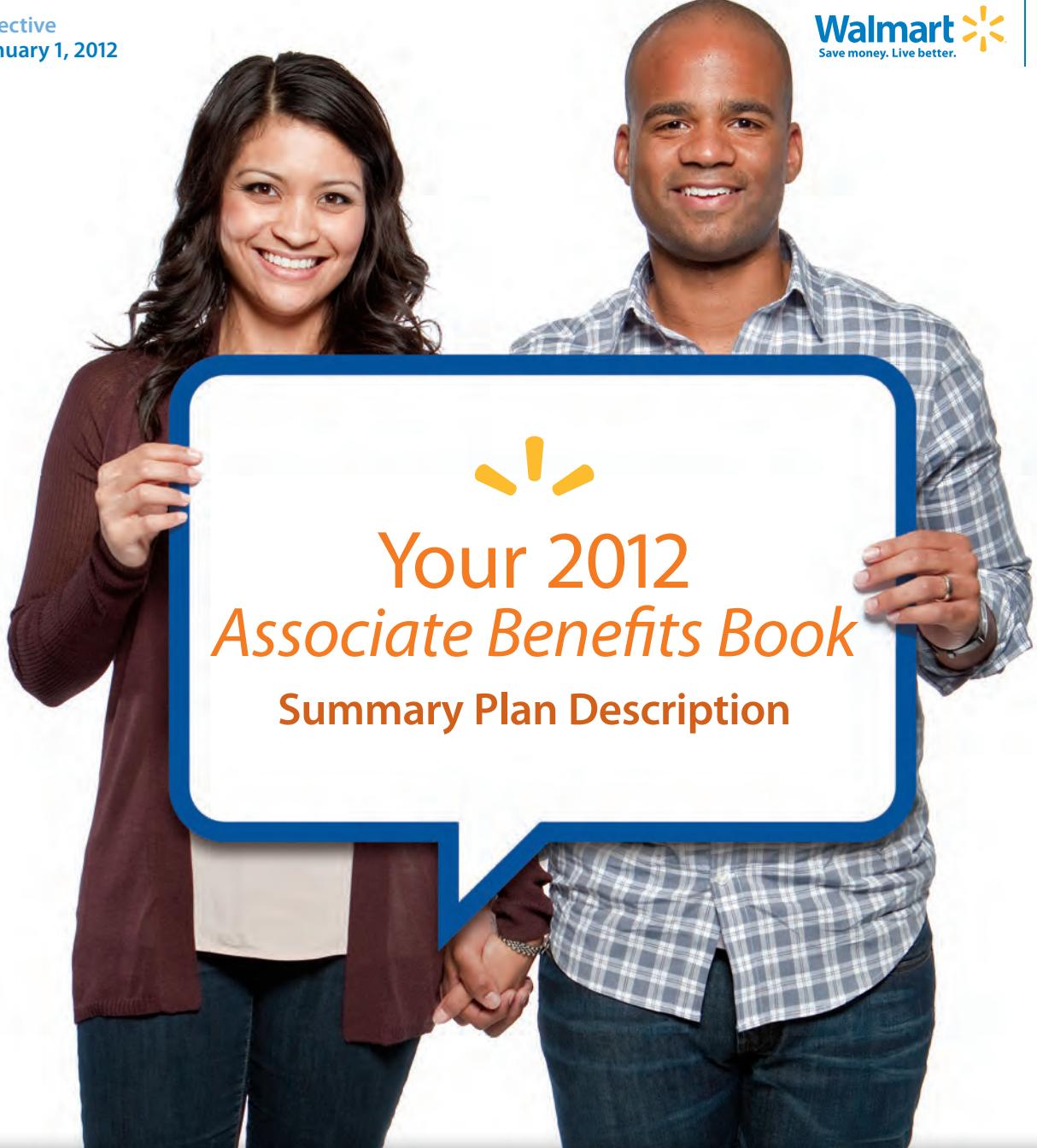


Effective
January 1, 2012



Your 2012
Associate Benefits Book
Summary Plan Description

What's inside:

- Medical plan
 - Dental plan
 - Pharmacy benefit
 - Life insurance & disability plans
 - Associate Stock Purchase Plan
 - Walmart 401(k) Plan
- ... and much more!*

Information made easy

Your 2012 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 2012 *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:

- Click "edit" on the top tool bar
- Click "search"
- Type the words or phrase that describe the information you're looking for, such as "checkups" or "vesting," and click "search."

You'll get instant results!



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Your 2012 Associate Benefits Book

This **2012 Associate Benefits Book** includes the Summary Plan Descriptions (SPDs) for the Associates' Health and Welfare Plan (the Plan) and the Walmart 401(k) Plan. Please take time to review each SPD to understand your benefits.

Information obtained during calls to Wal-Mart Stores, Inc. or to any Plan service provider does not waive any provision or limitation of the Plan. Information given or statements made on a call or in an e-mail do not guarantee payment of benefits. In addition, benefits quotes that are given by phone are based wholly on the information supplied at the time. If additional relevant information is discovered, it may affect payment of your claim. All benefits are subject to eligibility, payment of premiums, limitations and all exclusions outlined in the applicable Plan documents, including any insurance policies. You can request a copy of the documents governing these plans by writing to: [Custodian of Records, Benefits Customer Service, 508 SW 8th Street, Bentonville, AR 72716-3500](#).



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

O puede llamar para cualquier pregunta al (800) 421-1362. Tenemos asociados quienes hablan Español y pueden ayudarles a Ud comprender sus beneficios de Walmart.

El Libro de beneficios para asociados esta disponible en Español. Si usted desea una copia en Español, favor de ver su Representante de Personal.

Eligibility and enrollment

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eligibility and enrollment

If you have Medicare or will become eligible for Medicare in the next 12 months, you have more choices for your prescription drug coverage. See page 234 in the Legal information chapter for more details.

Eligibility and enrollment

Eligibility and enrollment resources		
Find What You Need:	Online:	Other Resources:
Enroll in Walmart benefits	The WIRE or mywalmart.com	Call Benefits Customer Service at (800) 421-1362
Notify Benefits Customer Service within 60 days of a status change event, such as dependent losing eligibility under the Plan		Call Benefits Customer Service at (800) 421-1362
Notify Benefits Customer Service if the payroll deductions for your benefits are incorrect		Call Benefits Customer Service at (800) 421-1362
Reinstate coverage upon your return from a military leave		Call Benefits Customer Service at (800) 421-1362
Pay premiums for benefits while on a leave of absence	<p>Send check or money order payable to the Associates' Health and Welfare Trust to:</p> <p>Benefits Customer Service P.O. Box 1039 Department 3001 Lowell, AR 72745</p> <p>Please be sure to include your name, insurance ID number (found on your insurance ID card) and facility number on your payment to ensure proper credit.</p>	<p>You may also pay by credit card by calling (800) 421-1362 and selecting the credit card payment option</p>

What you need to know about eligibility and enrollment

- You can enroll during your initial enrollment period as a newly hired associate, during annual enrollment and when you have a status change event.
- When your initial enrollment period begins depends on your job classification, and changes if your job classification changes. If you are an associate in Hawaii or Massachusetts, your eligibility and benefits information is explained in the **Eligibility and benefits for associates in Hawaii** and **Eligibility and benefits for associates in Massachusetts** chapters.
- Read this chapter and learn when you need to enroll and how enrollment in certain benefits (such as life insurance and disability benefits) after your initial enrollment period affects your participation in that benefit.
- Medical, dental, critical illness insurance, accident insurance, and accidental death and dismemberment (AD&D) coverage cannot be changed except during annual enrollment, unless you have a status change event.

The Associates' Health and Welfare Plan

The Associates' Health and Welfare Plan (the Plan) is a single, comprehensive employee benefit plan that offers medical, dental, critical illness insurance, accident insurance, AD&D, Business Travel Accident insurance, life insurance, disability and Resources For Living (employee assistance and wellness) coverage to eligible associates and eligible dependents. The eligibility for these benefits is described in this chapter, and the terms and conditions for these benefits are described in the applicable chapter of this **2012 Associate Benefits Book**. The Plan is sponsored by Wal-Mart Stores, Inc., and governed under the Employee Retirement Income Security Act of 1974 (ERISA) as amended.

If you are an associate in Hawaii or Massachusetts, you also should read the **Eligibility and benefits for associates in Hawaii** and **Eligibility and benefits for associates in Massachusetts** chapters.

Associate eligibility

The benefits you are eligible for depend on your hire date and your classification in the company's (Wal-Mart Stores, Inc.) payroll system. See the **Enrollment, eligibility and effective dates by job classification** section in this chapter for a list of the benefits you are eligible for and for your benefits eligibility waiting period based on your job classification.

Our expectation is that you will apply for or enroll in benefits using correct and accurate information. If not, you may be subject to the loss of benefits and/or loss of employment. To review Walmart's policy about intentional dishonesty, please refer to the Statement of Ethics, which can be found on the **WIRE**.

Full-time/part-time associate classification—hired on or after January 15, 2011

If you were hired on or after January 15, 2011, your classification is as follows:

- If you work an average of 34 or more hours per week and are classified as full-time, you are eligible for full-time benefits.
- If you work an average of between 24 to 33.9 hours per week and are classified as part-time, you are eligible for part-time benefits.
- If you work an average of less than 24 hours per week and are classified as part-time, you are ineligible to enroll for benefits.

- If you are classified as a part-time truck driver, you are exempt from the hours requirement.

Full-time/part-time associate classification—hired before January 15, 2011

If you were hired before January 15, 2011:

- To be classified as full-time, you must regularly work the following hours:
 - 20 hours per week if hired prior to September 1, 1979
 - 28 hours per week if hired and/or classified as full-time or management on September 1, 1979 through December 31, 2001
 - 34 hours per week if hired and/or classified as full-time or management on or after January 1, 2002

- You will be classified as part-time if you regularly work less than the hours outlined above.

Associates currently within the 20-hour-per-week requirement will be grandfathered in this requirement, regardless of any transition to part-time.

Associates within the 28-hour-per-week requirement who change status from full-time or management to part-time and back to full-time will be subject to the 34-hour-per-week requirement.

Associates who change status from full-time to management and back to full-time must maintain the hours per week requirement based on their original hire date.

Field Logistics and hourly pharmacists classified as full-time in the company's payroll system are exempt from the 34-hour-per-week requirement.

