your truck driver long-term disability benefit

The amount of your truck driver long-term disability is based on:

- Your average monthly wage; and
- Whether you enrolled for coverage during your initial enrollment period or as a late enrollee (see Enrolling in truck driver long-term disability and when coverage is effective earlier in this chapter).

### AVERAGE MONTHLY WAGE

<table>
<thead>
<tr>
<th>Length of employment</th>
<th>How average monthly wage is determined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed 12 months or more</td>
<td>Your activity pay, mileage rate and bonuses, paid in the 26 pay periods prior to your last day worked ÷ 12 months</td>
</tr>
<tr>
<td>Employed less than 12 months</td>
<td>Your activity pay, mileage rate and bonuses ÷ the number of months worked.</td>
</tr>
</tbody>
</table>

Your truck driver long-term disability benefit is shown below:

### YOUR TRUCK DRIVER LONG-TERM DISABILITY BENEFIT

<table>
<thead>
<tr>
<th>If you enrolled</th>
<th>Your coverage is</th>
</tr>
</thead>
<tbody>
<tr>
<td>During your initial enrollment period</td>
<td>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*)</td>
</tr>
<tr>
<td>After your initial enrollment period</td>
<td>40% of your average monthly wage for the first year minus the amount of other benefits or income you or your family are eligible to receive (for example, Social Security disability benefits*)</td>
</tr>
</tbody>
</table>

*See Other benefits or income that reduces truck driver long-term disability benefits for more information.

The maximum monthly benefit under the truck driver long-term disability plan is $15,000. Your benefit will be no less than $50 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 the month, as long as you continue to be disabled as defined by the Plan.

Liberty has the right to recover from you any amount that is overpaid to you for truck driver long-term disability benefits under the Plan.

### OTHER BENEFITS OR INCOME THAT REDUCES TRUCK DRIVER LONG-TERM DISABILITY BENEFITS

Your truck driver long-term disability 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 that begins 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 long-term disability benefits are subsequently adjusted by cost-of-living increases, your long-term disability 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 long-term disability policy by calling Benefits Customer Service at 800-421-1362.

### REDUCTION OF TRUCK DRIVER LONG-TERM DISABILITY BENEFIT EXAMPLE

<table>
<thead>
<tr>
<th>Benefit amount (50% of average monthly wage, subject to the $15,000 maximum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average monthly wage</td>
</tr>
<tr>
<td>$1,800</td>
</tr>
<tr>
<td>Benefit amount (50% of average monthly wage, subject to the $15,000 maximum)</td>
</tr>
<tr>
<td>$900</td>
</tr>
<tr>
<td>Less Social Security benefit</td>
</tr>
<tr>
<td>$500</td>
</tr>
<tr>
<td>Less dependent’s Social Security benefits</td>
</tr>
<tr>
<td>$250</td>
</tr>
<tr>
<td>Truck driver LTD payment (monthly)</td>
</tr>
<tr>
<td>$150</td>
</tr>
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</table>

*See Other benefits or income that reduces truck driver long-term disability benefits for more information.*
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 long-term disability 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 truck driver long-term disability plan and your Social Security disability claim is approved retroactively, you must reimburse Liberty for any long-term disability 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.

### DISABLED AND WORKING BENEFIT CALCULATION

\[
\frac{(A - B) \times C}{A} = D
\]

<table>
<thead>
<tr>
<th>A</th>
<th>Your indexed pre-disability monthly earnings</th>
</tr>
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<tbody>
<tr>
<td>B</td>
<td>Your current monthly earnings</td>
</tr>
<tr>
<td>C</td>
<td>The monthly benefit payable if you were qualified as totally disabled</td>
</tr>
<tr>
<td>D</td>
<td>The disabled and working benefit payable</td>
</tr>
</tbody>
</table>

Your “indexed 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.

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 long-term disability benefits, you must make benefits premium payments each pay period. These amounts will not be deducted from your truck driver long-term disability benefit payments. 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.

You will not be required to pay truck driver long-term disability premiums from any truck driver long-term disability benefit payments received. If, however, you receive any other earnings through the Walmart payroll systems while you are receiving truck driver long-term disability benefits, your premiums will be withheld from those payments.

Your coverage will not be canceled while you are receiving disability benefits under this policy.

IF YOU DIE WHILE RECEIVING TRUCK DRIVER LONG-TERM DISABILITY BENEFITS

Coverage under the truck driver long-term disability plan ends upon your death. However, if you die while you are receiving truck driver long-term disability benefits, a lump sum payment of $5,000 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 in equal shares. If you are not survived by a spouse/partner or children, the payment will be made to your estate.

When truck driver long-term disability benefits end

Truck driver long-term disability 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 job with Walmart where workplace modifications or accommodations are made to allow you to perform your occupation;
• The date you are able to work in your own occupation on a part-time basis but choose not to

FULL-DURATION COVERAGE

Full-duration coverage pays benefits for the longer of:
• The period of time shown in the Maximum duration of truck driver long-term disability chart below; or
• The amount of time between the disability and normal retirement age under the Social Security Act shown in the Social Security normal retirement age chart.

FIVE YEAR COVERAGE

Five-year coverage pays benefits for 60 months unless both the applicable periods in the Maximum duration of truck driver long-term disability chart and the Social Security normal retirement age chart below are less than five years. In that case, the five-year coverage will pay for the longer of those two periods.

MAXIMUM DURATION OF TRUCK DRIVER LONG-TERM DISABILITY

<table>
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<tr>
<th>Age when you become totally disabled</th>
<th>Benefits duration</th>
<th>Year of birth</th>
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<tr>
<td>67</td>
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<td>1943 through 1954</td>
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<tr>
<td>68</td>
<td>1½ years</td>
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<td>66 + 2 months</td>
</tr>
<tr>
<td>69 or older</td>
<td>1⅔ years</td>
<td>1956</td>
<td>66 + 4 months</td>
</tr>
<tr>
<td>1957</td>
<td></td>
<td>66 + 6 months</td>
<td></td>
</tr>
<tr>
<td>1958</td>
<td></td>
<td>66 + 8 months</td>
<td></td>
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<tr>
<td>1960 or after</td>
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<td>67</td>
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</tbody>
</table>
IF THE DISABILITY IS DUE TO MENTAL ILLNESS, ALCOHOLISM OR DRUG ADDICTION

To receive truck driver long-term disability 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 totally disabled again from the same or a related condition that caused the first period of disability, the recurrent total 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 total disability will be treated as a new disability. A new benefit waiting period must be met.

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.

When coverage ends

Your truck driver long-term disability coverage ends:

- At termination of your employment;
- On the last day of the pay period when your job status changes to part-time;
- Upon failure to pay your premiums;
- 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);
- When the benefit is no longer offered by the company; or
- On the day after you drop coverage.

If you leave the company and are rehired

If you leave the company and return to active full-time work for the company within 30 days, you will automatically be re-enrolled in the same truck driver long-term disability plan(s) you had when you left (or the most similar coverage offered under the Plan).

If you return to active full-time work for the company after 30 days, you will be considered newly eligible, and you can enroll for truck driver long-term disability coverage once the applicable waiting period is met.
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

<table>
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<tr>
<th>Find What You Need</th>
<th>Online</th>
<th>Other Resources</th>
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<tbody>
<tr>
<td>Enroll in the Plan or change your deduction amount</td>
<td></td>
<td>Associates must complete an online enrollment session on the <a href="http://WIRE">WIRE</a> or at <a href="http://WalmartOne.com">WalmartOne.com</a>.</td>
</tr>
<tr>
<td>• Access your account information</td>
<td>Go to the Computershare website at <a href="http://computershare.com/walmart">computershare.com/walmart</a></td>
<td>Call Computershare at 800-438-6278 (hearing impaired: 800-952-9245)</td>
</tr>
<tr>
<td>• Get your account statement</td>
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<tr>
<td>• Get a Form 1099</td>
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<tr>
<td>Send money directly to Computershare</td>
<td></td>
<td>Send check to: Computershare Attn: Walmart ASPP P.O. Box 43080 Providence, RI 02940-3080 (Company matching contributions will not be made on money sent directly to Computershare.)</td>
</tr>
<tr>
<td>Get information about setting up a line of credit for your account</td>
<td>Call USBancorp at 800-771-2265</td>
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</table>

### 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.
- If you have $2,000 or more of Walmart stock in your account, you may be eligible to borrow money using the stock in your Stock Purchase Plan account to secure a line of credit.
- 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 or at WalmartOne.com. 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 below), 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 W-2 form.

