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Sam's CLUB

2013 Associate Benefits Book

Summary Plan Description


Kathy Martinez


Xu Sun


Andrew Dale, wife Jamie & daughters Savannah & Alexandra


Sahid Kamara & dog Kutya

Effective
January 1, 2013

WHAT'S INSIDE:

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

...and much more!

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Your 2013 *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 2013 *Associate Benefits Book* PDF from the **WIRE** or **mywalmart.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:

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- Click "search"
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The medical plan

WHERE CAN I FIND?

The medical plan

ASSOCIATES' MEDICAL PLAN RESOURCES			
Find What You Need	**Online**	**By Phone**	**Other Resources**
Third Party Administrators:	Go to **mywalmart.com** or		
BlueAdvantage Administrators of Arkansas	**blueadvantagearkansas.com**	Health care advisor: **866-823-3790**	**BlueAdvantage Administrators of Arkansas P.O. Box 1460 Little Rock, AR 72203-1460**
Aetna	**aetna.com**	Health care advisor: **855-548-2387**	**Aetna 151 Farmington Avenue Hartford, CT 06156**
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 **mywalmart.com**	Call your health care advisor at the number on your medical plan ID card	
Get the cost for medical coverage	Go to the **WIRE** or **mywalmart.com**	Call Benefits Customer Service at **800-421-1362**	
For help getting your Certificate of Creditable Coverage from Walmart		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 medical plan ID card	
Request a paper copy of this 2013 Associate Benefits Book		Call Benefits Customer Service at **800-421-1362**	

What you need to know about medical benefits

- 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, coordinate care 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.
- 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.
- 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 (HRA funds 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.

(Continues on the next page)

- 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 lifetime maximum.
- The Associates' Medical Plan does not have a pre-existing condition limitation for Plan participants under the age of 19.
- Walmart also offers HMO (Health Maintenance Organization) plans in 13 states. HMO plans vary, so be sure to ask your personnel representative for a copy of the HMO plan material if an HMO is available in your area.
- The Associates' Medical Plan provides prescription drug coverage though 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.

	HRA HIGH PLAN		HRA PLAN		HSA PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual deductible Associate Only Associate + Dependent(s) *Applies for all services except as noted*	$1,750 $3,500	$3,500 $7,000	$2,750 $5,500	$5,500 $11,000	$3,000 $6,000	$6,000 $12,000
Walmart-provided dollars Associate Only Associate + Dependent(s)	$500 $1,000 *Maximum company contribution to HRA*		$250 $500		$300 $600 *Maximum matching Health Savings Account contribution*	
Annual out-of-pocket maximum Associate Only Associate + Dependent(s)	$5,000 $10,000	None	$5,000 $10,000	None	$6,250 $12,500	None
Eligible preventive care	100% *No deductible*	50% *No deductible*	100% *No deductible*	50% *No deductible*	100% *No deductible*	50% *No deductible*
Doctor visits and diagnostic tests	80% *After deductible*	50% *After deductible*	80% *After deductible*	50% *After deductible*	80% *After deductible*	50% *After deductible*
Hospitalization	80% *After deductible*	50% *After deductible*	80% *After deductible*	50% *After deductible*	80% *After deductible*	50% *After deductible*
"Centers of Excellence" Spine and heart surgery	100% *No deductible*	N/A	100% *No deductible*	N/A	100% *After deductible*	N/A
Behavioral health* (Inpatient and outpatient)	80% *After deductible*	50% *After deductible*	80% *After deductible*	50% *After deductible*	80% *After deductible*	50% *After deductible*
Pharmacy	See **The pharmacy benefit** chapter for details about your prescription drug coverage.					

*Benefit levels may differ for services in areas served by the Aetna Custom Performance Network. For more information, see the **Custom Performance Network** chart later in this chapter.

HRA FOR MIDYEAR ENROLLMENTS

If you enroll midyear in an HRA plan, Walmart will allocate a prorated amount to your HRA. The prorated amount will equal the annual HRA amount divided by 12 and will then be multiplied by the number of months remaining in the year from the effective date of your coverage. Your total annual deductible and out-of-pocket maximum will not be prorated.

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 2013 annual limit (as determined by the IRS) of $3,250 for individual coverage or $6,450 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 (like an HMO) to include different eligibility provisions relating to dependents, such as allowing coverage for a domestic partner, if recognized in that state. 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 Third Party Administrators (TPA) to handle administration of the Associates' Medical Plan: BlueAdvantage Administrators of Arkansas; Aetna Life Insurance Company (Aetna); and UnitedHealthcare (UHC). Depending on your work location, your coverage under the Associates' Medical Plan will be administered through one of these TPAs. The TPA makes medical claim determinations based on the Plan's guidelines and processes the claims. The TPA also provides a network of providers who 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 funded by the company. Each year Walmart will allocate money in an HRA for you and any covered family members to pay for covered medical expenses. You cannot contribute your own money to the HRA. The Plan will automatically pay your 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 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 services within that plan year.

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-funded 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. 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 plan's annual deductible.

Under the HRA plans you must meet separate annual deductibles for services provided by network providers and non-network providers. See **Your provider network** later in this chapter for more information on network and non-network providers.

The amount of your deductible is based on which plan you choose and whether you are covering just yourself (Associate Only) or any eligible dependents as well (Associate + Spouse, 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
- Non-network providers' charges that are above the maximum allowable charge
- 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 80 percent of eligible network covered expenses and you pay 20 percent. 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 percent of the maximum allowable charge and you pay the rest (i.e., you are responsible for the other 50 percent 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 percent 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.

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 when using non-network providers
- Non-network providers' charges that are above the maximum allowable charge
- 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, Associate + Child(ren) or Associate + Family coverage, you will have an out-of-pocket maximum for network expenses of $10,000. In this case, 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 percent of covered charges for any covered person until the entire family out-of-pocket maximum has been met.