Salaried status

Regardless of hire date, hourly associates or associates in some positions may qualify for the same benefits eligibility waiting period as management associates if:

- The job description of the hourly associate is substantially the same as a management associate of Walmart or a participating subsidiary; and
- State law mandates that the position be classified as hourly.

Temporary and ineligible associates

Temporary and ineligible associates are only eligible for Resources For Living and Business Travel Accident insurance benefits.

Special eligibility rules for certain insured benefits

HMO plans are available at some facilities. The policies for the HMO plans, as well as the insurance policies for dependent life insurance and AD&D insurance, may have different eligibility requirements than those described in this chapter. You may obtain an explanation of these differences by calling **(800) 421-1362**. The Plan will apply the eligibility requirements described in this chapter unless you contact Benefits Customer Service at the number above and request that a different eligibility provision in the policy be applied to you. For example, state law may require an insurance policy to include different eligibility provisions relating to dependents, such as allowing coverage for a dependent child after age 26 or coverage for a domestic partner if recognized in that state.

Localized associates

Associates who have been approved by the company as having localized status, and their dependents residing in the United States, will be eligible for the same benefits under the Plan as associates who are United States citizens residing and working in the United States, including medical, dental, life, disability, and any other benefit available to United States associates under the Plan.

These localized associates and applicable dependents no longer will be eligible for expatriate coverage under the Plan. For medical benefits, where an eligible dependent of a localized associate resides outside the United States, the eligible dependent may choose to utilize the BlueCard WorldWide Network, where available, or utilize any local provider. Medical benefits will be paid at 80% of covered expenses and processed as network claims, subject to otherwise applicable limitations and exclusions under the Plan. The localized associate or eligible dependent must file a claim for reimbursement under the Plan's otherwise applicable claims procedures.

Associates who are not eligible

You are not eligible for the Plan even if you are (or may be) reclassified by the courts, the IRS or the Department of Labor as a common-law employee of Wal-Mart Stores, Inc. or any participating subsidiary, or if you are:

- A leased employee;
- A nonresident alien (unless covered under a specific insurance policy for expatriates or third-country nationals who are employed by the company);
- An independent contractor;
- A consultant;
- Not classified as an associate of Wal-Mart Stores, Inc. or its participating subsidiaries; or
- Enrolled in Medicare Part D (applicable to eligibility for medical plan options under the Plan only).

You are also excluded if you are covered by a collective bargaining agreement, to the extent that the agreement does not provide for participation in the Associates' Health and Welfare Plan.

Dependent eligibility

Eligible dependents are limited to:

- Your legal spouse of the opposite gender, as long as you are not legally separated.
 - Part-time associates may cover their eligible children but may not cover their spouses for medical benefits.
 - Part-time truck drivers may cover their eligible children but may not cover their spouses for medical benefits.
- Your dependents up to age 26 who are:
 - Natural children;
 - Adopted children or children placed with you for adoption;
 - Stepchildren;
 - Foster child(ren); or
 - Someone for whom you have legal custody or legal guardianship, provided he or she is related to you (or living as a member of your household) and you provide more than half of his or her support.

If you are enrolled in an HMO and your dependent lives in an area that is not supported by the HMO, you may still enroll your dependent but he/she would not have access to an HMO plan provider in their geographic area and may only have emergency coverage. If you are unsure if your dependent lives outside the HMO coverage area, call the HMO at the number listed in their plan material to find out.

You may change coverage plans for both you and your dependent(s) during the special enrollment or annual enrollment period (you and your dependent must be enrolled in the same coverage plan).

If your child is incapable of self-support

Coverage for your eligible child may be continued beyond his or her 26th birthday if:

- The child is physically or mentally incapable of self-support;
- The child is covered as an eligible dependent under a Walmart-sponsored medical and dental plan, critical illness insurance, accident insurance, AD&D and/or dependent life insurance prior to his or her 26th birthday; and
- The child's doctor provides written medical evidence of disability and inability to provide self-support.

Dependents who are not eligible

Your dependent is not eligible under your coverage if he or she is:

- Covered by the Plan as an associate of Walmart (an associate may be either a covered associate or a covered dependent, but not both at the same time) except for optional and dependent life insurance or AD&D coverage;
- Covered by the Plan as a dependent of another associate of Walmart except for dependent life insurance or AD&D coverage;
- Enrolled in Medicare Part D (applicable to eligibility for medical plan options under the Plan only);

- Residing outside the United States, except those dependents attending college full-time outside of the United States or covered under a specific policy for expatriates or third-country nationals who are employed by the company (this statement does not apply to dependent life insurance or dependents of localized associates);
- An illegal immigrant; or
- Not an eligible dependent as defined above.

Legal documentation for dependent coverage

You may be required to provide legal documentation to prove the eligibility of your dependent(s). The Plan reserves the right to conduct a verification audit and require associates to provide written documentation of proof of dependent eligibility upon request. It is the associate's responsibility to provide the written documentation as requested by the Plan. If necessary documentation is not provided in the time frame requested, the Plan has the right to cancel dependent coverage until the requested documentation is received. It is the associate's responsibility to notify the Plan of any changes in their dependent(s) eligibility.

When your dependent becomes ineligible

You must notify Benefits Customer Service within 60 days from the date your dependent becomes ineligible for coverage under the Plan by calling **(800) 421-1362**.

Your dependent must elect Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage within 60 days of the event date that resulted in loss of eligibility in order to qualify for COBRA coverage. See the **COBRA** chapter for more information regarding COBRA.

Failure to notify the Plan when your dependent becomes ineligible for coverage may be considered an intentional misrepresentation of the material fact, which could cause coverage to be rescinded. In that case, you may be responsible for any charges mistakenly paid by the Plan after your dependent becomes ineligible. Refunds of associate premium contributions will be granted only if you notify Benefits Customer Service.

When you enroll for benefits

Once you have completed your eligibility waiting period (see the charts later in this chapter and find the one that applies to your job classification for more information), you can enroll for benefits:

- During your initial enrollment period, which is the first time you are eligible to enroll. The timing of your initial enrollment period will vary by job classification and will change if your job classification changes.
- During annual enrollment for all associates, which usually occurs in the fall of each year. Benefits you enroll for during annual enrollment are generally effective January 1 of the next year. However, if you enroll for optional life insurance or dependent life insurance during annual enrollment, such coverage will be effective the day Prudential approves or at the end of your eligibility waiting period, whichever is later (which could be before or after January 1 of the next year). In addition, if you choose to enroll for short-term disability, short-term disability plus or long-term disability during annual enrollment, you will have a one-year wait from the date you enroll. If an end-of-year pay period covers both the prior and new year, your deductions will reflect the deduction amount for the prior year through December 31 and the new deduction amount for the new year, prorated for the number of days covered from January 1 until the end of the pay period.
- When a status change event allows you to make changes to your coverage outside of annual enrollment and is in accordance with federal law.

If you are an associate in Hawaii or Massachusetts, your eligibility and benefits information is explained in the **Eligibility and benefits for associates in Hawaii** and **Eligibility and benefits for associates in Massachusetts** chapters.

If you are eligible and do not enroll during your initial enrollment period, you will not be eligible for the following benefits until the next annual enrollment period unless you have a status change event:

- Medical
- Dental
- HMO plans (if available)
- Critical illness insurance
- Accident insurance
- Accidental death & dismemberment

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

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

- Optional life insurance
- Dependent life insurance
- Short-term disability
- Short-term disability plus
- Long-term disability
- Truck driver long-term disability

Proof of Good Health includes completing a questionnaire regarding your medical history and possibly having a medical exam. The Proof of Good Health questionnaire is made available when you enroll.

Confirming your enrollment

Once you enroll for coverage, you can view your confirmation statement on the **WIRE** or **mywalmart.com**. If you believe there is an error regarding what benefits you enrolled in, you should immediately contact Benefits Customer Service at **(800) 421-1362**.

Your insurance ID card

When you enroll in an HRA plan or the HDP Standard plan, you will receive a BlueCross BlueShield insurance ID card at your home address. ID cards for dependents whose address is different from the associate's address will be sent directly to the dependent's address. Your insurance ID card will also serve as your pharmacy ID card. If you enroll in the dental plan and the medical plan, this card will also serve as your Delta Dental ID card.

When you enroll in an HMO and a dental plan or the dental plan only, you will receive a separate Delta Dental ID card at your home address.

You can update your or your dependent's address while enrolling online or at any time on the **WIRE** or **mywalmart.com**.

Attempts to enroll after hours of operation

If you attempt to enroll for coverage after hours of operation through the **WIRE** or **mywalmart.com** or you have made contact with Benefits Customer Service on the final day of your initial or annual enrollment period, you may enroll on the next business day. However, in no event will you be able to enroll as a part of annual enrollment after the beginning of the Plan year.

Automatic re-enrollment in the Associate's Medical Plan options

If you currently have medical coverage but do not actively enroll during annual enrollment, you automatically will be re-enrolled in coverage options as described in the annual enrollment materials and posted online at **mywalmart.com** and on the **WIRE** during annual enrollment. You also may call Benefits Customer Service at **(800) 421-1362** for more information.

It's important to note that you must actively complete an online enrollment session at **mywalmart.com** or on the **WIRE** to receive the tobacco-free rates if you (and/or your covered spouse) are eligible. For more information, see **Tobacco-free rates** in this chapter.

You may change or drop your coverage during annual enrollment. If you do not actively enroll during annual enrollment and are automatically enrolled in a coverage plan, you will not be able to change this coverage once the new Plan year has started (January 1) unless you experience a status change event or until the next annual enrollment period.

If you do not re-enroll during annual enrollment, you will be deemed to have consented to the automatic re-enrollment described in this section and your payroll deductions will be adjusted accordingly.

When coverage is effective

The charts on the following pages show when coverage for benefits becomes effective. You must be actively-at-work on the day your coverage is effective for coverage to begin. However, if you are not actively-at-work on the day your coverage for medical, dental, critical illness insur-

ance, accident insurance, AD&D and Resources For Living benefits is effective, your coverage for these benefits will begin as long as you have reported for your first day of work and enrolled for the benefit. There is no enrollment required for Resources For Living.