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, RI 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 are automatically reinvested to buy additional shares of stock for you, but do not count against the $125,000 maximum.

<table>
<thead>
<tr>
<th>If you contribute</th>
<th>Your Plan year payroll deduction contribution is</th>
<th>Walmart’s matching contribution* is</th>
<th>Total amount used to purchase Walmart stock</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10 biweekly</td>
<td>$260</td>
<td>$39</td>
<td>$299</td>
</tr>
<tr>
<td>$20 biweekly</td>
<td>$520</td>
<td>$78</td>
<td>$598</td>
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<tr>
<td>$70 biweekly</td>
<td>$1,820</td>
<td>$270 (Walmart matches $0.15 for every $1 up to $1,800)</td>
<td>$2,090</td>
</tr>
</tbody>
</table>

*Company contributions will be made only on stock purchased through payroll deductions. Company contributions will not be made on money sent directly to Computershare.
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.

Military Leave of Absence
If you are on a Military Leave of Absence, you will need to contact Benefits Customer Service to see whether you are eligible to receive company matching contributions during your leave.

Stock certificates
If, at any time, you decide that you would prefer to personally hold your shares of stock directly, you may request that a stock certificate be issued to you at no charge from Computershare. Stock certificates are negotiable securities and should be kept in a safe place.

Please note that any shares issued in stock certificate form are no longer part of the Plan, and dividends paid on those shares will not be automatically reinvested under the Plan. Once the shares are taken from your Associate Stock Purchase Plan account, the shares represented by the certificate will be tracked and treated as a “general shareholder” account. You may contact Computershare at 800-438-6278 for more information.

While you remain an associate or maintain a Plan account, you may send your shares back to Computershare at any time and designate in writing that you would like those shares placed back into the Plan.

If stock certificates in your possession are lost or stolen, you may request replacement certificates, at a cost. You will be required by Computershare to complete an Affidavit of Loss and purchase an Open Penalty Surety Bond. Special insurance, based on a percentage of the value of the stock certificate, is required to protect you from the loss of those certificates through the mail service. For more information about replacing lost or stolen certificates or any fees that may be incurred for the replacement of a lost certificate, please contact Computershare directly at 800-438-6278.

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. Although the Plan permits sales to be made through batch orders and such sales have been made in the past, all sales of stock under the Plan are now made solely pursuant to market orders. As a result, any stock you direct Computershare to sell will be sold at the best available price. However, the price at which your order will be executed is not guaranteed, and the last-traded price for our stock prior to the execution of your order to sell your stock is not necessarily the price at which your order will be executed. Your 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 Stock will be executed over the New York Stock Exchange, 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 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-1099DIV) enclosed with your annual statement in the first quarter of the following year (January through March). These documents will be mailed to your home address 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 e-mail 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 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.

**Borrowing money using your Plan account**

If you have $2,000 or more of Walmart stock in your account, you may be eligible to borrow money from USBancorp using the stock in your Stock Purchase Plan account to secure a line of credit. This program may enable you to borrow the money you need rather than selling your Walmart stock.

The line of credit is repaid through monthly payments you must make to USBancorp out of your resources. For more information, call 800-771-2265 and follow the prompts.

Decisions on applications for a line of credit are the responsibility of USBancorp. Applicants may be subject to a credit check. Walmart assumes no liability for any negotiation or transaction made by the associate and USBancorp.

Neither Walmart nor any of its subsidiaries will be responsible for the repayment of the amount you may owe to the lender under such borrowing arrangement. If you fail to repay any loan secured by the shares of stock, the lender may sell some or all of those shares to repay the amounts of principal and interest and any other fees that you owe the lender regarding the loan.

**Naming a joint tenant for your Plan account**

If you wish, you can name a joint tenant for your Stock Purchase Plan account. However, you should keep in mind that a joint tenant on your account has equal rights to your account, including the ability to sell shares of stock, get account statements or receive information about your account. Your joint tenant also becomes the sole owner of the stock if you die. (A joint tenant is not the same as a beneficiary.) To designate a joint tenant or to change your joint tenant, you must contact Computershare to complete the paperwork that is legally required to make such a designation. There are strict legal requirements that must be followed to remove a joint tenant from your account; therefore, you should consider carefully the implication of listing a person as a joint tenant on your account.

**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 or at WalmartOne.com.

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 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 brokers’ 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

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 188.

24,815,930 Shares

WAL-MART STORES, INC.

Common Stock
($.10 par value per share)

WAL-MART STORES, INC.
2004 Associate Stock Purchase Plan
(formerly, the Wal-Mart Stores, Inc. Associate Stock Purchase Plan of 1996)

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 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 Stock Ownership; fees and risks later in this chapter.

The date of this Prospectus is July 15, 2014

Introduction and overview


The Plan was most recently approved by the stockholders of Wal-Mart Stores, Inc. (the “company”) on June 4, 2004. Up to 142,624,272 shares of the company’s common stock, par value $.10 per share (the “Stock”), were available for purchase under the Plan as of June 4, 2004. As of the date of this Prospectus, 24,815,930 shares of Stock remain available. Those shares have been registered with the United States Securities and Exchange Commission for offer and sale on Registration Statements on Form S-8 (Commission File Nos. 333-62965 and 333-109417). 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 purchase Stock by payroll deduction. In addition, if they make or have made purchases through such payroll deductions under the Plan, they may also purchase Stock by making voluntary contributions to the Plan out of their own funds. Under the Outstanding Performance Award Program, the company may reward associates for exceptional job performance by awarding shares of Stock to them.

The company believes 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 ("Committee"), consisting of members of the company’s Board of Directors, 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 the company’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 the company for any reason. At the date of this Prospectus, the members of the Committee were Mr. Michael T. Duke, the President and Chief Executive Officer of the company; Mr. Gregory B. Penner, a director of the company; and Mr. S. Robson Walton, the Chairman of the Board of Directors of the company. Mr. Walton is also a managing member of Walton Enterprises LLC, which, at the date of this Prospectus, owned in excess of 49 percent of the outstanding shares of the Stock. 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: determine when, to whom and in what types and amounts contributions should be made; authorize the company to make contributions to eligible associates in any number and to determine the terms and conditions applicable to each such contribution; set a minimum and maximum dollar, share or other limitation on the various contributions permitted under the Plan; determine whether an affiliate should become (or cease to be) a Participating Employer (as defined below); determine whether (and which) associates of non-U.S. Participating Employers should be eligible to participate in the Plan; make all determinations deemed necessary or advisable for the administration of the Plan; establish, amend and revoke rules and regulations for the administration of the Plan; and 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 in trust for the benefit of the participants.

Plan participation and eligibility

If you are eligible, you can become a participant in the Plan by enrolling online (where available) 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 sufficient age.

• 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. affiliate, you may participate only if you are an approved associate (listed by category or by individual).

• If you are an officer, including an officer subject to subsection 16(a) of the Securities Exchange Act of 1934, or otherwise subject to the company’s 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, 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 or at WalmartOne.com. 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 or at WalmartOne.com. 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. 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 Stock that you hold outside of the Plan to your Plan account by making arrangements directly with Computershare.