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

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 80 percent of covered expenses for network charges and John Doe will be responsible for the remaining 20 percent.

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.

your covered expenses. See **Your provider network** later in this chapter for more information on network and non-network providers.

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, 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 Script's 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. 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 excluded by the Plan
- Charges for preventive services.

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

For the HSA Plan, after your annual deductible for eligible network expenses is met, the Plan pays 80 percent of covered expenses and you pay 20 percent. 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 percent of the maximum allowable charge and you pay the rest (i.e., you are responsible for the other 50 percent 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 percent 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 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
- Pharmacy copays/coinsurance.

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 when using non-network providers
- Non-network providers' charges that are above the maximum allowable charge
- 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 $6,250. If you choose Associate + Spouse, Associate + Child(ren) or Associate + Family coverage, you will have an out-of-pocket maximum for network expenses of $12,500. In this case, 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 percent of covered charges for any covered person until the entire family annual out-of-pocket maximum has been met.

HOW YOUR COVERAGE WORKS UNDER THE HRA PLANS AND THE HSA PLAN

	HRA High Plan and HRA Plan	HSA Plan
Paying from your account	Covered expenses (except prescriptions) are automatically paid from your HRA and 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.	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 money left in your Health Savings Account at the end of the Plan year remains in your account for your future use.
Meeting your annual deductible	After your HRA is used up, you pay covered medical expenses out of your own pocket until your annual deductible is met.	You pay expenses out of your own pocket or from your Health Savings Account until your annual deductible is met.
The Plan pays a percentage of covered expenses	After your network annual deductible is met, the Plan pays 80% of your covered network expenses and you pay 20%. The Plan pays 50% of covered out-of-network expenses up to the maximum allowable charge and you pay 50%. You are responsible for paying all amounts above the maximum allowable charge.	After your network annual deductible is met, the Plan pays 80% of your covered network expenses and you pay 20%. The Plan pays 50% of covered out-of-network expenses up to the maximum allowable charge and you pay 50%. You are responsible for paying all amounts above the maximum allowable charge.
The Plan pays 100% of covered network services after you meet your out-of-pocket maximum	After you have met your out-of-pocket maximum for the year, the Plan pays 100% of covered network expenses for the rest of the calendar year. (Charges by non-network providers after you have met your out-of-network annual deductible do not apply to your out-of-pocket maximum — you continue to be responsible for paying your share of these charges in full.)	After you have met your out-of-pocket maximum for the year, 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.)

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:

- Medically necessary (as defined below);
- Not in excess of the maximum allowable charge, which is the amount of a provider's charge (whether network or out-of-network) paid to providers in a given geographic area, as determined by the Third Party Administrator (TPA);
- Not excluded under the Plan — see **What is not covered by the Associates' Medical Plan** later in this chapter;
- Not in excess of Plan limits.

Medically necessary 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 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.

PRE-EXISTING CONDITION LIMITATION

The Plan does not cover treatment of pre-existing conditions for the first 12 months after you become a participant. A pre-existing condition is a physical or behavioral health condition for which you received medical care, advice, diagnosis or treatment, including prescription drugs, during the six-month period before your "determination date." Your determination date is:

- Usually the date you were employed by the company as an eligible associate, if you were enrolled for coverage when it was first available during your initial enrollment period; or
- The date your coverage under the Associates' Medical Plan became effective, if you enrolled for coverage at any other time than your initial enrollment period.

The pre-existing condition limitation does not apply to:

- Plan participants under the age of 19;
- Pregnancy-related expenses; and
- The pharmacy benefit.

Unless otherwise provided in the Plan, if you add a dependent during annual enrollment or due to a status change event and you have already satisfied either of the determination date time limits explained above, your newly enrolled dependent is also considered to have satisfied the requirements. The pre-existing condition waiting period will be waived for localized associates and their covered dependents.

Certificate of Creditable Coverage

When your coverage or an eligible dependent's coverage ends for any reason (including the end of COBRA), the law requires your employer or prior health plan to provide you with a certificate of creditable coverage. You may also request a certificate of creditable coverage from your prior plan for yourself or your dependent at any time.

The 12-month limitation period associated with pre-existing condition limitations can be reduced or eliminated if you had prior "creditable coverage" and you provide the Third Party Administrator with evidence of your prior creditable coverage. Creditable coverage is prior medical coverage you had before joining the Associates' Medical Plan if you did not have a break in coverage of 63 days or more between one period of health coverage and another. Creditable coverage includes:

- Coverage under another employer's group health plan
- Coverage under an individual health insurance policy
- Medicare

- Medicaid
- Coverage under a medical care plan for members and former members of the United States Uniformed Services (and their dependents)
- Coverage under a medical care program of the Indian Health Service or a tribal organization
- Coverage under a state health benefits risk pool
- The Federal Employees' Health Benefit Program
- A public health plan (federal, state and foreign government plans)
- Children's Health Insurance Program (CHIP)
- A health benefit plan of the Peace Corps Act.

If you need to obtain a certificate of creditable coverage, please contact:

Benefits Customer Service
508 SW 8th Street
Bentonville, AR 72716-3500
800-421-1362

You also have the right to demonstrate creditable coverage through documentation other than a certificate of creditable coverage, such as a Medicare identification card showing Plan A or B coverage, a military identification card for each individual (front and back), or correspondence from a plan or issuer indicating prior health coverage, including who was covered and the dates of coverage. You must cooperate fully with the Associates' Medical Plan to verify prior creditable coverage.

Within a reasonable time after receiving the certificate of creditable coverage or other proof of creditable coverage, the Third Party Administrator will:

- Inform you of its decision of creditable coverage and how it will be counted toward the pre-existing condition limitation;
- Notify you in writing of its decision regarding any pre-existing condition limitation period;
- Explain the basis for the decision and the information the Third Party Administrator relied on in making the decision; and
- Allow you the chance to appeal the decision and provide additional evidence of creditable coverage, if it was denied.