For all other benefits, if you are not actively-at-work for any reason other than a scheduled vacation on the effective date of your coverage, your coverage will be delayed until you return to active-work. If you are an associate in Hawaii or Massachusetts, your eligibility and benefit information is explained in the **Eligibility and benefits for associates in Hawaii** and **Eligibility and benefits for associates in Massachusetts** chapters.

Active-work or actively-at-work

For medical, dental, critical illness insurance, accident insurance, AD&D and Resources For Living coverage, actively-at-work or active-work means you are on active status and have reported to work at Walmart.

For company-paid life insurance optional life insurance, dependent life insurance, Business Travel Accident insurance, short-term disability, short-term disability plus, long-term disability, and truck driver long-term disability coverage, actively-at-work or active-work means you are actively-at-work with the company on a day that is one of your scheduled work days if you are performing all of the regular duties of your job on a full-time basis on that day. You will be deemed to be actively-at-work on a day that is not one of your scheduled work days only if you were actively-at-work on the preceding scheduled work day.

Delay of coverage

If you are on a leave of absence when your coverage is to become effective, your coverage will be delayed until you return to active-work. **This does not apply to medical, dental, critical illness insurance, accident insurance, AD&D or Resources For Living.**

Effective dates for benefits under the Plan

The following **Enrollment, eligibility and effective dates by job classification** charts provide your coverage effective dates if you enroll during your initial enrollment period. If you do not enroll during your initial enrollment period, you may enroll during annual enrollment or if you experience a status change event as described in the **Changing your benefits during the year: Status change events** section later in this chapter.

If you are an associate in Hawaii or Massachusetts, your eligibility and benefits information is explained in the **Eligibility and benefits for associates in Hawaii** and **Eligibility and benefits for associates in Massachusetts** chapters.

Enrollment, eligibility and effective dates by job classification

Full-time hourly associates with 180-day wait	
Plan:	Enrollment Periods and Effective Dates:
<ul style="list-style-type: none"> • Medical • HMO plans • Dental (Enrollment is for two full calendar years) • AD&D • Critical illness insurance • Accident insurance 	<p>Initial enrollment period: Between 120 days from your date of hire and prior to your 180th day.</p> <p>When coverage is effective: 181st day of continuous full-time employment</p> <p>Critical illness insurance: If you enroll during your initial enrollment period, your coverage will be effective on the 181st day of continuous full-time employment. All amounts elected outside of your initial enrollment period require Proof of Good Health which will be available electronically when you complete an online enrollment. If you do not complete the electronic Proof of Good Health questionnaire, you will have 60 days from the date you enroll for coverage to complete a paper form sent to you by Allstate.</p>
Company-paid life insurance	Automatically enrolled on 181st day from your date of hire.
<ul style="list-style-type: none"> • Business Travel Accident insurance • Resources For Living 	Automatically enrolled on your date of hire.
<ul style="list-style-type: none"> • Optional life insurance • Dependent life insurance • Short-term disability (Not available in California and Rhode Island; different coverage is available in Hawaii, New Jersey and New York) • Short-term disability plus (Not available in California and Rhode Island) • Long-term disability 	<p>Initial enrollment period: Between 120 days from your date of hire and prior to your 180th day.</p> <p>When coverage is effective: If you enroll during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential or on your benefits eligibility date whichever is later.</p> <p>For optional or dependent life insurance: You may enroll at any time during the year, but Proof of Good Health may be required.</p> <p>For STD, STD Plus and LTD: You may enroll at any time during the year, but if you enroll at any time other than your initial enrollment period, you will have a one-year wait and a reduction in benefits.</p>

NOTE: These benefits require you to meet the definition of active-work or actively-at-work. See the **Active-work or actively-at-work** section in this chapter for more information.

Full-time hourly Massachusetts associates with 90-day wait for medical and 180-day wait for all other benefits

Plan:	Enrollment Periods and Effective Dates:
<ul style="list-style-type: none"> • Medical • HMO Plans 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 90th day after your date of hire.</p> <p>When coverage is effective: If you enroll during your initial enrollment period, 91st day of continuous full-time employment.</p>
<ul style="list-style-type: none"> • Dental (Enrollment is for two full calendar years) • AD&D • Critical illness insurance • Accident insurance 	<p>Initial enrollment period: Between 120 days from your date of hire and prior to your 180th day.</p> <p>When coverage is effective: 181st day of continuous full-time employment.</p> <p>Critical illness insurance: If you enroll during your initial enrollment period, your coverage will be effective on the 181st day of continuous full-time employment. All amounts elected outside of your initial enrollment period require Proof of Good Health which will be available electronically when you complete an online enrollment session. If you do not complete the electronic Proof of Good Health questionnaire, you will have 60 days from the date you enroll for coverage to complete a paper form sent to you by Allstate.</p>
Company-paid life insurance	Automatically enrolled on 181st day from your date of hire.
<ul style="list-style-type: none"> • Business Travel Accident insurance • Resources For Living 	Automatically enrolled on your date of hire.
<ul style="list-style-type: none"> • Optional life insurance • Dependent life insurance • Short-term disability (Not available in California and Rhode Island; different coverage is available in Hawaii, New Jersey and New York) • Short-term disability plus (Not available in California and Rhode Island) • Long-term disability 	<p>Initial enrollment period: Between 120 days from your date of hire and prior to your 180th day.</p> <p>When coverage is effective: If you enroll during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential or on your benefits eligibility date whichever is later.</p> <p>For optional or dependent life insurance: You may enroll at any time during the year, but Proof of Good Health may be required.</p> <p>For STD, STD Plus and LTD: You may enroll at any time during the year, but if you enroll at any time other than your initial enrollment period, you will have a one-year wait and a reduction in benefits.</p>

NOTE: These benefits require you to meet the definition of active-work or actively-at-work. See the Active-work or actively-at-work section in this chapter for more information.

Full-time hourly Vision Center managers and walmart.com functional non-exempt associates with no wait

Plan:	Enrollment Periods and Effective Dates:
<ul style="list-style-type: none"> • Medical • HMO Plans • Dental (Enrollment is for two full calendar years) • AD&D • Critical illness insurance • Accident insurance 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 60th day after your date of hire.</p> <p>When coverage is effective: Your date of hire.</p> <p>Critical illness insurance: If you enroll for critical illness insurance during your initial enrollment period, your coverage will be effective on your date of hire. All amounts elected outside of your initial enrollment period require Proof of Good Health which will be available electronically when you complete an online enrollment session. If you do not complete the electronic Proof of Good Health questionnaire, you will have 60 days from the date you enroll for coverage to complete a paper form sent to you by Allstate.</p>
Company-paid life insurance	Automatically enrolled on your date of hire.
<ul style="list-style-type: none"> • Business Travel Accident insurance • Resources For Living 	Automatically enrolled on your date of hire.
<ul style="list-style-type: none"> • Optional life insurance • Dependent life insurance • Short-term disability (Not available in California and Rhode Island; different coverage is available in Hawaii, New Jersey and New York) • Short-term disability plus (Not available in California and Rhode Island) • Long-term disability 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 60th day after your date of hire.</p> <p>When coverage is effective: If you enroll during your initial enrollment period, your guaranteed issue amounts will become effective on your enrollment date. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential.</p> <p>For optional or dependent life insurance: You may enroll at any time during the year, but Proof of Good Health may be required.</p> <p>For STD, STD Plus and LTD: You may enroll at any time during the year, but if you enroll at any time other than your initial enrollment period, you will have a one-year wait and a reduction in benefits.</p>

NOTE: These benefits require you to meet the definition of active-work or actively-at-work. See the Active-work or actively-at-work section in this chapter for more information.

Part-time hourly associates* and part-time truck drivers with 365-day wait

Plan:	Enrollment Periods and Effective Dates:
<ul style="list-style-type: none"> • Medical • HMO Plans 	<p>Initial enrollment period: 60 days prior to your one-year anniversary date and prior to your one-year anniversary date.</p> <p>When coverage is effective: 366th day of continuous employment.*</p>
<ul style="list-style-type: none"> • Critical illness insurance • Accident insurance 	<p>Critical illness insurance: If you enroll during your initial enrollment period, your coverage will be effective on the 366th day of continuous employment. All amounts elected outside of your initial enrollment period require Proof of Good Health which will be available electronically when you complete an online enrollment session. If you do not complete the electronic questionnaire, you will have 60 days from the date you enroll for coverage to complete a paper form sent to you by Allstate.</p>
<ul style="list-style-type: none"> • Business Travel Accident insurance • Resources For Living 	Automatically enrolled on your date of hire.

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

* If you were hired on or after January 15, 2011, you must work the required number of hours - see **Associates eligibility** earlier in this chapter.

Full-time hourly pharmacists (excludes California pharmacists), full-time hourly field Logistics associates and full-time hourly field supervisor positions in stores and clubs with 90-day wait**

Plan:	Enrollment Periods and Effective Dates:
<ul style="list-style-type: none"> • Medical • HMO Plans • Dental (Enrollment is for two full calendar years) • AD&D • Critical illness insurance • Accident insurance 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 90th day after your date of hire.</p> <p>When coverage is effective: If you enroll during your initial enrollment period, 91st day of continuous full-time employment.</p> <p>Critical illness insurance: If you enroll during your initial enrollment period, your coverage will be effective on the 91st day of continuous full-time employment. All amounts elected outside of your initial enrollment period require Proof of Good Health which will be available electronically when you complete an online enrollment session. If you do not complete the electronic Proof of Good Health questionnaire, you will have 60 days from the date you enroll for coverage to complete a paper form sent to you by Allstate.</p>
Company-paid life insurance	Automatically enrolled on 91st day from your date of hire.
<ul style="list-style-type: none"> • Business Travel Accident insurance • Resources For Living 	Automatically enrolled on your date of hire.
<ul style="list-style-type: none"> • Optional life insurance • Dependent life insurance • Short-term disability (Not available in California and Rhode Island; different coverage is available in Hawaii, New Jersey and New York) • Short-term disability plus (Not available in California and Rhode Island) • Long-term disability 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 90th day after your date of hire.</p> <p>When coverage is effective: If you enroll during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential or on your benefits eligibility date whichever is later.</p> <p>For optional or dependent life insurance: You may enroll at any time during the year, but Proof of Good Health may be required.</p> <p>For STD, STD Plus and LTD: You may enroll at any time during the year, but if you enroll at any time other than your initial enrollment period, you will have a one-year wait and a reduction in benefits.</p>

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

NOTE: These benefits require you to meet the definition of active-work or actively-at-work. See the **Active-work or actively-at-work** section in this chapter for more information.