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 him 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 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 the shares (including any fractional shares) of Stock. The 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 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. There is no automatic lien or security interest on the shares of Stock held in your Plan account. However, if you pledge the Stock as collateral in connection with the Stock Secured Line of Credit Program maintained by US Bancorp, the lender will secure the loan that will yield net sales proceeds in an amount necessary to pay the amounts you owe the lender.

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. You may not direct the vote on any fractional shares of Stock held in your Plan account.
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 previous years' statements. 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, 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 the company remits your payroll deductions to Computershare for you, your payroll deductions (as well as the corresponding matching contributions) 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 for any or all full shares of Stock held in 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.
PROSPECTUS

You may request that Computershare sell all or a portion of the shares of Stock (including any fractional interests) held in 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](http://computershare.com/walmart).

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 the Stock held in Plan accounts to be made through batch orders and such sales have been made in the past, on and after the date of this Plan Prospectus, sales of the stock under the Plan will be made solely pursuant to market orders. As a result, any shares of the Stock you direct Computershare to sell will be sold at the 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 the Stock is not necessarily the price at which your order will be executed. Your 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 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 share 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 funds are typically converted one business day after the sale. The exchange rates displayed in newspapers, online and other publication are usually intra-bank rates and are not normally what a participant would receive. 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.

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 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 fractional shares) 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 (or a committee designated by the Board) 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 that have not yet been used to purchase Stock; (2) any shares (or fractional interests) of Stock in your Plan account; or (3) any dividends or distributions declared with respect to 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.

**STOCK PURCHASES UNDER THE STOCK PURCHASE PLAN**

You have no federal income tax consequences when you enroll in the Plan or when Stock is 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 contributions 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 Stock held in your Plan account. However, when you sell or otherwise dispose of your 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 the Stock.
Available information

To obtain additional information about the Plan or its administrators, please call Benefits Customer Service at 800-421-1362. You can also write to:

Benefits Customer Service
Wal-Mart Stores, Inc.
508 SW 8th Street
Bentonville, AR 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, RI 02940-3080

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, 2013;

• The company’s Quarterly Reports on Form 10-Q for the fiscal quarters ended April 30, 2013 and July 31, 2013;

• The company’s Current Reports on Form 8-K filed with the Commission on April 10, 2013 and June 12, 2013;

• The company’s definitive Proxy Statement for the 2013 Annual Shareholders’ Meeting, filed with the Commission on April 22, 2013; and

• The company’s Registration Statement on Form 8-A containing a description of company’s common stock, $0.10 par value per share.

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 this Prospectus.

These documents and the company’s latest Annual Report to Stockholders 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, AR 72716-0295

Or you may call Benefits Customer Service at 800-421-1362.
## The Walmart 401(k) Plan

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The Walmart 401(k) Plan

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<td>Enroll in or change your 401(k) contribution and your catch-up contribution</td>
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<td>• Request a rollover packet to make a rollover contribution</td>
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What you need to know about the Walmart 401(k) Plan

- Effective February 1, 2015, associates are eligible to make their own contributions to the Plan as soon as administratively feasible after their date of hire is entered into the payroll system. Prior to February 1, 2015, associates are eligible to contribute on the first day of the calendar month after their first anniversary of employment if credited with at least 1,000 hours during that first year. You can contribute from 1% to 50% of each paycheck to the Plan.

- Effective February 1, 2015, associates will begin receiving matching contributions on the first day of the calendar month following their first anniversary of employment with Walmart if 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.)

- 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 account, including your Company Match Account.

- If you do not elect how your current contributions to the Plan will be invested, they will be automatically invested in the Plan’s default investment alternative, 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.

This is a summary of benefits offered under the Plan as of October 1, 2014. 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; and
• Associates represented by a collective bargaining representative after Walmart has negotiated in good faith to impasse with the representative on the question of benefits.

For purposes of this Summary Plan Description, all participating subsidiaries are referred to as “Walmart.”

WHEN PARTICIPATION FOR SALARY DEFERRAL PURPOSES BEGINS

Effective February 1, 2015, 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. If you were hired before February 1, 2015, you will be entitled to begin making contributions to the Plan immediately on February 1, 2015. (Note, however, that you will not be entitled to receive matching contributions to the Plan until you satisfy the matching contribution eligibility requirements below.)

Prior to February 1, 2015, eligible associates can begin participating in the Plan on the first day of the calendar month following their first anniversary of employment with Walmart if they are credited with at least 1,000 hours of service during the first year. For example, if your date of hire was December 15, 2013 and you are credited with 1,095 hours by December 15, 2014 (your first anniversary), then you can begin making your own contributions to the Plan on January 1, 2015.

To begin making contributions to the Plan, you can enroll on WalmartOne.com, the WIRE, or through benefits.ml.com (see Enrolling in the Plan later in this summary).

WHEN PARTICIPATION FOR MATCHING CONTRIBUTION PURPOSES 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, 2013 and you are credited with 1,095 hours by December 15, 2014 (your first anniversary), then you will be eligible to receive matching contributions on January 1, 2015 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, you will be eligible to receive matching contributions on your contributions on the February 1 after the first Plan year (February 1–January 31) in which you are credited with at least 1,000 hours of service. For example, if your date of hire is December 15, 2013 and you are credited with only 595 hours by December 15, 2014 (your first anniversary), but you work 1095 hours during the February 1, 2014–January 31, 2015 plan year, you will be eligible to receive matching contributions on February 1, 2015 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, hours of service are credited as follows:

• All eligible hours, including overtime hours, worked by hourly associates for Walmart or any subsidiary are counted toward the 1,000-hour requirement.
• Paid vacation, illness protection time and personal time are also counted.
• Hours are credited for the Plan year worked. Before February 1, 2015, hours for a payroll period that overlaps years are prorated between the two years. On and after February 1, 2015, actual hours worked for each day are counted.

For salaried associates and truck drivers, hours of service 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 became a Walmart associate as the result of Walmart’s 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 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 Benefits Customer Service at 800-421-1362 for more details.

Enrolling in the Plan

Shortly before you become eligible for participation (or, effective February 1, 2015, 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 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.

When making elections regarding your contributions to the Plan, keep in mind that you will not be eligible to receive matching contributions on your contributions until you satisfy the eligibility requirements for matching contributions, as explained above. 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. You will always be 100% vested in Your 401(k) Account and the Company Match Account.

To begin making contributions to the Plan, you can enroll online at WalmartOne.com, the WIRE, or benefits.ml.com or by calling 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 amount 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 account among the Plan’s investment options. The Plan’s investment funds and procedures are described in the enrollment packet.

After you enroll, a confirmation statement will be mailed to your home address, or you will receive an email notification when the confirmation is available if you have chosen electronic delivery of Plan documents, so that you can see whether your enrollment information is correct. It will show the percentage of your pay that you have chosen to contribute from each check and the investment fund(s) you have elected.

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 above).

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. 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.

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:

- **Your 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; and
• Your rollover contribution will be placed in your 401(k) Rollover Account and will be 100% vested.

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 choose to contribute from 1% up to 50% (in whole percentages) 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 2014, the limit is $17,500. 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 2014, this limit is $260,000.

Your 401(k) contributions to the Plan are deducted from your pay before federal income taxes are withheld. This means that you don’t pay federal income taxes on amounts you pay to the Plan. Earnings on these contributions continue to accumulate tax-free and are not taxed until they are 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. Payouts 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 an adjusted gross income (AGI) of $60,000 or less (for 2014) or a single taxpayer with $30,000 or less (for 2014) in AGI 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.