See the **Claims and appeals** chapter for details about your right to appeal.

If the Third Party Administrator approves your creditable coverage and later determines that you did not have the claimed creditable coverage, the Third Party Administrator may modify its original decision if notice of the reconsideration is provided in writing to you, and if, until the final decision is made, the Third Party Administrator acts in a manner consistent with the initial decision for purposes of approving access to medical services.

Your provider network

Network providers accept an amount negotiated by the Third Party Administrator (TPA) as payment in full, 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).

Depending on each covered associate's work location, participants in the Associates' Medical Plan are enrolled for coverage under one of the following 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. After you have met your applicable annual deductible, the Plan will pay 80 percent of covered expenses if you use a network provider and 50 percent of the maximum allowable charge if you use a non-network provider. You are responsible for paying all remaining amounts (i.e., your 50 percent share of the maximum allowable charge 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 **mywalmart.com** or the **WIRE**.

If your doctor leaves the network, your benefit may be reduced 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).

In the case of transplant procedures or care covered by the Centers of Excellence program, neither the Plan nor the TPA will seek to direct your choice of providers or your provider relationship.

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.

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

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

- 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, 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.

If your TPA determines that any of the above circumstances apply, services will be covered at the network coinsurance rate of 80 percent. 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 his/her actual charge.

The Plan will cover services provided in an emergency room of a hospital without any prior authorization and without regard to whether the services are provided in a network facility or by a network provider.

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 percent of 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 percent 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.

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.

THE "ALTERNATE NETWORK" 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 an alternate network of providers. The 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 the 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 are as follows:

- GA: Blue Open Access POS
- NH: Blue Open Access POS
- MN: Blue Performance Regional
- 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
- PA: Western Region Managed Care Network.

For additional information about alternate networks, including details about service areas, go to the **WIRE** or **mywalmart.com** or call your health care advisor at the number on the back of your medical plan ID card.

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 rewarded with a richer level of benefits under the Plan, in the form of lower annual deductibles and lower coinsurance. The chart below shows a comparison of benefits under the Custom Performance Network (CPN) and the benefits available in Aetna's broader network.

	HRA HIGH PLAN			HRA PLAN			HSA PLAN		
	Aetna	Aetna CPN	Out-of-Network	Aetna	Aetna CPN	Out-of-Network	Aetna	Aetna CPN	Out-of-Network
Annual deductible Associate Only Associate + Dependent(s) *Applies for all services except as noted*	$1,750 $3,500	$1,250 $2,500	$3,500 $7,000	$2,750 $5,500	$2,250 $4,500	$5,500 $11,000	$3,000 $6,000	$2,500 $5,000	$6,000 $12,000
Annual out-of-pocket maximum Associate Only Associate + Dependent(s)	$5,000 $10,000	$3,000 $6,000	None	$5,000 $10,000	$3,000 $6,000	None	$6,250 $12,500	$4,250 $8,500	None
Eligible preventive care	100% *No deductible*		50% *No deductible*	100% *No deductible*		50% *No deductible*	100% *No deductible*		50% *After deductible*
Doctor visits and diagnostic tests	80% *After deductible*	90% *After deductible*	50% *After deductible*	80% *After deductible*	90% *After deductible*	50% *After deductible*	80% *After deductible*	90% *After deductible*	50% *After deductible*
Hospitalization	80% *After deductible*	90% *After deductible*	50% *After deductible*	80% *After deductible*	90% *After deductible*	50% *After deductible*	80% *After deductible*	90% *After deductible*	50% *After deductible*
"Centers of Excellence" Spine and heart surgery	100% *No deductible*		N/A	100% *No deductible*		N/A	100% *After deductible*		N/A
Emergency care *Non-emergency care from out-of-network providers will be covered at 50%	80% *After deductible*	80% *After deductible*	80%* *After deductible*	80% *After deductible*	80% *After deductible*	80%* *After deductible*	80% *After deductible*	80% *After deductible*	80%* *After deductible*
Behavioral health (Inpatient and outpatient)	90% *After deductible*	90% *After deductible*	50% *After deductible*	90% *After deductible*	90% *After deductible*	50% *After deductible*	90% *After deductible*	90% *After deductible*	50% *After deductible*

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 percent 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 percent, 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 detail and to answer questions regarding available preventive care services.

For the most up-to-date list of covered preventive services, go to the **WIRE** or **mywalmart.com** or call the Third Party Administrator.

COVERED PREVENTIVE SERVICES FOR ADULTS

- **Abdominal aortic aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **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
- **Type 2 diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **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/**
- **Obesity** screening and counseling for all adults
- **Sexually transmitted infection (STI)** prevention counseling for adults at higher risk
- **Tobacco use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk

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 mammography** screenings every 1–2 years for women over 40
- **Breast cancer chemoprevention** counseling for women at higher risk
- **Breastfeeding** comprehensive support and three counseling visits from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Please check with your Third Party Administrator for details on how to obtain a breast pump.
- **Cervical cancer** screening for sexually active women
- **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
- **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
- **Tobacco use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Sexually transmitted infections (STI)** counseling for sexually active women
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Well-woman visits** to obtain recommended preventive services for women

COVERED PREVENTIVE SERVICES FOR CHILDREN

- **Alcohol and drug Use** assessments for adolescents
- **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
- **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/**
- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **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
- **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 percent, during the September – March flu season. Details of the program include:

- Vaccinations will be provided in Walmart and Sam's Club facilities by Mollen, the company Walmart has partnered with to provide the flu vaccine program.
- Associates' Medical Plan participants must show their medical 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 percent through the preventive care program. If you go to a provider who is not in the network, the benefit is 50 percent of the maximum allowable charge, and you will be responsible for the other 50 percent 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.