Temporary and ineligible associates and part-time associates hired on or after January, 15, 2011 who do not work the required number of hours for benefits eligibility

Plan:	Enrollment Periods and Effective Dates:
<ul style="list-style-type: none"> • Business Travel Accident insurance • Resources For Living 	Automatically enrolled on your date of hire.

NOTE: Temporary associates are not eligible for any other benefits including company-paid life insurance and disability.

Management associates, management trainees, California pharmacists and full-time truck drivers: No wait

Plan:	Enrollment Periods and Effective Dates:
<ul style="list-style-type: none"> • Medical • HMO Plans • Dental (Enrollment is for two full calendar years) • AD&D • Critical illness insurance • Accident insurance 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 60th day after your date of hire.</p> <p>When coverage is effective: Your date of hire.</p> <p>Critical illness insurance: If you enroll for during your initial enrollment period, your coverage will be effective on your date of hire. All amounts elected outside of your initial enrollment period require Proof of Good Health which will be available electronically when you complete an online enrollment session. If you do not complete the electronic Proof of Good Health questionnaire, you will have 60 days from the date you enroll for coverage to complete a paper form sent to you by Allstate.</p>
Company-paid life insurance	Automatically enrolled on your date of hire.
<ul style="list-style-type: none"> • Business Travel Accident insurance • Resources For Living 	Automatically enrolled on your date of hire.
<ul style="list-style-type: none"> • Optional life insurance • Dependent life insurance • Long-term disability • Truck driver long-term disability 	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 60th day after your date of hire.</p> <p>When coverage is effective: If you enroll during your initial enrollment period, your guaranteed issue amounts will become effective on your enrollment date. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential.</p> <p>For optional or dependent life insurance: You may enroll at any time during the year, but Proof of Good Health may be required.</p> <p>For LTD: You may enroll at any time during the year, but if you enroll at any time other than your initial enrollment period, you will have a one-year wait and a reduction in benefits.</p> <p>For Truck Driver LTD: You may enroll at any time during the year, but if you enroll at any time other than your initial enrollment period, you will be required to provide Proof of Good Health. You will have a reduction in benefits for one year from 50 percent of average monthly wage to 40 percent.</p>

STD and STD Plus are not available to management associates, management trainees, full-time truck drivers and California pharmacists.

NOTE: These benefits require you to meet the definition of active-work or actively-at-work. See the **Active-work or actively-at-work** section in this chapter for more information.

Paying for your benefits

Payroll deductions will be withheld from your Walmart paycheck to pay for your benefits selections. Generally, the first paycheck after your effective date should reflect deductions for each day that you had coverage within that pay period. If an end-of-year pay period covers both the prior and new year, your deductions will reflect the amount for the prior year through December 31 and the new amount for the new year, prorated for the number of days covered from January 1 until the end of the pay period.

Your payroll deductions reflect your cost for benefits for the payroll period ending on the date of your paycheck. So, if you are paid biweekly, your deductions pay for coverage for the previous two weeks. Deductions are based on biweekly (every other week) pay periods (except in Rhode Island which has weekly pay periods).

If you are enrolled in the HDP Standard plan, you also can contribute to a Health Savings Account on a pre-tax basis. See the **Health Savings Account** chapter for more information.

If your payroll deductions are not withheld for any reason, unpaid premiums must be paid in full from your original effective date. This could result in extra deductions from your paycheck.

It's important to check your paycheck stub to be sure that the proper deductions are being taken. Remember, you can view your paycheck stub online the Monday before payday by going to **Online Paystub on mywalmart.com**. If the coverage and deductions you selected are not correct on your paycheck stub, call Benefits Customer Service immediately at **(800) 421-1362**.

Many of your Walmart benefits are paid for with pretax dollars. Purchasing with pretax dollars means your payroll deductions for coverage are deducted from your paycheck before federal and, in most cases, state taxes are withheld. The result is that your pay remains the same but your taxes are lower, your benefits dollars go further and you get more for your money.

Because Social Security taxes are not withheld on any pretax dollars you spend for benefits, amounts you pay for benefits with pretax dollars will not be counted as wages for Social Security purposes. As a result, your future Social Security benefits may be reduced somewhat.

Deductions for premiums or contributions that are past due or for retroactive elections may be made on an after-tax basis.

Tobacco-free rates

If you (and/or your covered spouse) are tobacco-free, you can receive lower tobacco-free rates for medical/precription drug coverage, optional life insurance, spouse life insurance, and/or critical illness insurance. "Tobacco-free" means that you (and/or your covered spouse) do not use tobacco in any form – cigarettes, e-cigarettes, cigars, pipes, snuff, or chewing tobacco. To be considered a non-tobacco user and eligible for the lower tobacco-free rate, you must pledge to remain tobacco-free in 2012 and not have used any type of tobacco product:

- For 30 days before you enroll, if you are a newly eligible associate; or
- As of a specified date before annual enrollment.

If you become tobacco-free after you enroll, you can begin receiving the tobacco-free rates for the plan year following your next annual enrollment.

The lower tobacco-free rates are offered on the honor system. The statement below is shown on the screen when enrolling for benefits and answering the tobacco-free questions:

"Our expectation is that you will apply for or enroll in benefits using correct and accurate information. If not, you may be subject to the loss of benefits and/or loss of employment. To review Walmart's policy about intentional dishonesty, please refer to the Statement of Ethics, which can be found on the WIRE."

If a report of abuse is brought forward, an ethics investigation will take place.

HIPAA requires the Plan to offer a reasonable accommodation to participants who are deemed medically incapable of quitting smoking. Accordingly, associates and spouses who are able to answer "Yes" to the following question will receive the discount:

"Has your physician told you that it is unreasonably difficult to quit using tobacco due to a medical condition or medically inadvisable for you to attempt to stop using tobacco products at this time?"

Walmart offers the free Quit Tobacco program to all associates. For more information, see **Quit Tobacco programs** in **The medical plan** chapter.

Benefits continuation if you go on a leave of absence

A leave of absence provides you with needed time away from work while maintaining eligibility for benefits and continuity of employment. To accommodate situations that necessitate absence from work, the company provides three types of leave:

- **Family Medical Leave Act of 1993 (FMLA):** An approved FMLA leave provides you with time away from work so that you can receive medical treatment and/or recover from medical treatment, injury or disability. This includes disabilities, pregnancy, childbirth, other serious health conditions, to care for a child after childbirth or adoption, to care for a spouse, child or parent who has a serious medical condition, or to take care of certain needs when a spouse, child or parent is called to active military duty.
- **Personal Leave:** An approved personal leave provides you with time away from work so that you can deal with personal situations, such as a family crisis, or continuing your education.
- **Military Leave:** If you volunteer for or are required to perform active, full-time U.S. military duty or to fulfill National Guard or Reserve obligations, you will be granted a military leave.

Walmart will maintain medical, dental, critical illness insurance, accident insurance, life, AD&D, short-term disability plus and Resources For Living coverage while you are on FMLA or Personal Leave, where such coverage was provided before the leave was taken. Such coverage generally will be maintained on the same terms and conditions as if you had continued to work during the leave period. You must make arrangements by contacting Benefits Customer Service at **(800) 421-1362** to pay your share of health benefits costs during your leave.

If you cancel your coverage during your FMLA or Personal Leave and return to work, you may contact Benefits Customer Service to reinstate your coverage. See the **If you go on a leave of absence** section to learn more about each benefit.

You may continue or suspend coverage for yourself and/or your eligible dependents while on Military Leave. You may also have a right to re-instate coverage upon your return. Contact Benefits Customer Service at **(800) 421-1362**.

Decisions about leaves of absence are made by the company, not the Plan.

You should contact a member of your management team for additional information about FMLA, Personal or Military Leave, or refer to Walmart's Leave of Absence Policy on the [WIRE](#) for more specific information. You may also contact your personnel representative if you have questions about the application of the FMLA, Personal or Military Leave Policy.

Paying for benefits while on a leave of absence

To continue coverage for the following benefits, you must make payments for your portion of the contribution by paying those costs on an after-tax basis while you are on a leave of absence. Please be sure to include your name, insurance ID and facility number on the payment to ensure proper credit. Please allow 10-14 days for processing. Premium payments you are responsible for include:

- Medical
- Dental
- Critical illness insurance
- Accident insurance
- Optional life insurance
- Dependent life insurance
- Accidental death and dismemberment
- Short-term disability plus

You are paying for coverage for the previous pay period. You may experience an interruption in the payment of medical, dental, pharmacy, critical illness insurance, accident insurance, life insurance and AD&D claims. To avoid an interruption, you can pay for coverage in advance when you pay your regular premium. For more information call Benefits Customer Service at **(800) 421-1362**.

Payments for premiums or contributions may be made by check or money order and should be payable to Associates' Health and Welfare Trust and mailed to:

Benefits Customer Service
P.O. Box 1039
Department 3001
Lowell, AR 72745

Please be sure to include your name, insurance ID and facility number on the payment to ensure proper credit.

You may also pay by credit card by calling **(800) 421-1362** and selecting the credit card payment option, using either Visa, MasterCard or Discover credit cards.

If you are on a leave of absence and you owe payments for benefits to the Plan, any check issued by the company including during or after your leave of absence (i.e. vacation, incentive, etc.), will have the full amount of premiums deducted. Payment arrangements can also be made by notifying Benefits Customer Service prior to your return to work.

Generally, payments to continue your coverage can only be accepted from you, a family member or a health care provider.

If your coverage is cancelled, please see the applicable benefit section for how to reinstate coverage.

Changing your benefits during the year: status change events

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

- After-tax benefits can be added or dropped at any time. After-tax benefits are optional life insurance, dependent life insurance, short-term disability, short-term disability plus, long-term disability and truck driver long-term disability.
- Pretax benefits generally can only be changed during annual enrollment unless you have a status change event. Pretax benefits are the Associates' Medical Plan, HMO plans, dental, AD&D, critical illness insurance and accident insurance.

Because of the pretax nature of these premiums, federal tax law generally requires that your pretax benefit choices remain in effect for the entire calendar year in which the choice was made. Pretax contributions to a Health Savings Account can be changed at any time.