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PROFIT SHARING AND 401(k) ACCOUNT DIFFERENCES

2015 Associate Benefits Book | Questions? Log on to WalmartOne.com or the WIRE, or call Benefits Customer Service at 800-421-1362
HOW YOUR 401(K) CONTRIBUTION IS DETERMINED
The percentage of pay you elect to contribute to the Plan will be applied to the following pay:

- Regular salary or wages, including bonuses and any pretax dollars you use for your 401(k) contributions or to purchase benefits available under Walmart’s Associates’ Health and Welfare Plan, unless paid more than 2½ months after your termination of employment or after the end of the Plan year in which your termination occurs;
- Overtime, ill ness protection, vacation, holiday, personal, bereavement, jury duty and premium pay;
- Most incentive plan payments;
- Holiday and fire brigade bonuses;
- Special recognition awards, such as the Outstanding Performance Award; and
- 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.

Your contribution will not be withheld from:

- The 15% Walmart match on the Associate Stock Purchase Plan;
- Reimbursement for expenses like relocation;
- 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 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 2014, your catch-up contributions may be any amount up to the lesser of $5,500 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 $17,500 in the 2014 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 $5,500 during the 2014 calendar year. If you are interested in making catch-up contributions, you can enroll online at WalmartOne.com, the WIRE 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 $17,500 for the 2014 calendar year. (Your catch-up contributions do not count toward this limit.) 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, the excess must be included in your income for that year and will be taxed. In addition, you may be taxed a second time when the excess amount is later paid to you (after you terminate employment). For this reason, you may wish to request that the excess be returned to you. If you wish to request that the excess amount be returned to you, you must contact Benefits Customer Service 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 miss 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 Benefits Customer Service 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 first 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 in which you make a deferral and will continue 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 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 the Uniformed Services Employment and Reemployment Rights Act of 1994 (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 Benefits Customer Service 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:

<table>
<thead>
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<th>Years of Service</th>
<th>Vested percentage</th>
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<tr>
<td>Less than two</td>
<td>0%</td>
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<tr>
<td>Two</td>
<td>20%</td>
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<td>Three</td>
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<td>Five</td>
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<tr>
<td>Six or more</td>
<td>100%</td>
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*Applies to participants actively employed on or after January 31, 2008.

NOTE: If you terminated employment before January 31, 2008, 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), death or total and permanent disability, 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.

To be considered for a disability payout, contact Benefits Customer Service at 800-421-1362 to find out what information is required from the Social Security Administration to provide proof that you were declared disabled while still employed with Walmart.

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 accounts

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 Retirement Plans 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 and money market funds, as a participant gets closer to retirement. “myRetirement Funds” is a term developed by Walmart for describing its funds specific to the Plan.

- 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 choices. 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, profit-sharing assets, as a whole, are significantly invested in Walmart stock. 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 or, 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, the Retirement Plans 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 funds 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/eb sab/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 confirmation notices. 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 company, 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 account and carefully consider how you choose to invest your Accounts in the Plan. 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 part 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 Retirement Plans Committee of the total votes cast. The Retirement Plans 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 Retirement Plans Committee will vote those shares at its discretion. If neither you nor the Retirement Plans 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 Walmart 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 Retirement Plans 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 Retirement Plans Committee determines that a situation has potential for undue influence by the Company with respect to your rights as shareholder (through your Plan Account), the Retirement Plans 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 Walmart 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 will also be reinvested in Walmart stock, except as noted below.

If you are an active participant 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. Also, if you are a terminated participant who had more than six years of service when
you terminated and you continue to maintain your balance 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. 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, Walmart 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.

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 of some or all of your accounts while you’re still working:

- In the case of a financial hardship (as defined by the IRS); and
- After you attain age 59½.

It’s 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.

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, effective January 1, 2014, 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, effective January 1, 2014, 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, effective January 1, 2014, 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 at age 59½ 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

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 funds, 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 account. You can find information on fees in the Annual Participant Fee Disclosure Notice and online at benefits.ml.com.
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.

SPECIAL PROVISIONS FOR FORMER PARTICIPANTS IN THE WAL-MART.COM USA, LLC 401(K) PLAN AND THE KOSMIX CORP. 401(K) PLAN

If you were a former participant in the Wal-Mart.com USA, LLC 401(k) Plan, your account was transferred to the Walmart 401(k) Plan on or about December 1, 2008. If you were a former participant in the Kosmix Corp. 401(k) Plan, your account was transferred to the Walmart 401(k) Plan on or about September 17, 2012. Any rollover contributions that were transferred to the Walmart 401(k) Plan from either previous plan may be withdrawn at any time, even if you are still working for Walmart or its subsidiaries.

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 or on the WIRE. 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 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 accounts in the Plan — your 401(k) accounts and your Profit Sharing 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:

- Living spouse or partner; 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.

Again, it is very important for you to keep your beneficiary information up to date. Beneficiary choices should be made at WalmartOne.com or on the WIRE.

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:
  - live together in an ongoing, exclusive and committed relationship similar to marriage and have been for at least twelve months and intend to continue sharing a household 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 may need to take immediate action to ensure that your beneficiary under the Plan reflects your current intent. Beneficiary choices should be made at WalmartOne.com or on the WIRE.

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 the Participant’s 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 20, 2015, you may elect your payout on or after August 19, 2015.

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 or after October 31, 2003.

If you leave Walmart and your account is eligible for an automatic payout, and you do not consent to payout, your 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 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 obtain 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 (both profit-sharing and 401(k) accounts) is or becomes $1,000 or less. 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 August 19, 2015, your payout will automatically be made to you as soon as possible after October 31, 2015; or
- If you are over age 65 (or, effective February 1, 2015, 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 65 (or, effective February 1, 2015, age 70), unless you consent to an earlier payout as described above. For instance, if you turn age 70 in July 2015 and your account is eligible for automatic payout and you do not consent to payout on August 19, 2015, your payout will automatically be made to you as soon as possible after October 31, 2015; or
If your total vested Plan balance is more than $1,000 and you are under age 65 (or, effective February 1, 2015, 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 you wish, you can delay your payout until any date up to age 65 (or, effective February 1, 2015, 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 Individual Retirement Account (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 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 distribution 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 65 (or, effective February 1, 2015, 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 65 (or, effective February 1, 2015, 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 after your participation in the Plan began and are later rehired by Walmart or a participating subsidiary, you will automatically be eligible to participate in the Plan on your rehire date. Similarly, if you leave Walmart and its subsidiaries after you have met the 1,000-hour requirement but before your actual participation date, you will become a participant on the later of the date you would have initially become a participant or your rehire 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 become a participant in the Plan. (Note that any eligible associate rehired on or after February 1, 2015 will be immediately eligible to make his or her own contributions to the Plan on the date of rehire.)

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 less than 500 hours of service. If you are absent from work due to an FMLA leave and have worked less than 500 hours in the Plan year, you will be credited with enough hours to bring you up to 500 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 a participating 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 participating 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 your nonvested Company Funded Profit Sharing Account 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 the Kosmix Corp. 401(k) Plan. 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 check 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 Plan distribution), 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 you roll over to a Roth IRA.)
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 not 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. If the stock has increased in value since it was purchased by the Plan, you will not be taxed on this increased value, called “net unrealized appreciation,” until you actually sell the stock. You can elect, however, to be taxed on this increase in value at the time of your payout. These special tax rules apply only in certain specific situations and may not be available for distributions taken while you are still working. You should consult your tax advisor to see if they apply to your payout.

You should also keep in mind that if you are eligible to 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, Walmart will be entitled to deduct dividends paid on shares subject to this election.

TAXATION OF PAYOUTS TO BENEFICIARIES

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 has 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.