Covered network services are paid at 80 percent after you've met your annual deductible or 50 percent of the maximum allowable charge if you use a non-network provider, even after you have reached your out-of-pocket maximum. You will be responsible for your 50 percent 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.

Pre-notification

Coverage for medical and behavioral health services may be pre-approved by calling the number on the back of your medical plan ID card. Third Party Administrators should be notified at least 24 hours prior to all scheduled medical and behavioral health admissions. For all emergency medical and behavioral health admissions, Third Party Administrators should be notified as soon as possible but no later than 24 hours after admission.

NOTE: Prior approval does not guarantee payment or assure coverage; it means that the information furnished to the Third Party Administrator at the time indicates that the proposed services meet the medical necessity requirement.

Coverage under the Associates' Medical Plan 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 that any other basis exists for denial of the claim under the terms of the Plan. For pre-approval, please have your provider call the number on the back of your medical plan ID card. The pre-approval process helps you and your provider determine whether the services being recommended are covered expenses under the Plan.

Helping you manage your health

When you need to communicate with your Third Party Administrator for any reason — whether to locate providers, seek pre-approval for a planned service, inquire about a claim or for another matter — you will be asked to call the number on your medical 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 appropriately to the proper 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.

Your nurse care manager works for you and with your providers to help you deal with the difficulties associated with illness or injury, as well as with routine questions about care and interactions with medical providers. The primary objective of the nurse care manager is to identify and coordinate cost-effective medical care while meeting accepted standards of medical practice.

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 telephone number on the back of your medical 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 enrolled in Walmart's HRA plans or the HSA Plan and their covered dependents ages 18 and older. 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 at **mywalmart.com/MSP**. Select "Quit Tobacco" as a Healthy Living goal. Create an MSP goal to quit tobacco and link to the program that 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 and dependents covered under the Plan.

Whether you're starting a family, adding to one, or just thinking about it, the Life with Baby maternity program 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 telephone number on the back of your medical 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 pre-conception, pregnancy, delivery (including three

lactation visits) and child development. Enroll in the Life with Baby maternity program and you'll get a personal registered nurse you can talk with confidentially 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.

Centers of Excellence

Associates and dependents enrolled in one of the HRA plans or the HSA Plan may be eligible to receive 100 percent coverage for heart or spine surgery at one of the Associates' Medical Plan's Centers of Excellence. Claims for eligible heart and spine services performed at one of the Centers of Excellence are covered at 100 percent with no annual deductible. However, if you are enrolled in the HSA Plan you must meet your annual deductible before the Plan will make any payments, due to federal tax laws. Additionally, travel, lodging and a daily allowance will be provided for the recipient and a caregiver and must be scheduled through the Centers of Excellence program. Payment is subject to otherwise applicable limits.

If your doctor recommends a cardiac or spine procedure, call your health care advisor at the telephone number on the back of your medical plan ID card to determine eligibility and obtain authorization for the program.

NOTE: Cardiac or spine procedures performed at facilities other than one of the Centers of Excellence, or services outside the Centers of Excellence program, 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.

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. If you have a question on the coverage of a particular service, please contact the Third Party Administrator. Contact information is provided on your medical plan ID card.

While the Associates' Medical Plan covers most medically necessary expenses, some expenses are subject to limitations or restrictions. Those are described below. The limitations and restrictions described are in addition to other Associates' Medical Plan rules, including annual deductibles, coinsurance and exclusions. Consideration may be given for additional coverage when deemed medically necessary by the Third Party Administrator, consistent with the Third Party Administrator's policies and procedures.

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 if other transportation would threaten the life or limb of the patient.

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 or caregiver 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

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 three provider visits per calendar year for:

- 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 recommended by a physician which provides comfort and support services for the terminally ill. 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 short-term grief counseling for immediate family members 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 180 days per illness. 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).

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.

This shall not be construed to require coverage of 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
- Hospital expenses 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 when appropriate.

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.

PROSTHESIS

Replacement prosthesis will be allowed only with a change of prescription. A licensed prosthetician must perform replacements of artificial limbs.

REHABILITATIVE CARE

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

- 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.

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.

VISION SERVICES

The diagnosis and treatment of injury or disease of the eye, including but not limited to diabetic retinopathy, glaucoma and macular degeneration, is 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.

Coverage for transplants and lung volume reduction surgery (LVRS)

To be eligible for transplants and lung volume reduction benefits, participants must be continuously enrolled in the Associates' Medical Plan or an HMO offered through the Plan for at least 12 months. The twelve-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 pre-transplant 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, 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) are covered at 100 percent with no annual deductible. However, if you are enrolled in the HSA Plan you must meet your annual deductible before the Plan will make any payments due to federal tax laws. Additionally, travel, lodging and a daily allowance will be provided for the recipient and a caregiver. Payment is subject to otherwise applicable limits.
- The Plan does not cover the transplantation of body parts (e.g., face, hands, feet, legs, arms) under any circumstances. Experimental and/or investigational transplant-related services are not covered unless those services are recommended and performed by Mayo Clinic or an approved facility.
- Benefits for a covered transplant procedure at Mayo Clinic and related expenses, including travel, lodging and a daily allowance, will end one year post-transplant or after a one-year post-transplant evaluation is performed.
- Non-transplant services performed at Mayo Clinic rendered at the time of the doctor visit, such as lab work, X-rays or other tests, are subject to the Plan guidelines, including annual deductible and coinsurance.
- 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

- If 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 the transplant, you may file a claim with an Independent Review Panel of the Plan, which may approve the transplant for a different facility. 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 found 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. The transplant will be covered in accordance with the otherwise applicable terms of the Plan, including the rules governing network and out-of-network benefits. 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 80 percent for network providers after the annual deductible has been met.
- Claims will be covered at 50 percent 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 percent 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 evaluation at Mayo Clinic.
- Upon approval by Mayo Clinic or the Independent Review Panel, the transplant may be performed at the facility of your choice.
- Travel, lodging and a daily allowance will be provided only if the transplant is performed at Mayo Clinic.