However, you may make certain coverage changes if a status change event occurs. A status change event is an event that allows you to make changes to your coverage outside of annual enrollment. Federal law generally requires that your requested election change be due to and correspond with your change in status, and affect eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the change you request.

Status change events include:

Events that change your marital status:

- Marriage
- Death of your spouse
- Divorce (including the end of a common-law marriage in states where a divorce decree is required to end a common-law marriage; the company may require this documentation)
- Annulment
- Legal separation

Events that change the number of your dependents:

- Birth
- Adoption
- Placement for adoption
- Death of a dependent
- Gain of custody of a dependent
- Loss of custody of a dependent for whom you have previously been awarded legal custody or guardianship of by a judge
- Your paternity test result
- When a dependent loses eligibility, such as at the age of 26

Employment changes of you, your spouse or your dependent:

- Going on or returning from an approved leave of absence
- Gain or loss of coverage due to starting or ending employment
- A change in work location that affects medical coverage. If the change affects your medical coverage, you will have 60 calendar days from your transfer to submit a request to change your coverage. If you transfer work locations where your medical benefits are affected and do not submit a request, you will automatically be enrolled in a predetermined plan.
- If you, your spouse or your dependent(s) gain or lose coverage under any other employer plan, you may change your coverage in a manner consistent with the change. For example, if your spouse enrolls in or drops coverage during an annual enrollment at his or her place of employment or due to a status change event, you may change your coverage in a manner consistent with your spouse's change in coverage.

- If your ex-spouse enrolls in or drops coverage for your eligible dependent children during an annual enrollment period at his or her place of employment or due to a status change event, you may change your coverage in a manner consistent with that change in coverage.

Loss of coverage

- You may add medical and/or dental coverage for you and/or your eligible spouse and dependent(s) if you originally declined coverage because you and/or your spouse and dependent(s) had COBRA coverage and that COBRA coverage has ended (non-payment of premiums is not sufficient for this purpose), or you and/or your spouse and dependent(s) had non-COBRA medical coverage and the other coverage has terminated due to loss of eligibility for coverage or employer contributions toward the other coverage have terminated.
- A change may also be allowed if there is a significant loss of coverage under the benefits available at Walmart, such as an HMO plan in your area discontinuing service or ceasing to operate. The Plan will determine whether a significant loss of coverage has occurred.
- A change may be allowed if the lifetime maximum for all medical benefits under another plan has been met.
- If you, your spouse or your eligible dependents lose coverage under a governmental plan including Title XIX of the Social Security Act (Medicaid) or a state children's health plan under Title XXI of the Social Security Act, an educational institution's plan, or a tribal government plan, you can add coverage under the Associates' Medical Plan, an HMO plan, accident insurance or critical illness insurance within 60 days of the loss of coverage.
- A change may also be allowed pursuant to a court order.

Gain of other coverage

- If an order resulting from a divorce, legal separation, annulment or change in legal custody (including Qualified Medical Child Support Order — see **QMCSO** later in this chapter) requires you to provide medical and/or dental coverage for your eligible dependents, you may add coverage for your eligible dependent (and yourself, if you are not already covered). If the order requires your spouse, former spouse or other

person to provide medical and/or dental coverage for your dependent, and that other coverage is in fact provided, you may drop coverage for the dependent.

- If you, your spouse or your eligible dependents are enrolled in the Associates' Medical Plan, an HMO plan, accident insurance or critical illness insurance, you can drop that coverage to the extent you, your spouse or your dependents become entitled to Medicare or Medicaid benefits.
- If you, your spouse or your eligible dependents gain eligibility under a governmental plan (other than Medicare or Medicaid), you cannot drop the Associates' Medical Plan, an HMO plan, accident insurance or critical illness insurance coverage except during annual enrollment.
- If you, your spouse or your eligible dependents become eligible for assistance for Plan coverage under Title XIX of the Social Security Act (Medicaid) or a state children's health plan under Title XXI of the Social Security Act, you must request coverage under the Plan within 60 days of becoming eligible for assistance. Such coverage will be effective on the date you enroll in the Plan.

Making status change event changes

When you have a status change event, you must request your change within 60 days from the date of the event. Any changes you request as a result of the status change event must be consistent with the event and the gain or loss of coverage. This means there must be a logical relationship between the event and the change you request. For example, if you have a status change event that affects your dependent child's eligibility, you can only drop or add coverage for that child. It would not be consistent to add a spouse due to this event.

Unless otherwise provided in the Plan, if you add a spouse or eligible dependent due to a status change event, they will be subject to the same plan limitations that apply to you at that time, if any (for example, limits concerning transplant coverage). If you change from an HRA plan to the HDP Standard plan, or from the HDP Standard plan to an HRA plan, or from an HMO to either the HDP Standard plan or an HRA plan due to a status change event, your annual deductible and out-of-pocket maximum will reset. If you change to an HRA plan, your HRA amount will be prorated. If you change from an HRA plan, your HRA balance will be forfeited. See **The medical plan** chapter for more information.

When dependent(s) are added due to a status change event during annual enrollment, the associate and dependent will be subject to the same Plan limitations that apply to whichever of them has been continuously covered on the Plan for the longer period of time. This applies to benefits that have a one-year wait and pre-existing waiting periods. Plan participants under the age of 19 are not subject to pre-existing condition limitations.

The Plan reserves the right to request additional necessary documentation to show proof of a status change event.

HIPAA special enrollment for medical coverage

Under the Health Insurance Portability and Accountability Act (HIPAA), you also may have a right to a special enrollment in medical coverage under the Plan if you lose other coverage or acquire a dependent. These events are described in the list of status change events and include:

- If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that coverage (or if the employer stops contributing toward your or your dependents' other coverage).

However, you must request enrollment within 60 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

- If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your eligible dependents. However, you must request enrollment within 60 days.
- If you or a dependent is no longer eligible for coverage under Title XIX of the Social Security Act (Medicaid) or a state children's health plan under Title XXI of the Social Security Act or you or a dependent becomes eligible for assistance for Plan coverage under Title XIX of the Social Security Act (Medicaid) or a state children's health plan under Title XXI of the Social Security Act, you must request enrollment within 60 days of the prior coverage terminating or becoming eligible for assistance. Such coverage will be effective upon the date you enroll in the Plan.

To request special enrollment or obtain more information, read the status change events information in this chapter or contact Benefits Customer Service at **(800) 421-1362**.

How to change your elections due to a status change event

You can make changes online within 60 days on the **WIRE** at work or on **mywalmart.com** for status changes due to:

- Marriage
- Birth
- Divorce
- Gain or loss of coverage by your eligible spouse
- Special enrollment period

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

Changes to your coverage will be effective on the event date or on the day after the event date of the status change. If a change is made due to your unpaid leave of absence, the change will be effective as of the effective date of your leave of absence.

This does not apply to optional life insurance, dependent life insurance, STD, STD plus, LTD or Truck Driver LTD; see each individual chapter for effective date information.

If you do not notify Benefits Customer Service or go online and make a change within 60 days of the status change event, you will not be able to add or drop coverage until the next annual enrollment period or when you have a different status change event.

Also, if the status change event is your dependent losing eligibility, your dependent will lose the right to elect COBRA coverage for medical or dental benefits if you do not notify Benefits Customer Service of the event within 60 days. Similarly, if the status change event is your divorce, your former spouse will lose the right to elect COBRA coverage for medical or dental benefits if he or she does not notify Benefits Customer Service of the

event within 60 days. See the **COBRA** chapter for more information.

If your job classification changes

If you transition from one job classification to another, you may be eligible (or ineligible) for certain benefits.

When you become a part-time associate, your spouse will no longer be eligible for medical, critical illness insurance and accident insurance. You and your family members will no longer be eligible for dental, life, AD&D or disability coverage. See the respective chapters in this book for more information.

Coverage effective dates when transferring from one job classification to another

Part-time or temporary associates transferring to a full-time hourly supervisor or full-time hourly Logistics position with 90-day wait

If Your Transition Occurs:	Date Coverage Is Effective:
And you have been continuously employed for more than one year, and were eligible for coverage under the Plan immediately prior to your transition	<ul style="list-style-type: none"> You will have 60 days to enroll from the first day of the pay period your transition occurs. Your coverage will be effective the first day of the pay period your transition occurs. Remember, premiums will be deducted from your paycheck back to your effective date once you enroll. You will be eligible to enroll in dental, AD&D, life and disability insurance. If you enroll for optional life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential. If you are currently enrolled in medical, critical illness and/or accident insurance, you can increase your coverage type to Associate + Spouse or Associate + Family. If you are not currently enrolled in medical, critical illness and/or accident insurance, you will only be able to enroll in Associate + Spouse or Associate + Family until the next annual enrollment period or with a valid status change event. (As a part-time associate you were eligible for Associate Only and Associate + Child(ren) coverage, therefore you are not eligible to select from these coverage tiers.)
And you have been continuously employed for more than one year, and were not eligible for coverage under the Plan immediately prior to your transition	<ul style="list-style-type: none"> You will have 60 days to enroll from the first day of the pay period your transition occurs. Your coverage will be effective the first day of the pay period your transition occurs. Remember, premiums will be deducted from your paycheck back to your effective date once you enroll. You will be eligible to enroll in medical, dental, critical illness, accident insurance, AD&D, life and disability insurance. If you enroll for optional life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential.
And you have been continuously employed more than 90 days but less than one year	<ul style="list-style-type: none"> You will have 60 days to enroll from the first day of the pay period your transition occurs. Your coverage will be effective the first day of the pay period your transition occurs. Premiums will be deducted from your paycheck back to your effective date once you enroll. You will be eligible to enroll in medical, dental, AD&D, life, disability, critical illness and accident insurance. If you enroll for optional life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential.
And you have been continuously employed less than 90 days	<ul style="list-style-type: none"> You will have 60 days to enroll from the first day of the pay period your transition occurs. Your coverage will be effective the 91st day of continuous employment from your hire date. Premiums may be deducted from your paycheck back to your effective date of coverage if you enroll after your 90th day of continuous employment. You will be eligible to enroll in medical, dental, AD&D, life, disability, critical illness and accident insurance. If you enroll for optional life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential.