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 Retirement Plans Committee or its delegate at:

Wal-Mart Stores, Inc.
Attn: Benefits Customer Service
508 SW 8th Street
Bentonville, AR 72716-0295

For questions about filing a claim, contact Benefits Customer Service 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 Benefits Customer Service receives your claim. The Retirement Plans Committee 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 Retirement Plans Committee or its delegate, you can request a review of the decision by the Retirement Plans Committee. The Retirement Plans Committee 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 Retirement Plans Committee at:

Wal-Mart Stores, Inc.
Attn: Benefits Customer Service
508 SW 8th Street
Bentonville, AR 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 Retirement Plans Committee 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 Retirement Plans Committee will promptly conduct the review. Written notice of the Retirement Plans Committee’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 Committee’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 Committee on appeal (or, if earlier, the date the Committee 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 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: Benefits Customer Service
508 SW 8th Street
Bentonville, AR 72716-0295
800-421-1362

As the 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 Retirement Plans Committee or the trustee of the Trust. ERISA is the federal law that imposes certain responsibilities on Walmart, the Retirement Plans Committee and the trustee with respect to our retirement benefits.

Subsidiaries of Walmart are permitted to participate in the Plan. You may obtain a list of subsidiaries currently participating in the Plan by contacting Benefits Customer Service.

PLAN SPONSOR’S EMPLOYER IDENTIFICATION NUMBER
71-0415188

NAMED FIDUCIARY
Wal-Mart Stores, Inc.
Retirement Plans Committee
508 SW 8th Street
Bentonville, AR 72716-0295

As the named fiduciary of the Plan, the Retirement Plans Committee is generally responsible for the management, interpretation and administration of the Plan, including but not limited to eligibility determinations, investment policies, benefit payments and other functions required, necessary or advisable to carry out the purpose of the Plan.

PLAN TRUSTEE
Northern Trust Company
50 S. LaSalle Street
Chicago, IL 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, DE 19801

Service of legal process may also be made on the 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 the Retirement Plans Committee with the prior written consent of the Executive Committee of Walmart’s Board of Directors. Neither the Plan nor the benefits described in this summary may be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by a management associate of Walmart or a participating subsidiary, by any member of the Retirement Plans Committee or by Merrill Lynch.

You may obtain a copy of the formal Plan document by writing to:

Wal-Mart Stores, Inc.
Attn: Benefits Customer Service
508 SW 8th Street
Bentonville, AR 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 Retirement Plans Committee 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 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 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 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: Benefits Customer Service
  508 SW 8th Street
  Bentonville, AR 72716-0295

- 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 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 Plan Administrator or the Retirement Plans Committee 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 Plan Administrator or the
Retirement Plans Committee. 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 Plan Administrator or the Retirement Plans Committee. 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.
Claims and appeals

WHERE CAN I FIND?

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- Company-paid life insurance, optional associate and dependent life insurance, business travel accident insurance and AD&D claims process: 221
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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

<table>
<thead>
<tr>
<th>Find What You Need</th>
<th>How to Contact</th>
</tr>
</thead>
</table>
| Designate an authorized representative to submit claims or appeals on your behalf | Call Benefits Customer Service at 800-421-1362  
Call BlueAdvantage Administrators of Arkansas at 866-823-3790  
Call Aetna at 855-548-2387  
Call UnitedHealthcare National Appeals Service Center at 888-285-9255  
Call Express Scripts at 800-887-6194  
Call VSP at 866-240-8390 |
| Appeal a decision on eligibility for coverage under the benefit plans | Write to:  
Walmart Benefits Administration  
Attn: Internal Appeals  
Or for COBRA appeals, write to: CONEXIS  
Addresses listed later in this chapter. |
| Submit a claim for benefits | Submit claims to the Plan’s Third Party Administrators as shown later in this chapter. |
| Appeal the denial of a claim | Submit appeals for:  
- Medical and non-Mayo transplant claims to the Plan’s Third Party Administrators as shown later in this chapter  
- Centers of Excellence for heart, spine, and knee and hip replacement surgeries and Mayo transplant claims to Health Design Plus  
- Centers of Excellence for cancer care to HealthSCOPE Benefits  
- Dental to Delta Dental  
- Pharmacy to Express Scripts  
- Vision to VSP  
- Life insurance, business travel accident insurance and AD&D to Prudential  
- Short-term disability for New York, New Jersey or Hawaii to Liberty  
- Short-term disability for all other states to Sedgwick  
- Long-term disability to Liberty  
- Critical illness and accident insurance to Allstate Benefits  
Submit requests for voluntary review for denied appeals (including COBRA) or dental benefits to: Walmart Benefits Administration, Attn: Voluntary Appeals.  
Submit external appeals for:  
- Medical, pharmacy, Centers of Excellence and transplants to Walmart Benefits Administration, Attn: External Appeals  
All addresses are listed later in this chapter. |
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, Centers of Excellence or transplant 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.
• Decisions regarding enrollment, eligibility status and claims for the following plans are not eligible for external review, but will be eligible for voluntary review under the Plan: dental, vision, life insurance, AD&D, business travel accident, critical illness and accident insurance. In addition, for the medical plan, appeals denied for administrative (nonmedical) 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 or dental claims, 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 will not be counted against the 180 days you have to file a lawsuit.

Benefits may not be assigned

Except as specifically provided in the Plan document or the 2015 Associate Benefits Book, or where required under state Medicaid law or in a Qualified Medical Child Support Order, you may not transfer or assign any benefit or right under the Plan. All such assignments will be void. This non-assignment provision does not apply to assignments to a non-network physician or health care provider who accepts assignments.
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 Benefits Administration
Attn: Internal Appeals
508 SW 8th Street
Bentonville, AR 72716-3500

Eligibility decisions regarding the transplant 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:

CONEXIS (COBRA Appeals)
P.O. Box 226591
Dallas, TX 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, transplant, dental and vision claims process

This section describes the claims process that will be used for the following benefits only:

- Medical, pharmacy, Centers of Excellence and transplant benefits except for HMO; see HMO plan claims and appeals procedures later in this chapter;
- Dental benefits if you are covered by Delta Dental (PPO or Premier);
- Vision benefits if you are covered by 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 (including the administrator of the Centers of Excellence program) requires you or your provider to preauthorize services, and your request for prior authorization is denied, that decision is subject to appeal.

Your initial claim will be determined by Plan Administrators as follows:

- For medical and transplant claims not required to be performed at Mayo and for services performed at a Centers of Excellence facility but not covered under the Centers of Excellence program: BlueAdvantage Administrators of Arkansas, Aetna or UnitedHealthcare, depending on the Third Party Administrator that administers your claims;
- For Centers of Excellence claims for heart, spine, and hip and knee replacement surgeries: Health Design Plus;
- For Centers of Excellence claims for cancer care: HealthSCOPE Benefits;
- For transplant benefits to be performed at Mayo: Health Design Plus. For transplant benefits performed elsewhere, see the special transplant claims procedures below;
- For non-transplant benefits (including at Mayo): Blue Advantage Administrators of Arkansas, Aetna, or UnitedHealthcare, depending on the Third Party Administrator that administers your claims;
- For pharmacy claims: Express Scripts;
- For dental claims: Delta Dental; and
- For vision claims: VSP.
The time period in which your claim will be determined depends on the type of claim. The Plan requires prior authorization for Centers of Excellence 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 below shows deadlines for making claims determinations for these types of claims.

<table>
<thead>
<tr>
<th>CLAIMS PROCESS AND TIMING</th>
<th>Urgent claims</th>
<th>Pre-service claims</th>
<th>Post-service claims</th>
<th>Concurrent care claims</th>
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<tbody>
<tr>
<td><strong>Urgent claims</strong></td>
<td>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.</td>
<td>If your pre-service claim is improperly filed, you will be sent notification within five days of receipt of the claim.</td>
<td>A notice will be sent within a reasonable time period, but not longer than 30 days from receipt of the claim.</td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>If your pre-service 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.</td>
<td>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.</td>
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<tr>
<td>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.</td>
<td>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.</td>
<td>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.</td>
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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, transplant and vision benefits, the denial also will 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.

**Internal appeal process**

**APPEALING A MEDICAL, TRANSPLANT, 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, transplant and dental claims) or 180 days (for pharmacy 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 allows two levels of review. The second appeal must be submitted within 60 days of the date of the first appeal denial.