MORE ABOUT TRANSPLANT 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, in 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 the back of your medical 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 for 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), 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 (see **Women's Health and Cancer Rights Act of 1998** below), 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

Early intensive behavioral intervention: Including but 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 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.

Freestanding substance abuse or mental health/psychiatric residential treatment center: Substance abuse or mental health treatment received at a freestanding residential substance abuse treatment center or at a freestanding mental health or psychiatric residential treatment facility is not covered. For assistance in locating a provider as a possible alternative to a freestanding center, call the number on the back of your medical plan ID card.

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 intracryopreservation, 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.

Learning and educational disorders: Including but not limited to reading disorders, alexia, developmental dyslexia, dyscalculia, spelling difficulties and other learning difficulties.

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, snug seats, recreational items, home improvements and home appliances, spas, wigs and knee braces for sports.

Phone, video conference and online consultations

Pre-existing conditions: For Plan participants age 19 and over. (See **Pre-existing condition limitation** earlier in this chapter for details.)

Residential long-term care facilities: Mental health and eating disorder residential long-term care facilities, youth homes, schools, therapeutic camps or any similar institutions.

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 aid: 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** section of this chapter.

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 the 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 medical 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 back of your medical 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 **mywalmart.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. See the **Claims and appeals** chapter for details.

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 percent 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 trusteed 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 plan 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

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

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:

- No-fault coverage, personal injury protection and medical payment coverage are always primary, and the Associates' Medical Plan is always secondary to those types of plans.
- 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 and the parent with custody has not remarried, that parent's plan is primary.
- When the parent with custody has remarried, 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 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 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), unless, at the time you become entitled to such Medicare coverage, coverage under the Plan was not due to employment with Walmart;
- 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.
- You or your dependent is an active participant or COBRA participant entitled to 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.

ARREARS CANCELLED/BREAK IN COVERAGE

If your coverage has been cancelled due to nonpayment of premiums and you return to actively-at-work status within one year from cancellation, you will automatically be re-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.

If you return to work after one year or add coverage under a status change event, you will be considered newly eligible; you may enroll for coverage within the applicable time periods described in the **Eligibility and enrollment** chapter. For information regarding pre-existing condition limitation periods, see **Pre-existing condition limitation** earlier in this 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 or re-enroll within 30 days, 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). In this case, the annual deductible, out-of-pocket maximum and HRA (if applicable) will not reset.

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

Other information about the medical plan

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- 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**.

COVERAGE WHEN YOU TRAVEL TO A FOREIGN COUNTRY

If you need medical care when traveling abroad, follow these steps:

- Before you leave, contact the Third Party Administrator at the number on the back of your medical plan ID card for coverage details. Coverage outside the United States may vary.
- Always carry your medical plan ID card with you when you travel, and present it when you receive medical services.
- For more information about emergency medical services received in a foreign country, call your Third Party Administrator at the number on the back of your medical plan ID card.

A NOTE ABOUT MATERNITY ADMISSIONS

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

The pharmacy benefit

WHERE CAN I FIND?

The pharmacy benefit

The pharmacy benefit is an important part of your benefits package. Prescription drugs play a critical role in treating illnesses and 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.

PHARMACY BENEFIT RESOURCES

Find What You Need	Online	Other Resources
• Find a Walmart, Sam's Club or Express Scripts network pharmacy • Get the list of covered brand-name drugs • Get the list of medications that require the collection of additional information	Go to the **WIRE**, **mywalmart.com** or **Express-Scripts.com/walmart**	Call Express Scripts at **800-887-6194**

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).

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 medical plan ID card at a Walmart or Sam's Club or Express Scripts network pharmacy. Remember, you must use a Walmart/Sam's Club or Express Scripts network pharmacy or no benefits will be paid. Visit **mywalmart.com** to find information about:

- Walmart or Sam's Club pharmacies;
- Retail network pharmacies in 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 **mywalmart.com**, or you may call Express Scripts at **800-887-6194**.

- 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 that appears in this chapter for complete details about copays.
- As an HSA Plan participant, you pay the full retail/mail-order price for your plan 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 exception is medications on 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 the medical out-of-pocket maximum is reached, eligible prescriptions will be paid at 100 percent 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. (Please note that the copay for a compound prescription is determined by the primary ingredient for the compound.)

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 medications covered by the Plan. The formulary is reviewed quarterly and can change. You can view an abbreviated list on the WIRE or at mywalmart.com, or you may call Express Scripts at 800-887-6194.

Note that all prescription drugs, whether they fall under the generic, brand-name or specialty drug category, must be covered under the Plan — that is, they must be included on the Plan's formulary — for pharmacy benefits to be paid.

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 **mywalmart.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 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 on the following page. 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 percent. 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 full retail/mail 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 on the following page. 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 percent. The exception is medications on 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.