Part-time or temporary associates transferring to a full-time hourly position with 180-day wait

If Your Transition Occurs:	Date Coverage Is Effective:
And you have been continuously employed for more than one year, and were eligible for coverage under the Plan immediately prior to your transition	<ul style="list-style-type: none"> You will have 60 days to enroll from the first day of the pay period your transition occurs. Your coverage will be effective the first day of the pay period your transition occurs. Keep in mind, premiums will be deducted from your paycheck back to your effective date once you enroll. You will be eligible to enroll in dental, AD&D, life and disability insurance. If you enroll for optional life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential. If you are currently enrolled in medical, critical illness and/or accident insurance, you can increase your coverage type to Associate + Spouse or Associate + Family. If you are not currently enrolled in medical, critical illness and/or accident insurance, you will only be able to enroll in Associate + Spouse or Associate + Family until the next annual enrollment period. (As a part-time associate you were eligible for Associate Only and Associate + Child(ren) coverage, therefore you are not eligible to select from these coverage tiers.)
And you have been continuously employed for more than one year, and were not eligible for coverage under the Plan immediately prior to your transition	<ul style="list-style-type: none"> You will have 60 days to enroll from the first day of the pay period your transition occurs. Your coverage will be effective the first day of the pay period your transition occurs. Remember, premiums will be deducted from your paycheck back to your effective date once you enroll. You will be eligible to enroll in medical, dental, critical illness, accident insurance, AD&D, life and disability insurance. If you enroll for optional life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential.
And you have been continuously employed more than 180 days but less than one year	<ul style="list-style-type: none"> You will have 60 days to enroll from the first day of the pay period your transition occurs. Your coverage will be effective the first day of the pay period your transition occurs. Premiums will be deducted from your paycheck back to your effective date once you enroll. You will be eligible to enroll in medical, dental, AD&D, life, disability, critical illness and accident insurance. If you enroll for optional life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential.
And you have been continuously employed less than 180 days	<ul style="list-style-type: none"> You will have 60 days to enroll from the first day of the pay period your transition occurs if your transition occurs after your 120th day of employment. Your coverage will be effective on your 181st day of employment. You will be eligible to enroll in medical, dental, AD&D, life, disability, critical illness and accident insurance. If you enroll for optional life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential.

Part-time or temporary associates transferring to management

If Your Transition Occurs:	Date Coverage Is Effective:
And you have been continuously employed for more than one year, and were eligible for coverage under the Plan immediately prior to your transition	<ul style="list-style-type: none"> You will have 60 days to enroll from the first day of the pay period your transition occurs. Your coverage will be effective the first day of the pay period your transition occurs. Premiums will be deducted from your paycheck back to your effective date once you enroll. You will be eligible to enroll in dental, AD&D, life and long-term disability insurance (short-term disability is not required for management associates). If you enroll for optional life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential. If you are currently enrolled in medical, critical illness and/or accident insurance, you can increase your coverage to Associate + Spouse or Associate + Family. If you are not currently enrolled in medical, critical illness and/or accident insurance, you will only be able to enroll in Associate + Spouse or Associate + Family until the next annual enrollment period or with a valid status change event. (As a part-time associate you were eligible for Associate Only and Associate + Child(ren) coverage, therefore you are not eligible to select from these coverage tiers.)
And you have been continuously employed for more than one year, and were not eligible for coverage under the Plan immediately prior to your transition	<ul style="list-style-type: none"> You will have 60 days to enroll from the first day of the pay period your transition occurs. Your coverage will be effective the first day of the pay period your transition occurs. Remember, premiums will be deducted from your paycheck back to your effective date once you enroll. You will be eligible to enroll in medical, dental, critical illness, accident insurance, AD&D, life and disability insurance. If you enroll for optional life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential.
And you have been continuously employed for less than one year	<ul style="list-style-type: none"> You will have 60 days to enroll from the first day of the pay period your transition occurs. Your coverage will be effective the first day of the pay period your transition occurs. Premiums will be deducted from your paycheck back to your effective date once you enroll. You will be eligible to enroll in medical, dental, AD&D, life and long-term disability insurance, critical illness and accident insurance (short-term disability is not required for management associates). If you enroll for optional life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential.

Full-time hourly associates with 180-day wait transferring to management

If Your Transition Occurs:	Date Coverage Is Effective:
And you have been continuously employed for more than 180 days	<ul style="list-style-type: none"> No changes will take place to the benefits plans in which you are currently enrolled unless you are enrolled in short-term disability and short-term disability plus. They will be cancelled on the first day of the pay period your transition occurs.
And you have been continuously employed for less than 180 days	<ul style="list-style-type: none"> You will have 60 days to enroll from the first day of the pay period your transition occurs. Your coverage will be effective the first day of the pay period your transition occurs. Premiums will be deducted from your paycheck back to your effective date once you enroll. You will be eligible to enroll in medical, dental, AD&D, life and long-term disability insurance, critical illness and accident insurance (short-term disability is not required for management associates). If you enroll for optional life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential.

Full-time hourly associates with a 90-day wait transferring to management

If Your Transition Occurs:	Date Coverage Is Effective:
And you have been continuously employed for more than 90 days	<ul style="list-style-type: none">No changes will take place to the benefits plans in which you are currently enrolled unless you are enrolled in short-term disability and short-term disability plus. They will be cancelled on the first day of the pay period your transition occurs.
And you have been continuously employed for less than 90 days	<ul style="list-style-type: none">You will have 60 days to enroll from the first day of the pay period your transition occurs.Your coverage will be effective the first day of the pay period your transition occurs. Premiums will be deducted from your paycheck back to your effective date once you enroll.You will be eligible to enroll in medical, dental, AD&D, life and long-term disability insurance, critical illness and accident insurance (short-term disability is not required for management associates). If you enroll for optional life insurance during your initial enrollment period, your guaranteed issue amount will become effective on your enrollment date or your eligibility date, whichever is later. If you have to complete Proof of Good Health, your coverage will be effective upon approval by Prudential.

Full-time hourly associates with no wait transferring to management

If Your Transition Occurs:	Date Coverage Is Effective:
And you have been continuously employed with no wait time	<ul style="list-style-type: none">No changes will take place to the benefits plans in which you are currently enrolled unless you are enrolled in short-term disability and short-term disability plus. They will be cancelled on the first day of the pay period your transition occurs.

Management associates transferring to full-time hourly

	<ul style="list-style-type: none">No changes will take place to the benefits plans in which you are currently enrolled.You will automatically be defaulted into short-term disability and short-term disability plus on the first day of the pay period your transition occurs (except in California, Rhode Island, Hawaii, New York and New Jersey where state mandated short-term disability laws apply).If you don't want short-term disability and short-term disability plus, you can cancel at any time by completing an online enrollment session on the WIRE or mywalmart.com, or by calling Benefits Customer Service at (800) 421-1362.
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Temporary associates transferring to full-time hourly or management

	<ul style="list-style-type: none">Eligibility rules apply based on the job you are transferring to. You will have 60 days to enroll.The amount of time you have been continuously employed will apply toward the required eligibility wait time of the job you are transferring to.Your coverage will be effective on the first day of the pay period after your transition occurs and have completed the required wait time. Premiums may be deducted from your paycheck back to your effective date once you enroll as applicable.
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Temporary associates transferring to part-time

If Your Transition Occurs:	Date Coverage Is Effective:
And you have been continuously employed for more than one year	<ul style="list-style-type: none"> You will have 60 days to enroll from the first day of the pay period your transition occurs. The amount of time you have been continuously employed will apply toward the required eligibility wait time of the job you are transferring to. Your coverage will be effective the first day of the pay period your transition occurs. Keep in mind premiums will be deducted from your paycheck back to your effective date once you enroll. You will only be eligible to enroll in medical and critical illness and accident insurance. You can select Associate Only or Associate + Child(ren) coverage. Associate + Spouse and Associate + Family is not available to part-time associates.
But have NOT met your eligibility waiting period	<ul style="list-style-type: none"> If you were hired on or after 1/15/11 and have worked the required hours, you will have 60 days prior to your 365th day of employment to enroll in medical, critical illness and accident insurance. The amount of time you have been continuously employed will apply toward the required eligibility wait time of the job you are transferring to. You can select Associate Only or Associate + Child(ren) coverage. Associate + Spouse and Associate + Family is not available to part-time associates. Your coverage will be effective on your 366th day of continuous employment.

Full-time hourly associates transferring to part-time

If Your Transition Occurs:	Date Coverage Is Effective:
And have met your eligibility waiting period, and were eligible for coverage under the Plan immediately prior to your transition	<ul style="list-style-type: none"> If you are enrolled in medical, critical illness and/or accident insurance coverage, your coverage type will automatically adjust to Associate Only or Associate + Child(ren) (depending on if you have covered dependents) effective the first day of the pay period after your transition occurs. Associate + Spouse and Associate + Family coverage is not available to part-time associates. All other coverage (dental, AD&D, life and disability) will be cancelled effective the first day of the pay period after your transition occurs. You may be able to convert your and your dependent's life insurance, critical illness and/or accident insurance to an individual policy.
But have NOT met your eligibility waiting period	<ul style="list-style-type: none"> If you were hired on or after 1/15/11 and have worked the required hours, you will have 60 days prior to your 365th day of employment to enroll in medical, critical illness and accident insurance. You can select Associate Only or Associate + Child(ren) coverage. Associate + Spouse and Associate + Family is not available to part-time associates. Your coverage will be effective on your 366th day of continuous employment.

Management associates transferring to part-time...

	<ul style="list-style-type: none"> If you are enrolled in medical coverage, your coverage type will automatically adjust to Associate Only or Associate + Child(ren) (depending on if you have covered dependents) effective the first day of the pay period after the date your transition occurs. Your critical illness and accident insurance will automatically adjust to Associate Only or Associate + Child(ren) (depending on if you have covered dependents) effective the first day of the pay period after your transition occurs. (Part-time associates are not eligible for Associate + Spouse or Associate + Family coverage tiers.) All other coverage (dental, AD&D, life and disability) will be cancelled effective the first day of the pay period after your transition occurs. You may be able to convert your and your dependent's life insurance, critical illness and/or accident insurance to an individual policy.
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You will have 60 days from the date of your transition to a part-time hourly or part-time truck driver position to elect any other medical coverage option available to you and/or dependents under the Plan. You may not drop medical coverage for yourself and/or your dependent children during the Plan year. If you do not elect to change your coverage option within the 60-day enrollment period, you will continue in the same full-time medical coverage option excluding spouse coverage. You may change elections during any future annual enrollment period or as the result of a status change event.