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, and for services performed at a Centers of Excellence facility but not covered under the Centers of Excellence program**

Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, KY 40512
855-548-2387

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, AR 72203-1460
866-823-3790

UnitedHealthcare National Appeals Service Center
P.O. Box 30575
Salt Lake City, UT 84130-0575
888-285-9255
centers of excellence for heart, spine, and hip and knee replacement surgeries and mayo transplant appeals:
health design plus

coe: walmart
attn: appeals coordinator
1755 georgetown
hudson, oh 44236

centers of excellence for cancer care appeals:
healthscope benefits

healthscope benefits, inc.
attn: appeals coordinator
27 corporate hill drive
little rock, ar 72205

pharmacy appeals
express scripts
8111 royal ridge parkway
irving, tx 75063
800-887-6194

dental appeals
delta dental of arkansas
appeals committee
p.o. box 15965
little rock, ar 72231-5965

vision appeals
vsp
member appeals
3333 quality drive
rancho cordova, ca 95670

note: there is a special claims and appeals process for certain transplant 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 below, depending on the type of claim:

<table>
<thead>
<tr>
<th>appeal process and timing</th>
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<tr>
<td>urgent claims</td>
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<tr>
<td>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).</td>
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<tr>
<td>pre-service claims</td>
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<tr>
<td>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).</td>
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<tr>
<td>post-service claims</td>
</tr>
<tr>
<td>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).</td>
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</table>

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;
• an explanation of this rule (or a statement that it is available upon request), if your denial is based on a medical necessity or similar limitation;
• 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, Centers of Excellence and transplant 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);
- 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;
- 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 request to receive a transplant at a facility other than Mayo if there is significant risk that travel to Mayo could result in death. This request would be considered a prior authorization claim. 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 claim with the Plan.

These claims will be determined by an Independent Review Panel appointed by the Plan’s Administrative Committee, which may approve the transplant for a different acceptable facility.

The Independent Review Panel will not include any employee of Walmart, Mayo Clinic or a Third Party Administrator of the Plan. The Independent Review Panel 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 Benefits Administration
Attn: Internal Appeals
508 SW 8th Street
Bentonville, AR 72716-3500
800-421-1362

The claim must be received by the Plan within 120 calendar days of the initial denial of the transplant by Mayo Clinic. If the claim is urgent, the Independent Review Panel will make its determination within 72 hours after receipt of the claim (otherwise, the Independent Review Panel will make its determination with 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 time may be extended 15 days. 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 Panel. The Independent Review Panel 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.

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 outlined earlier in this chapter.

REQUESTING A VOLUNTARY REVIEW OF YOUR DENIED APPEAL FOR ENROLLMENT OR ELIGIBILITY STATUS DETERMINATIONS (INCLUDING COBRA) OR DENTAL BENEFITS

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, eligibility status or dental benefits to:

Walmart Benefits Administration
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, AR 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 APPEAL FOR ADMINISTRATIVE REASONS

You may request a voluntary review of the decision on your appeal 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 Benefits Administration
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, AR 72716-3500

External appeal process for medical, pharmacy, Centers of Excellence or transplant benefits

If your internal appeal for medical, pharmacy, Centers of Excellence or transplant benefits under the Plan is denied, 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 Benefits Administration
Attn: External Appeals
508 SW 8th Street
Bentonville, AR 72716-3500
800-421-1362

External pharmacy appeals should be sent to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

Information regarding rights related to medical, pharmacy, Centers of Excellence, transplant, dental and vision 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 benefits that are not covered by the Plan, for a participant who is not covered by the Plan, when other insurance is primary or other similar circumstances, the Plan has the right to recover the overpayment. The Plan 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 you and/or your dependents. Failure to comply with this request will entitle the Plan to withhold benefits due you and/or an outside collection agency if internal collection efforts are unsuccessful. The Plan may also bring a lawsuit to enforce its rights to recover overpayments.

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, as well as providers. The Plan may reduce or deny benefits for otherwise covered services for all current and/or future claims with the provider and/or you and your dependents 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, 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’s Administrative Committee 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’s Administrative Committee.

Whether a covered person has a “total and permanent physical or mental disability” will be determined based on criteria developed and applied by the Administrative Committee 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 Administrative Committee 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 Committee.

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 Benefits Administration
Attn: Subrogation Review Committee
508 SW 8th Street
Bentonville, AR 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 FOR BENEFITS 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 Benefits Administration  
Attn: Internal Appeals Committee  
508 SW 8th Street  
Bentonville, AR 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 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.
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 41448
Jacksonville, FL 32203-1488

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 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.

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 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.

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.

APPELLING 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, all documents that are 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 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 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 502(a). You cannot take any legal action until you have exhausted the Plan’s claims review procedure described above.

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, PA 19176

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.

APPELLING 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 above 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 above, the claim shall be deemed denied on appeal.

**VOLUNTARY SECOND APPEAL**

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 all types of disability coverage claims**

This section describes the claim process for the short-term disability plan, the short-term disability plus program, the long-term disability plan and the truck driver long-term disability plan.

Short-term disability and short-term disability plus claims for all states except California, Hawaii, New Jersey, New York and Rhode Island should be submitted to:

**Sedgwick Claims Management Services, Inc.**
P.O. Box 14028
Lexington, KY 40512

Short-term disability and Short-Term Disability Plus claims for associates who work in Hawaii, New Jersey and New York only, and all long-term disability and truck driver long-term disability claims should be submitted to:

**Liberty Group — Charlotte WM**
P.O. Box 7216
London, KY 40742-7216

Short-term disability claims 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 chapter.

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.

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;
• 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 send a written appeal to Sedgwick or Liberty, respectively, at the address shown later in this chapter 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, respectively, 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 appeals 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.

Short-term disability appeals should be sent to:
Disability Claim Appeal Unit
Sedgwick Claims Management Services, Inc.
P.O. Box 14028
Lexington, KY 40512

Long-term disability and truck driver long-term disability appeals should be sent to:
Group Benefits Claim Appeal Unit
Liberty
Group — Charlotte WM
P.O. Box 7216
London, KY 40742-7216

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 Liberty or by calling Liberty at 800-492-5678.

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 chapter.

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 Benefits Customer Service or file a claim or appeal by writing to the following address:

Walmart Benefits Administration
Attn: Internal Appeals
508 SW 8th Street
Bentonville, AR 72716-3500

Any claims or appeals will be determined under the time frames and requirements in the medical, pharmacy, Centers of Excellence, transplant, dental and vision claims sections, respectively, in this chapter.
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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.

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<td>Contact the Plan Administrator</td>
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<td>Write to: Walmart The Administrative Committee Associates’ Health and Welfare Plan 508 SW 8th Street Bentonville, AR 72716-3500 Call 479-621-2058</td>
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<tr>
<td>Answers to questions about the HIPAA Privacy Notice</td>
<td>Email your question to <a href="mailto:privacy@wal-mart.com">privacy@wal-mart.com</a></td>
<td>Call Benefits Customer Service at 800-421-1362</td>
</tr>
<tr>
<td>Answers to questions about Medicare Part D</td>
<td>Visit medicare.gov for personalized help</td>
<td>800-MEDICARE (800-633-4227) TTY users should call 877-486-2048</td>
</tr>
<tr>
<td>Answers to your questions about Medicaid/CHIP</td>
<td>Visit insurekidsnow.gov</td>
<td>877-KIDSNOW (877-543-7669)</td>
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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


Plan Year: January 1 through December 31

Plan Number: 501

Type of Plan: Welfare, including medical, dental, vision, short-term disability, Short-Term Disability Plus, 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 Committees (or their 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 Committees (or their 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 Appeals Committee, 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, AR 72716-0295

Plan Administrator/Named Fiduciary: The Administrative Committee
Associates’ Health and Welfare Plan
508 SW 8th Street
Bentonville, AR 72716-3500
479-621-2058

Agent for Service of Legal Process: Corporation Trust Company
1209 Orange Street Corporation Trust Center
Wilmington, DE 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: JP Morgan
4 New York Plaza, 15th Floor
New York, NY 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, by a management associate of the company, or by any member of the applicable committees of the Plan. Only written statements by the applicable committee of the Plan 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 are entitled to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. 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 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/ebisa.
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 notice applies 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 through a Health Maintenance Organization (HMO). The HMO in that case 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 personal 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 Plan Sponsor. The Plans may use or disclose your PHI to Walmart, the Plan Sponsor. The Plan 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 Plan 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 family member (including your spouse/partner) or friend who is involved in your medical care or payment for your care, provided that you agree to this disclosure, or we give you an opportunity to object to this disclosure.
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 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 disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans), and if required by the appropriate military command authorities.