PHARMACY BENEFITS

	HRA Plans		HSA Plan	
	Walmart or Sam's Club Pharmacy	Express Scripts Network	Walmart or Sam's Club Pharmacy	Express Scripts Network
Retail prescriptions: Each copay covers up to a 30-day supply of an eligible prescription unless otherwise noted.				
Generic drugs Up to 30-day supply 31- to 60-day supply 61- to 90-day supply	 $4 copay $8 copay $12 copay	 $12 copay $24 copay $36 copay	 $4 copay $8 copay $12 copay *After the medical plan's network annual deductible is met**	 $12 copay $24 copay $36 copay *After the medical plan's network annual deductible is met**
Brand-name drugs	Greater of $30 or 20% of allowed cost	Greater of $50 or 20% of allowed cost	Greater of $30 or 20% of allowed cost *After the medical plan's network annual deductible is met**	Greater of $50 or 20% of allowed cost *After the medical plan's network annual deductible is met**
Specialty drugs	Greater of $50 or 20% of allowed cost	Greater of $50 or 20% of allowed cost	Greater of $50 or 20% of allowed cost *After the medical plan's network annual deductible is met**	Greater of $50 or 20% of allowed cost *After the medical plan's network annual deductible is met**
Mail-order prescriptions: Copays shown below are for prescription quantities of 35 to 90 days. If you order 1–34 days of medication through the mail, you will pay the 1 to 30-day supply copay shown above.				
Generic drugs	$8 copay	$8 copay	$8 copay *After the medical plan's network annual deductible is met**	$8 copay *After the medical plan's network annual deductible is met**
Brand-name drugs	Greater of $60 or 20% of allowed cost	Greater of $60 or 20% of allowed cost	Greater of $60 or 20% of allowed cost *After the medical plan's network annual deductible is met**	Greater of $60 or 20% of allowed cost *After the medical plan's network annual deductible is met**
Specialty drugs	Greater of $100 or 20% of allowed cost	Greater of $100 or 20% of allowed cost	Greater of $100 or 20% of allowed cost *After the medical plan's network annual deductible is met**	Greater of $100 or 20% of allowed cost *After the medical plan's network annual deductible is met**

*Covered medications that are on 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** later in this chapter for details.

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 percent of your previous prescription for the same drug has been used.
- Note that if you enroll for medical coverage in the HSA Plan, you must meet the medical plan's network annual deductible before prescription drug benefits are payable. Exceptions include certain medications on Express Scripts' list of approved preventive medications that are not subject to the HSA Plan's network annual deductible.
- If you are eligible for and choose to enroll in a Health Maintenance Organization (HMO), you will receive your prescription drug benefits through your HMO.
- To be covered under the Plan, prescription drugs must be on the Plan's formulary, which is a list of covered generic and brand-name prescription medications. The list includes only those medications that have been tested for quality and effectiveness and believed to be a necessary part of a quality treatment program. The formulary is reviewed quarterly and can change.
- No benefits are available if you have prescriptions filled by non-network pharmacies.
- Prescription drug copays count toward the medical plan's annual out-of-pocket maximum; once your out-of-pocket maximum is met, eligible prescription drug charges are paid at 100 percent.
- Certain eligible preventive over-the-counter medications are fully covered if prescribed by a physician. See **Preventive over-the-counter medications** later in this chapter.

MAIL-ORDER PRESCRIPTIONS

Mail-order prescriptions 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.

See the **Pharmacy benefits** chart on the previous page for information on copays and coinsurance when you order your prescriptions by mail.

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

Beginning in 2013, women will have access to all Food and Drug Administration approved contraceptive methods. Contraception has additional health benefits such as reduced risk of cancer and protection against osteoporosis. Under the terms of the Affordable Care Act, all prescribed generic contraceptives under the HRA and HSA Plans will be covered at 100 percent.

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

Beginning in 2013, there are certain preventive medications that will be covered under the HSA Plan without the Plan deductible being applied. 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 like 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 **mywalmart.com**.

PREVENTIVE OVER-THE-COUNTER MEDICATIONS

If you are enrolled in the Associates' Medical Plan, costs of certain prescribed over-the-counter (OTC) medications are covered at 100 percent when 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 percent by the pharmacy benefit plan, you must have a prescription from your doctor.

Some of the most common preventive over-the-counter 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 **mywalmart.com** or call Express Scripts.

PREVENTIVE OVER-THE-COUNTER MEDICATIONS Recommended by the U.S. Preventive Services Task Force (USPSTF)	
Oral fluoride	By prescription when appropriate for children 6 months to 6 years of age
Iron supplementation	By prescription in symptomatic children 6 to 12 months of age
Folic acid	By prescription for all women planning or capable of pregnancy
Aspirin	By prescription for men age 45 to 79 and women age 55 to 79

MEDICATIONS THAT REQUIRE ADDITIONAL INFORMATION

Due to the nature of certain medications, a 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**.

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 **mywalmart.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 percent of the cost.

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. 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 **mywalmart.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 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 when they give us personal information. Protecting it 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

WHERE CAN I FIND?

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.

HEALTH SAVINGS ACCOUNT RESOURCES

Find What You Need	Online	Other Resources
Establish or change your contribution amount	Log on to the **WIRE** or **mywalmart.com**	Call Benefits Customer Service at **800-421-1362**
Open your Health Savings Account	Log on to **hsamember.com** or **myhsa.usbank.com** to complete an electronic signature	Call your Health Savings Account Solution Contact Center at **800-358-3494** Administered by ACS on behalf of The Bank of New York Mellon (BNY Mellon) and U.S. Bank
Get a list of qualified medical expenses (I.R.C.§ 213(d)) Get eligibility and tax return reporting responsibilities associated with a Health Savings Account	**irs.gov** **irs.gov** or **treasury.gov**	Call your Health Savings Account Solution Contact 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 contributed on a dollar-for-dollar basis, 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; this will automatically open the account on the effective date of your HSA Plan coverage.
- You will receive a welcome kit mailed to your home address directly from your Health Savings Account custodian, The Bank of New York Mellon (BNY Mellon) or U.S. Bank. This is the financial institution where your account will be held. ACS provides the administration for both custodians.
- 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 electronic signature and completed any other steps required by your Health Savings Account custodian.
- Upon opening your account, address changes will need to be made with your custodian.

Health Savings Account advantages: tax breaks and Walmart contributions

The Health Savings Account offers HSA Plan participants:

- Additional 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-qualified medical expenses, income tax will apply and a 20 percent penalty may also apply.
- Over-the-counter drugs are considered qualified medical expenses, eligible for reimbursement under a Health Savings Account, if they are prescribed by a doctor.
- The opportunity to select a Health Savings Account custodian — either BNY Mellon or U.S. Bank. Both are established financial institutions.
- Interest on the balance in your account — Interest earnings 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.
- Investment opportunities for your account balance, once that balance reaches a certain amount. Earnings on investments made with your 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
- 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. Please see the **Opening your Health Savings Account** section of this chapter. 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;
- Receiving benefits under TRICARE; 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 contact the Health Savings Account Solution Contact Center at **800-358-3494**.