Qualified Medical Child Support Orders (QMCSO)

A QMCSO is a final court or administrative agency order that requires an associate or other parent or guardian to provide health care coverage for eligible dependents after a divorce or child custody proceeding. Federal law requires the Plan to provide medical and/or dental benefits to any eligible dependent of a Plan participant required by a court order meeting the qualifications of a QMCSO.

The written procedures for determining whether an order meets the federal requirements may be obtained free of charge by contacting Benefits Customer Service at **(800) 421-1362**.

Once the Plan determines an order to be a QMCSO, coverage will begin the first day of the pay period in which the Plan receives the order unless another date is specified in the order. If you are eligible for the medical and/or dental plan and have not elected coverage before the order was received and the QMCSO does not specify otherwise, you will be enrolled in the 2012 default HRA Basic, Associate + Child(ren) tobacco-rate coverage. If you were enrolled for coverage before the order was received, your child will be added under your existing coverage. If you are enrolled in an HMO plan, your coverage will change to the HRA Enhanced. You will have 60 days to call Benefits Customer Service to select a different medical plan.

If the Plan receives a QMCSO prior to you satisfying your initial waiting period, the order will be put into effect when your initial waiting period is satisfied.

Dropping or changing QMCSO coverage

You may drop the court-ordered child's coverage that was put into effect due to a QMCSO if the following applies:

- The QMCSO is terminated by a court or administrative agency order — you must request your change within 60 days.
- The QMCSO is rescinded by a court or administrative agency order.
- A child who was the subject of the court order reaches the age identified in the state issuing the court-order for termination of coverage. Contact your state child support enforcement agency for details.

The court-ordered child's coverage will end on the first day of the pay period in which the Plan receives the order or the date specified in the order. If the rescind order is received, coverage will be retroactively withdrawn and you will be returned to the coverage or no coverage that you had before the QMCSO was enforced to the extent permitted by law.

When a QMCSO terminates, an associate may drop medical and/or dental coverage for the children named in the QMCSO, however, under federal law governing pretax benefits, you may not drop your own coverage or coverage for any dependent voluntarily added after the QMCSO was put into effect unless there is a change in status for you or your child(ren), or during annual enrollment. For dental coverage, you may not drop coverage at annual enrollment or due to a status change event, unless you have been covered for two full calendar years.

When your Plan coverage ends

Coverage under the Associates' Health and Welfare Plan for you and your dependents will end on the earliest of the following:

- At termination of your employment;
- Upon failure to pay your premiums within 30 days of the date your premium is due;
- On the date of your (the associate's) death for you and your dependents;
- On the date of death for a deceased dependent;
- On the date you, a dependent spouse or child loses eligibility;
- When the benefit is no longer offered by Walmart;
- Upon misrepresentation or the fraudulent submission of a claim for benefits or eligibility; or
- The day after you drop coverage.

Remember that premium deductions will be withheld from your final paycheck since your deductions are paying for coverage for the previous two weeks.

Eligibility and benefits for associates in Hawaii

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Eligibility and benefits for associates in Hawaii

Aloha! As an associate in Hawaii, you have special rules for enrolling in the medical plan and two medical plan options: Health Plan Hawaii (HMSA) and the Kaiser Foundation Health Plan. Because Hawaii has a state-mandated disability plan, you are not eligible for the company short-term disability plan. Other than the eligibility and benefit differences described in this chapter, the information in this *2012 Associate Benefits Book* applies to you.

Resources for Hawaii associates		
Find What You Need:	Online:	Other Resources:
Health Plan Hawaii (HMSA)	hmsa.com	(808) 948-6372
Kaiser Foundation Health Plan	kaiserpermanente.org	(800) 966-5955
Enroll for benefits	Complete, print and fax an enrollment form located on the WIRE	Fax to (479) 621-2513
Make changes to your benefits due to a status event change	Complete, print and fax an enrollment form located on the WIRE	Fax to (479) 621-2513

What you need to know as a Hawaii associate

- Full-time hourly associates (including full-time hourly pharmacists, field Logistics associates and field supervisor positions in stores and clubs), part-time and temporary associates in Hawaii each have different initial eligibility periods for medical coverage.
- Associates in Hawaii have two medical coverage options: Health Plan Hawaii (HMSA) and the Kaiser Foundation Health Plan. For more information about these medical options, see your personnel representative.
- Associates in Hawaii follow the eligibility guidelines as described in the **Eligibility and enrollment** chapter for dental, company-paid life insurance, optional and dependent life insurance, critical illness insurance, accident insurance, accident death and dismemberment (AD&D), Business Travel Accident insurance, short-term disability plus, long-term disability and Resources For Living.
- Associates in Hawaii are not eligible to enroll for short-term disability because there is a state-mandated disability plan. For additional information, contact the plan provider at **(808) 534-7073**.
- Associates in Hawaii enrolling in or changing their critical illness or accident insurance coverage must complete an Allstate form. Complete, print and fax the form located on the [WIRE](#).
- Associates in Hawaii must enroll for benefits by completing an enrollment form. A copy is on the [WIRE](#).

Eligibility waiting period for medical coverage for management associates and management trainees

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

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

Medical coverage for full-time hourly associates (including full-time hourly pharmacists, field Logistics associates, field supervisor positions in stores and clubs, full-time hourly Vision Center managers and walmart.com functional non-exempt associates) and part-time and temporary associates in Hawaii will become effective as of the earlier of:

Full-time hourly associates:

- The first day of the pay period following a period of working at least 20 hours per week for four consecutive weeks; or
- Full-time hourly associates in Hawaii can enroll for medical coverage between 120 days from your date of hire and prior to your 180th day. Your coverage will be effective on the 181st day of continuous full-time employment.

Part-time hourly associates:

- The first day of the pay period following a period of working at least 20 hours per week for four consecutive weeks; or
- Part-time associates in Hawaii can enroll for medical coverage 60 days prior to your one-year anniversary date of continuous employment. Coverage will be effective as of the 366th day of continuous work.

Temporary associates:

- Temporary associates in Hawaii can enroll on the first day of the pay period following a period of working at least 20 hours per week for four consecutive weeks. Medical coverage will become effective as of the first day of the pay period (following a period of working at least 20 hours per week for four consecutive weeks).

Associates in Hawaii follow the eligibility guidelines as described in the **Eligibility and enrollment** chapter for dental, optional and dependent life insurance, critical illness insurance, accident insurance, AD&D, Business Travel Accident insurance, short-term disability plus and long-term disability.

Medical coverage options for Hawaii associates

Associates in Hawaii have two coverage options:

- Health Plan Hawaii (HMSA) and
- Kaiser Foundation Health Plan.

For more information about these medical options, see your personnel representative.

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

Management and full-time hourly associates (including full-time hourly pharmacists, field Logistics associates, field supervisor positions in stores and clubs, full-time hourly Vision Center managers and walmart.com functional non-exempt associates) and part-time and temporary associates in Hawaii have the same status change event guidelines as described in the **Eligibility and enrollment** chapter except as described in this chapter.

Status change events

If the status change form or online form is dated or the status change event is called in to Benefits Customer Service more than 60 days past the event date, changes will not be allowed.

Paying premiums during a leave of absence for Hawaii associates

Because the associate portion of your medical premium is wage-based, there will be no premium due if there are no wages. The only premium due while on a leave of absence with no wages will be the dependent portion of your premium. All other coverages require payment as described in the **Eligibility and enrollment** chapter.

Under Hawaiian law, Walmart is required to contribute at least 50 percent of the premium of associate medical coverage (but not dependent coverage). Associates are required to pay the rest of the biweekly cost of premium, but only up to 1.5 percent of their wages or 50 percent of the biweekly cost of the premium, whichever is less. So, for example, if an associate's biweekly wages were \$1,000, that associate could not be required to pay more than \$15 biweekly for coverage (assuming that the entire premium is at least \$30 biweekly).

Eligibility and benefits for associates in Massachusetts

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massachusetts

Eligibility and benefits for associates in Massachusetts

As an associate working in a location in Massachusetts, you have special rules for enrolling in a medical plan and several medical plan options: HRA or HDP Standard plans as well as an HMO where available. Other than the eligibility and benefit differences described in this chapter, the information in this *2012 Associate Benefits Book* applies to you.

Associates' Medical Plan resources			
Find What You Need:	Online:	By Phone:	Other Resources:
Third Party Administrator: BlueAdvantage Administrators of Arkansas	Go to mywalmart.com or blueadvantageadministrators ofarkansas.com	Customer service: (866) 823-3790 Medical pre-notification: (866) 823-3790 Behavioral Health pre-notification: (877) 709-6822	BlueAdvantage Administrators of Arkansas P.O. Box 1460 Little Rock, AR 72203-1460
Get a network directory	Go to the WIRE or mywalmart.com or see your Personnel representative	Call your provider locator telephone number which is located on your insurance ID card	
Get the cost for medical coverage	Go to mywalmart.com or the WIRE	Call Benefits Customer Service at (800) 421-1362	
For help getting your Certificate of Creditable Coverage (COCC) from Walmart		Call Benefits Customer Service at (800) 421-1362	
Medical advice from a registered nurse, available 24/7		Call the Ask Mayo Clinic Nurse Line at (800) 418-0758	
Request a paper copy of this 2012 Associate Benefits Book		Call Benefits Customer Service at (800) 421-1362	

What you need to know as a Massachusetts associate

- Full-time hourly associates (including full-time hourly pharmacists, field Logistics associates and field supervisor positions in stores and clubs) who work in Massachusetts have different initial eligibility periods for medical coverage.
- Associates who work in Massachusetts follow the eligibility guidelines as described in the **Eligibility and enrollment** chapter for dental, optional and dependent life insurance, critical illness insurance, accident insurance, accidental death and dismemberment (AD&D), Business Travel Accident insurance, short-term disability, short-term disability plus and long-term disability.
- Not all plans are considered "creditable" in all states. Ask your tax advisor if the plan you select is creditable to avoid any penalties.