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:
   - (a) for the institution to provide health care services to you;
   - (b) for the safety and security of the institution; and/or (c) 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.** 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. Military and Veterans’ Activities. If you are an armed forces personnel, a Plan may disclose your PHI for the purpose of assuring the proper execution of a military mission only if the proper military authority has published in the Federal Register certain information specified in the HIPAA regulations. A Plan may also disclose to the Department of Veterans Affairs (DVA) information pertaining to your eligibility for DVA benefits.

17. 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

Any other uses or disclosures of your PHI that are not covered by this notice or the laws that apply to us, specifically including 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 will be made only with written authorization. Though it is permissible in certain situations to obtain an authorization that covers more than one type of disclosure or use of PHI, any authorization obtained by the Plan will be for a specified and singular use or disclosure. The Plan will not condition your authorization on any condition including eligibility to participate in the Plan or benefits under the Plan. 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.

Unless you provide the Plan with the necessary authorization it will not disclose to a family member, close personal friend, or other person involved with your health care information regarding your health care, payment for health care, and information to assist such person learn of your location, general condition, or death. Nor will the Plan disclose information upon your death to persons who were involved in your care prior to your death unless you provided such person with the necessary authorization, or to a personal representative. These types of uses and disclosures of your PHI are otherwise permitted under the HIPAA regulations without your authorization.

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. Additional information regarding state privacy laws may be located on the WIRE.

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. Additionally, you have the right to request that we limit our disclosure of your PHI to individuals involved in your care or the payment for your care, such as family members and friends. 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 below 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:

**Benefits Customer Service**
Attn: HIPAA Compliance Team
508 SW 8th Street
Mail stop #3500
Bentonville, AR 72716-3500

Email your questions to: privacy@wal-mart.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 with 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 assistance 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.

**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
- HRA
- HMO

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 an HRA plan or an HMO, 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 either of the HRA plans or the HSA Plan or an HMO. 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.

If you are enrolled in the HSA Plan, you may want to consider switching to a Medicare prescription drug coverage 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, 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 consecutive 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.

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 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 HRAs, the HSA Plan or an HMO plan 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 a Walmart medical plan, 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.

If you enroll in a Medicare Part D plan and decide within 60 days to switch back to a Walmart plan, 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 Benefits Customer Service 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. You can also get more information about Medicare prescription drug plans from these sources:

- Visit medicare.gov for personalized help.
- Call your state health insurance assistance program (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).

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 that you are not required to pay a higher premium amount.

Name of Sender: Associates’ Health and Welfare Plan

Contact: Associates’ Health and Welfare Plan

508 SW 8th Street

Bentonville, AR 72716-3500

800-421-1362

Medicaid and the Children’s Health Insurance Program (CHIP) offer free or low-cost health coverage to children and families

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from Wal-Mart Stores, Inc., your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can 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, you can contact your state Medicaid or CHIP office, call 877-KIDSNOW, or visit insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for the Plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, the Plan is required to permit you and your dependents to enroll in the Plan — as long as you and your dependents are eligible, but not already enrolled in the employer’s Plan. 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, you can contact the Department of Labor electronically at askedsa.dol.gov or by calling toll-free 866-444-EBSA (866-444-3272).
If you live in one of the following states, you may be eligible for assistance paying your health plan premiums. The following list of states is current as of July 31, 2014. For current contact information, go to your state’s website. You should contact your state for further information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website</th>
<th>Phone (in state)</th>
<th>Phone (out of state)</th>
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<tbody>
<tr>
<td>ALABAMA — MEDICAID</td>
<td>Website: <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a></td>
<td>855-692-5447</td>
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<tr>
<td>ALASKA — MEDICAID</td>
<td>Website: <a href="http://health.hss.state.ak.us/dpa/programs/">http://health.hss.state.ak.us/dpa/programs/p.png</a></td>
<td>888-318-8890</td>
<td>907-269-6529</td>
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<tr>
<td>COLORADO — MEDICAID</td>
<td>Website: <a href="http://www.colorado.gov">http://www.colorado.gov</a></td>
<td>800-866-3513</td>
<td>800-221-3943</td>
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<tr>
<td>FLORIDA — MEDICAID</td>
<td>Website: <a href="https://www.flmedicaidtplrecovery.com/">https://www.flmedicaidtplrecovery.com/</a></td>
<td>877-357-3268</td>
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<td>IDAHO — MEDICAID</td>
<td>Medicaid Website: <a href="http://www.healthandwelfare.idaho.gov">www.healthandwelfare.idaho.gov</a>/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx</td>
<td>800-926-2588</td>
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<td>INDIANA — MEDICAID</td>
<td>Website: <a href="http://www.in.gov/fssa">http://www.in.gov/fssa</a></td>
<td>800-889-9949</td>
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<td>IOWA — MEDICAID</td>
<td>Website: <a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a></td>
<td>888-346-9562</td>
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<td>KANSAS — MEDICAID</td>
<td>Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a></td>
<td>800-792-4884</td>
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<td>KENTUCKY — MEDICAID</td>
<td>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
<td>800-635-2570</td>
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<tr>
<td>LOUISIANA — MEDICAID</td>
<td>Website: <a href="http://www.lahipp.dhh.louisiana.gov">http://www.lahipp.dhh.louisiana.gov</a></td>
<td>888-695-2447</td>
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<tr>
<td>MASSACHUSETTS — MEDICAID AND CHIP</td>
<td>Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a></td>
<td>800-462-1120</td>
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<td>MINNESOTA — MEDICAID</td>
<td>Website: <a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a></td>
<td>800-657-3629</td>
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<td>MISSOURI — MEDICAID</td>
<td>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
<td>573-751-2005</td>
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<td>MONTANA — MEDICAID</td>
<td>Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a></td>
<td>800-694-3084</td>
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<tr>
<td>NEBRASKA — MEDICAID</td>
<td>Website: <a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a></td>
<td>855-632-7633</td>
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<tr>
<td>NEVADA — MEDICAID</td>
<td>Website: <a href="http://dwss.nv.gov">http://dwss.nv.gov</a></td>
<td>800-992-0900</td>
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<tr>
<td>NEW JERSEY — MEDICAID AND CHIP</td>
<td>Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
<td>609-631-2392 CHIP Phone: 800-701-0710</td>
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<tr>
<td>State</td>
<td>Medicaid Website</td>
<td>Medicaid Phone</td>
<td>CHIP Website</td>
<td>CHIP Phone</td>
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<td>NORTH CAROLINA — MEDICAID</td>
<td>Website: <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a></td>
<td>Phone: 919-855-4100</td>
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<td>NORTH DAKOTA — MEDICAID</td>
<td>Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a></td>
<td>Phone: 800-755-2604</td>
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<tr>
<td>PENNSYLVANIA — MEDICAID</td>
<td>Website: <a href="http://www.dpw.state.pa.us/hipp">http://www.dpw.state.pa.us/hipp</a></td>
<td>Phone: 800-692-7462</td>
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<td>RHODE ISLAND — MEDICAID</td>
<td>Website: <a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a></td>
<td>Phone: 401-462-5300</td>
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<td>SOUTH CAROLINA — MEDICAID</td>
<td>Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a></td>
<td>Phone: 888-549-0820</td>
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<tr>
<td>SOUTH DAKOTA — MEDICAID</td>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
<td>Phone: 888-828-0059</td>
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<td>TEXAS — MEDICAID</td>
<td>Website: <a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a></td>
<td>Phone: 800-440-0493</td>
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<tr>
<td>VERMONT — MEDICAID</td>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
<td>Phone: 800-250-8427</td>
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<tr>
<td>VIRGINIA — MEDICAID AND CHIP</td>
<td>Medicaid Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>Medicaid Phone: 800-432-5924</td>
<td>CHIP Website: <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
<td>CHIP Phone: 855-242-8282</td>
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<td>WASHINGTON — MEDICAID</td>
<td>Website: [<a href="http://hrsa.dshs.wa.gov/medicaid/premium">http://hrsa.dshs.wa.gov/medicaid/premium</a> pymt/pages/index.aspx](<a href="http://hrsa.dshs.wa.gov/medicaid/premium">http://hrsa.dshs.wa.gov/medicaid/premium</a> pymt/pages/index.aspx)</td>
<td>Phone: 800-562-3022_ext.15473</td>
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<tr>
<td>WEST VIRGINIA — MEDICAID</td>
<td>Website: <a href="http://www.dhhr.wv.gov/bms/">www.dhhr.wv.gov/bms/</a></td>
<td>Phone: 877-598-5820, HMS Third Party Liability</td>
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<tr>
<td>WISCONSIN — MEDICAID</td>
<td>Website: <a href="http://www.badgercareplus.org/pubs/p-10095.htm">http://www.badgercareplus.org/pubs/p-10095.htm</a></td>
<td>Phone: 800-362-3002</td>
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</table>