During the Plan year, you may be required to confirm account eligibility to continue contributions (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, a Health Savings Account is established by the associate and administered by ACS on behalf of BNY Mellon or U.S. Bank.

If you have non-high deductible health plan coverage through Walmart or any other employer (e.g., your spouse's employer), including a Flexible Spending Account (FSA) or a Health Reimbursement Account (HRA), you are generally ineligible to make Health Savings Account contributions (but you can continue to 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 the Health Savings Account Solution Contact Center at **800-358-3494** or contact your Health Savings Account custodian online: BNY Mellon at **hsamember.com** or U.S. Bank at **myhsa.usbank.com**.

Opening your Health Savings Account

When you enroll online in the HSA Plan through the **WIRE** or **mywalmart.com**, you will choose:

- Your Health Savings Account custodian — either BNY Mellon or U.S. Bank; and
- 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 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.

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 (or complete 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 **hsamember.com** (for BNY Mellon) or **myhsa.usbank.com** (for U.S. Bank) 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 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 is 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.

For questions about your account status or fulfillment (welcome kit, debit card or checkbook), you may call the Health Savings Account Solution Contact Center at **800-358-3494** and select either BNY Mellon or U.S. Bank. You may also log on to BNY Mellon at **hsamember.com** or U.S. Bank at **myhsa.usbank.com**.

Once Walmart receives confirmation from your Health Savings Account custodian 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.

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

If you do not open your Health Savings Account through BNY Mellon or U.S. Bank 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 either BNY Mellon or U.S. Bank as your Health Savings Account custodian when you enroll. However, you may move your funds to another Health Savings Account custodian (other than U.S. Bank or BNY Mellon) at any time. If you move your Health Savings Account custodian to a bank other than BNY Mellon or U.S. Bank, 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 custodian's account set-up fee, if any, if you are newly enrolled in the HSA Plan and do not have an existing Health Savings Account.

The company will pay the monthly maintenance fees for either BNY Mellon or U.S. Bank if you are enrolled in the HSA Plan. The fee will be paid to the custodian to which your payroll contributions are directed.

The company will not pay overdraft fees, excess contributions, lost card or replacement check fees, or any set-up fees you are charged if you elect to change your custodian. 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 contact your Health Savings Account custodian or call **800-358-3494** to learn 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.

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 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 contribution to the specified limit only for contributions made through payroll deductions.

Contributions will end upon closing your account.

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 2013, $3,250 for individual coverage; or
- For 2013, $6,450 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.

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

Your HSA Plan network annual deductible	Company matching contribution limit — $1 for $1 up to	Maximum annual contribution limit (associate and company contributions combined)
$3,000 (Associate Only coverage)	$300	$3,250
$6,000 (Family coverage)	$600	$6,450

If married associates are both eligible to contribute to individual Health Savings Accounts, the contribution limit for 2013 for both accounts combined is based on the maximum amount that can be contributed for a family, $6,450. Note, however, if either of the associates is age 55 or older in 2013, the total combined contribution is increased by $1,000 for each associate age 55 or older.

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.

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 the Health Savings Account Solution Contact 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 your Health Savings Account custodian at **800-358-3494** or online (BNY Mellon at **hsamember.com** or U.S. Bank at **myhsa.usbank.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 **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.

OPENING AND CHANGING 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 **mywalmart.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 2013, the catch-up contribution limit is $1,000. Please call the Health Savings Account Solution Contact 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 company will not contribute funds or pay any fees associated with the Health Savings Account for your spouse. Please call the Health Savings Account Solution Contact Center at **800-358-3494** for information on how to open a second Health Savings Account for your spouse.

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 percent penalty if you are under the age of 65. You will be required to report the distribution and any applicable penalty on your federal and state tax return. 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. Please visit **mywalmart.com** or **hsamember.com** or **myhsa.usbank.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 your Health Savings Account custodian, BNY Mellon or U.S. Bank.

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. Form 1099-SA reports the distributions from your Health Savings Account in the previous calendar year. 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 a Form 8889 with your annual tax filing if you (or someone on your behalf, including your employer) make contributions to a Health Savings Account during the year. 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

BNY Mellon and U.S. Bank both offer investment options within your Health Savings Account. Once your account has reached a particular balance, any amount over that balance can be invested in the selected mutual funds. Contact your Health Savings Account custodian for more information.

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 (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. If you choose to no longer maintain the account, it is your responsibility to contact the Health Savings Account custodian to close your account (for example, if you are no longer enrolled in the HSA Plan).

The dental plan

WHERE CAN I FIND?

The dental plan

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

DENTAL PLAN RESOURCES		
Find What You Need	Online	Other Resources
Get a listing of Delta Dental Preferred (PPO) and Delta Dental Premier dentists	Go to the **WIRE**, **mywalmart.com** or **deltadentalar.com**	Call Delta Dental at **800-462-5410** or Benefits Customer Service at **800-421-1362**
Get answers to questions about your dental claims and to contact Delta Dental Customer Service	Go to **deltadentalar.com** and select "Subscriber" to create your account	Call Delta Dental at **800-462-5410**
Get a claim form if you use a nonparticipating dentist	Go to the **WIRE**, **mywalmart.com** or **deltadentalar.com**	