To see if any more states have added a premium assistance program since July 31, 2014 or for more information on special enrollment rights, you can contact either:

**U.S. Department of Labor**
Employee Benefits Security Administration  
[dol.gov/ebsa](http://dol.gov/ebsa)  
866-444-EBSA (3272)

**U.S. Department of Health and Human Services**
Centers for Medicare & Medicaid Services  
[cms.hhs.gov](http://cms.hhs.gov)  
877-267-2323, x 61565
Glossary of terms
**Glossary of terms**

**Actively-at-work or active work:** For medical, dental, vision, Resources For Living, critical illness, accidental death and dismemberment, and accident insurance coverage, “actively-at-work” or “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, short-term disability, Short-Term Disability Plus, long-term disability and truck driver long-term disability, actively-at-work or active-work means you are actively-at-work with the company 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 on a full-time basis on that day. 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 network and out-of-network charges before the Plan will begin to pay. (If you choose one of the HRA plans, the Plan allows you to use your Walmart-provided HRA funds. For more information on the HRA plans, see How the HRA plans pay benefits in The medical plan chapter.)

**Annual enrollment or annual enrollment period:** The period, usually in the fall of each year, during which associates make benefit elections for the next Plan year.


**Associates’ Medical Plan (AMP):** Refers to the medical plans offered by Walmart (HRA Plan, HRA High Plan and HSA 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; or
- Intensive outpatient care that requires two to four hours of service per day, three to five days per week.

**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 age 55 or older. Catch-up contributions are allowed by the IRS to an associate’s 401(k) plan if the associate is age 50 or older.

**COBRA:** 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. For example, you pay 25% for eligible nonpreventive network expenses under the medical plan; the medical plan pays 75%. 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 (COB):** When two benefits plans insure the same participant and coordinate coverage, the process of designating one plan as primary and the other as secondary.

**Copay:** A fixed dollar amount required for certain prescriptions or for certain services under the vision plan, or if enrolled in an HMO, for each doctor or hospital visit.

**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 the long-term disability and truck driver long-term disability plans, “disability” means that, due to an injury or sickness during the benefit waiting period and for the next 12 months of disability, you are unable to perform the material and substantial duties of your own occupation (or, under the truck driver long-term disability plan, you lose medical certification in accordance with the Federal Motor Carrier Safety Regulations). After 12 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, 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 long-term disability 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); and
• Liberty must receive and approve certification with accompanying medical documentation of a disability from your qualified doctor before benefits are considered for payment.

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:
  – Live together in an ongoing, exclusive and committed relationship similar to marriage and have been for at least 12 months and intend to continue sharing a household 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;
  – 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.

Eligibility waiting period: The time between an associate’s hire date and the date the associate is eligible to enroll for benefits.

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 HRA or HSA options, 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 amount of money the company sets aside 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 Plan, Walmart will contribute $250 if you select associate-only coverage, or $500 if you cover your dependents. 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. 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 BNY Mellon, 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 $300 if you select associate-only coverage, or $600 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.

**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-pocket maximum:** The most you will pay each year for eligible network services, including prescriptions.

**Partially disabled or partial disability:** Under the long-term disability and truck driver long-term disability 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 an 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. Preauthorization requirements are imposed by the Third Party Administrators Aetna and UnitedHealthcare; by Health Design Plus, the administrator of the heart, spine, and hip and knee replacement services under the Centers of Excellence program; and by HealthSCOPE Benefits, the administrator of cancer services under the Centers of Excellence Program. 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:** 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.

**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 [mywalmart.com](http://mywalmart.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:
  - Live together in an ongoing, exclusive and committed relationship similar to marriage and have been for at least twelve months and intend to continue sharing a household 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;
  - 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 and Short-Term Disability Plus plans, “total disability” means:

- You are unable to perform the essential duties of your job for your normal work schedule due to a mental or physical illness or injury, or pregnancy. Failure to meet requirements necessary to maintain a license to perform the duties of your occupation does not mean you are totally disabled. 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; and

- In order to qualify for disability benefits, you must be under the continuous care of a qualified doctor and following the course of treatment prescribed. 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.

**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.
For more information
## For more information

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<th>IF YOU HAVE QUESTIONS ABOUT…</th>
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| • When you’re eligible for benefits  
• How and when to enroll | Walmart Benefits Customer Service:  
• 800-421-1362  
• TDD 800-335-4225 for the hearing impaired  
WalmartOne.com |
| Benefits, medical claims or care management applicable to your medical plan | Call your health care advisor at the number on your medical plan ID card:  
• BlueAdvantage Administrators of Arkansas: 866-823-3790  
• Aetna: 855-548-2387  
• UnitedHealthcare: 888-285-9255 |
| Finding a network provider | • Call your health care advisor (see phone numbers above)  
• The WIRE or WalmartOne.com |
| Pharmacy benefits | Express Scripts: 800-887-6194 or WalmartOne.com/Pharmacy |
| Health Savings Account (HSA) | BenefitWallet Service Center: 800-358-3494 or WalmartOne.com/HSA |
| Dental benefits | Delta Dental: 800-462-5410 or WalmartOne.com/Dental |
| Vision benefits | VSP: 866-240-8390 or WalmartOne.com/Vision  
• Short-term disability  
• Short-Term Disability Plus  
• Long-term disability  
• Truck driver long-term disability  
• Accident insurance  
• Critical illness insurance  
• Company-paid life insurance  
• Optional associate life insurance  
• Optional dependent life insurance  
• Accidental death and dismemberment (AD&D) insurance  
• Business travel accident insurance |
| Life with Baby Maternity Program | Call your health care advisor (see phone numbers above) |
| Resources For Living* | Call 24 hours a day, 7 days a week:  
• 800-825-3555  
• TDD 800-827-3707 for the hearing impaired  
Or WalmartOne.com/RFL |
| Walmart 401(k) Plan | Customer Service Center: 888-968-4015 or WalmartOne.com/401k |
| Associate Stock Purchase Plan | Computershare:  
• 800-438-6278  
• 800-952-9245 for the hearing impaired  
• WalmartOne.com |