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 are reviewed by dental consultants to help assure that the treatment provided meets the guidelines of this policy.
- If you have medical coverage with the Associates' Medical Plan, both the dental and medical information are on the back of your medical plan ID card. Your medical 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, 2013, your coverage must remain in effect until December 31, 2015. 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;
- 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 ($50 per person/$150 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		
Annual deductible Waived for preventive and diagnostic care and orthodontia care	$50 per person/$150 maximum annual deductible per family	
Maximum benefits Does not apply to orthodontia care	$2,500 per covered person per calendar year	
	Delta Dental Premier dentists and Preferred (PPO) dentists	**Non-network dentists**
Preventive and diagnostic care Charges (if any) do not count toward annual deductible	100% covered; no annual deductible applies	80% of maximum plan allowance; no annual deductible applies
Basic care Including fillings, non-surgical periodontics and root canal therapy	80% of maximum plan allowance after annual deductible is met	
Major care (12-month wait) Including surgical periodontics, crowns and dentures	50% of maximum plan allowance after annual deductible is met	
Orthodontia assistance (12-month wait) Charges do not count toward annual deductible	80% of maximum plan allowance up to $1,500 lifetime maximum orthodontia benefit per person; no annual deductible applies	

The twelve-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.

The maximum plan allowance is the maximum amount of payment for covered services based on the applicable reimbursement schedules as determined by Delta Dental. Delta Dental network providers (Delta Dental Preferred (PPO) and Delta Dental Premier dentists) agree to accept the maximum plan allowance as payment in full, subject to the annual deductible and coinsurance amounts. Non-network providers may charge more than the maximum plan allowance. You will be responsible for any amount charged above the maximum plan allowance.

The Plan pays benefits for covered expenses until you reach the maximum benefit limit, which is $2,500 per covered person per calendar year. This maximum does not apply to orthodontia assistance, which has a separate lifetime maximum benefit of $1,500 per covered person.

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 strongly recommended that a proposed treatment plan be submitted for treatment totaling $800.00 or more, particularly when the treatment includes services classified as Major Services. 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 Preferred (PPO) or Delta Dental Premier dentists. You'll save money because network dentists will not charge more than the maximum plan allowance for their services and also provide Delta Dental participants with discounted prices. You'll save time because network dentists will often file your claims for you.

The Delta Dental Preferred (PPO) network of dentists is available only in some states. To find a Delta Dental Preferred (PPO) or Delta Dental Premier dentist near you, see **Dental plan resources** at the beginning of this chapter.

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 12 months (18 months if you have other dental plan coverage and must coordinate benefits with your other plan) 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. See the **Claims and appeals** chapter for more information.

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. A copy can be found on the **WIRE** and **mywalmart.com**. If you have medical coverage with the Plan, your dental prescriptions would be covered as any medical prescription.

IT PAYS TO USE NETWORK DENTISTS		
	Delta Dental Premier dentists and Preferred (PPO) dentists	Non-network dentists
Dentist often files claim forms for you	Yes	No
Dentist accepts the maximum plan allowance as payment in full, subject to annual deductible and coinsurance amounts	Yes	No
Dentist offers discounted prices for Delta Dental participants	Yes	No

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 employer's 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: Up to four X-rays in any consecutive 12-month period. Additional periapical X-rays are covered when ordered in conjunction with palliative treatment or emergency exams. Bitewing X-rays are not separately payable if performed in conjunction with a full-mouth series. In addition, bitewings are not payable until after 12 full consecutive months of a full-mouth series. Only one periapical X-ray will be allowed on the same day as a root canal. Any additional periapicals will be disallowed.

Complete 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.

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.

Oral evaluation: Two oral evaluations during a calendar year. Coverage amount will be based on the amount payable for a periodic oral evaluation. Emergency evaluations performed by dentists are not subject to the calendar year restriction.

Sealants: Covered for unrestored occlusal surface, first and second permanent molars 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 percent of the maximum plan allowance for basic care.

Amalgam fillings: Benefits are payable once per tooth surface in any consecutive 24-month period.

Composite resin fillings: Benefits for the replacement of an existing composite resin filling are payable only if at least 24 months have passed since the existing filling was placed.

Benefits for composite resin fillings for posterior teeth will be 70 percent 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.

Periodontic maintenance: Periodontal prophylaxis is covered only if done 180 days after the completion of active periodontal treatment. Thereafter, periodontal prophylaxis 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 percent 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 satisfactory standard course of treatment. For example, a bridge will be allowed only when a partial denture will not suffice.

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 supported retainer is covered once in every seven-consecutive-year period.
- An implant maintenance procedure is covered once in any 12 consecutive months.
- Implant removal is covered once in a lifetime per tooth.

Crowns, cast restorations, inlays and onlays: 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 or onlay 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.

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 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 percent of the maximum plan allowance, up to a lifetime benefit of $1,500 per person for both network (Delta Dental Preferred 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 annual deductible 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.

- Only one periapical X-ray will be allowed on the same day as a root canal. Any additional periapicals will be disallowed.
- 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: These services 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 or dentures: Repair, relining or recementing of bridgework or dentures 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.

Experimental or investigational: Charges for treatment or services, including hospital care, that are experimental, investigational or inappropriate.

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.

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: 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).

Restorations: Composite or acrylic restorations (fillings) in molar teeth. (An allowance for amalgam restoration will be provided.)

Retainers: Separate charges for retainers (appliances that are intended to retain orthodontic relationship) or harmful habit appliances 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 were 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;
- Full-mouth debridement (an allowance for prophylaxis, subject to the limitation, will be provided);
- 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

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

If your coverage is cancelled for failure to pay premiums while you are on leave and you return to actively-at-work status within one year of cancellation, your coverage will be effective on the first day of the pay period that you meet the actively-at-work requirement.

If your coverage is cancelled for failure to pay 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 and you may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

Special rules may apply if you are on or return from a leave that qualifies under the Family and Medical Leave Act (FMLA) or a Military Leave of Absence. See the **Eligibility and enrollment** chapter for more information.

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 or re-enroll within 30 days, you will automatically be re-enrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan).

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