The initial enrollment period for medical coverage for full-time hourly associates in Massachusetts

As a full-time hourly associate who works in facilities in Massachusetts, eligibility wait times vary. The following chart provides your coverage effective dates if you enroll during your initial enrollment period. If you do not enroll during your initial enrollment period, you may enroll during annual enrollment or if you experience a status change event. See **Changing your benefits during the year: status change events** found in the **Eligibility and enrollment** chapter for more information.

Full-time hourly Massachusetts associates: 90-day wait for medical/180-day wait for all other benefits	
Plan:	Enrollment Periods and Effective Dates:
<ul style="list-style-type: none">• Medical• HMO plans	<p>Initial enrollment period: Between the date of your first paycheck and prior to your 90th day after your date of hire.</p> <p>When coverage is effective: If you enroll during your initial enrollment period, 91st day of continuous full-time employment.</p>
<ul style="list-style-type: none">• Dental (Enrollment is for two full calendar years)• AD&D• Critical illness insurance• Accident insurance	<p>Initial enrollment period: Between 120 days from your date of hire and prior to your 180th day.</p> <p>When coverage is effective: 181st day of continuous full-time employment.</p> <p>Critical illness insurance: If you enroll during your initial enrollment period, your coverage will be effective on the 181st day of continuous full-time employment. If you enroll after your initial enrollment period has ended, Proof of Good Health will be required for all coverage amounts for you and your spouse (if applicable). If you choose not to complete the electronic questionnaire, you will have 60 days from the date you enroll for coverage to complete a paper form sent to you by Allstate.</p>
Company-paid life insurance	Automatically enrolled on 181st day from your date of hire.
<ul style="list-style-type: none">• Business Travel Accident insurance• Resources For Living	Automatically enrolled at your date of hire.
<ul style="list-style-type: none">• Optional life insurance• Dependent life insurance• Short-term disability• Short-term disability plus• Long-term disability	<p>Initial enrollment period: Between 120 days from your date of hire and prior to your 180th day.</p> <p>When coverage is effective: If you enroll during your initial enrollment period, your coverage will be effective on the 181st day of continuous full-time employment.</p> <p>For optional or dependent life insurance: You may enroll at any time during the year, but Proof of Good Health may be required. If Proof of Good Health has not been completed by the 181st day of continuous full-time employment, your coverage will be effective upon approval by Prudential.</p> <p>For STD, STD Plus and LTD: You may enroll at any time during the year, but if you enroll at any time other than your initial enrollment period, you will have a one-year wait and a reduction in benefits.</p>

NOTE: All benefits above require you to meet the definition of active-work or actively-at-work. See the **Active-work or actively-at-work** section in the **Eligibility and enrollment** chapter for more information.

The medical plan

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medical plan

The medical plan

Associates' Medical Plan resources			
Find What You Need:	Online:	By Phone:	Other Resources:
Third Party Administrator: BlueAdvantage Administrators of Arkansas	mywalmart.com or blueadvantagekansas.com	Customer service: (866) 823-3790 Medical pre-notification: (866) 823-3790 Behavioral Health pre-notification: (877) 709-6822	BlueAdvantage Administrators of Arkansas P.O. Box 1460 Little Rock, AR 72203-1460
Locate a network provider	Go to the WIRE or mywalmart.com or bcbs.com	Call your provider locator telephone number which is located on your insurance ID card	
Get the cost for medical coverage	Go to mywalmart.com or the WIRE	Call Benefits Customer Service at (800) 421-1362	
For help getting your Certificate of Creditable Coverage (COCC) from Walmart		Call Benefits Customer Service at (800) 421-1362	
Medical advice from a registered nurse, available 24/7		Call the <i>Ask Mayo Clinic</i> Nurse Line at (800) 418-0758	
Request a paper copy of this 2012 Associate Benefits Book		Call Benefits Customer Service at (800) 421-1362	

What you need to know about medical benefits

- The HRA Elite 3000, HRA Elite 5000, HRA Enhanced and HRA Basic all include a Health Reimbursement Account (HRA). An HRA is an amount of money the company sets aside to help pay your eligible medical expenses before you have to pay anything (except prescriptions). Read this chapter to learn how company-provided dollars in your HRA can help pay for eligible medical expenses.
- Any HRA money that is left at the end of the year rolls over year-to-year up to your total annual deductible amount as long as you continue to enroll in an HRA plan.
- The HDP Standard plan allows you to open a Health Savings Account (HSA) where you can save money through payroll deduction to pay for eligible medical expenses (as defined by the IRS), and Walmart will match your contributions up to predetermined limits.
- The HRA plans and HDP Standard 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 offers HMOs (Health Maintenance Organizations) in 13 states. HMO plans vary, so be sure to ask your personnel representative for a copy of the HMO plan material if one 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.

The Walmart medical plans

The following charts show the coverage tiers offered by the Associates' Medical Plan. The following sections explain how the medical plans work and what the terms mean.

Plan features	HRA Elite 3000	HRA Elite 5000	HRA Enhanced	HRA Basic
Company contribution to an HRA If you enroll in: <ul style="list-style-type: none">• Associate Only• Associate + Spouse• Associate + Child(ren)• Associate + Family	\$250 \$500 \$500 \$500	\$250 \$500 \$500 \$500	\$250 \$500 \$500 \$500	\$250 \$500 \$500 \$500
Your total annual deductible before HRA is applied (Your 2012 Walmart-provided HRA deposit and any rollover dollars you have from your 2011 HRA help you meet your annual deductible.) If you select: <ul style="list-style-type: none">• Associate Only• Associate + Spouse• Associate + Child(ren)• Associate + Family	\$1,250 \$2,500 \$2,500 \$2,500	\$1,250 \$2,500 \$2,500 \$2,500	\$1,750 \$3,500 \$3,500 \$3,500	\$2,700 \$5,400 \$5,400 \$5,400
Out-of-pocket maximum before HRA is applied If you select: <ul style="list-style-type: none">• Associate Only• Associate + Spouse• Associate + Child(ren)• Associate + Family	\$3,000 \$6,000 \$6,000 \$6,000	\$5,000 \$10,000 \$10,000 \$10,000	\$5,000 \$10,000 \$10,000 \$10,000	\$5,000 \$10,000 \$10,000 \$10,000

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 will not be prorated.

Plan features	HDP Standard
Maximum matching company contribution to an HSA* If you enroll in: <ul style="list-style-type: none">• Associate Only• Associate + Spouse• Associate + Child(ren)• Associate + Family	\$300 \$600 \$600 \$600
Annual deductible If you select: <ul style="list-style-type: none">• Associate Only• Associate + Spouse• Associate + Child(ren)• Associate + Family	\$3,000 \$6,000 \$6,000 \$6,000
Out-of-pocket maximum If you select: <ul style="list-style-type: none">• Associate Only• Associate + Spouse• Associate + Child(ren)• Associate + Family	\$6,050 \$12,100 \$12,100 \$12,100

* Walmart matches your payroll deductions dollar-for-dollar to your HSA, up to the matching limit described in the chart. Your and Walmart's combined contributions to your HSA cannot exceed the 2012 annual limit (as determined by the IRS) of \$3,100 for individual coverage or \$6,250 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 are described in materials provided separately by the HMO provider. To find out if an HMO is available, 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. HMO plans limit payment refunds and retroactive coverage to 60 days. 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 to you relating to your dependents.

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, which is funded by the company.

The Associates' Medical Plan is administered by a Third Party Administrator (TPA), BlueAdvantage Administrators of Arkansas, that makes medical claim determinations based on the Plan's medical policy and processes the claims. The TPA also provides a network of providers who charge discounted rates to Plan participants.

How the HRA plans pay benefits

The HRA Elite 3000, HRA Elite 5000, HRA Enhanced and HRA Basic plans include a Health Reimbursement Account (HRA) that is funded by the company. Walmart will set aside money in an HRA for you and any covered family members to pay for covered medical expenses before you have to pay anything. You cannot contribute your own money to the HRA, and the Plan will automatically pay your covered medical expenses until the HRA is used up (except prescriptions). The amount your HRA pays toward eligible medical expenses applies toward your annual deductible and out-of-pocket maximum.

Any money left in your HRA at the end of the year will roll over to the next year as long as you continue to enroll in an HRA plan. The funds will roll over each year until it reaches a maximum amount equal to the annual deductible for the plan in which you are enrolled. If your HRA is at that maximum amount at the beginning of a calendar year, the company will not add any additional funds to your HRA for that calendar year, even if some of the HRA money is used during the year. If your HRA is close to the maximum at the beginning of a calendar year, the company will add only enough money to your HRA to reach the annual deductible of the plan in which you are enrolled.

If you leave the company, cancel your coverage, lose eligibility or change from an HRA plan to the HDP Standard 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.

If your effective date in the HRA Elite 3000, HRA Elite 5000, HRA Enhanced or HRA Basic plan is in January, your HRA will receive the full company contribution for that calendar year. If your effective date is at any other time of the year (as newly eligible or due to a status change event), your HRA company contribution amount will be prorated based on the number of months you are a plan participant. For example:

- If your effective date is any day in February, you will receive a prorated HRA contribution for 11 months; or
- If your effective date is any day in September, your prorated HRA contribution would be for four months.

How the HRA plan's annual deductible works

Your annual deductible is the amount you are responsible for paying each year (Jan. 1 – Dec. 31) for eligible network expenses before the Plan begins paying a portion of your covered expenses. Your current year Walmart-provided HRA deposit and any rollover dollars you have from your previous year(s) HRA help you meet your annual deductible.

If you enroll in an HRA plan and choose Associate Only coverage, you will have an individual annual deductible. If you choose Associate + Spouse, Associate + Child(ren) or Associate + Family coverage, you will have an annual deductible that is two times the individual annual deductible. The annual deductible may be met by one or any combination of covered family members.

How coinsurance and your out-of-pocket maximum works

For the HRA plans, after your annual deductible is met, the Plan pays 80 percent of covered network expenses and you pay 20 percent. If you use an out-of-network provider (except for emergency care), 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). The amount you pay for out-of-network services will apply toward your annual deductible but will not apply toward your out-of-pocket maximum.

After you've met your out-of-pocket maximum, the Plan then pays 100 percent of covered network medical expenses.

The expenses you pay that apply toward your out-of-pocket maximum include:

- Your annual deductible (including amounts paid by the HRA)
- Your coinsurance when using a network provider
- Pharmacy copays

Your out-of-pocket maximum may be met by any combination of covered medical services.

If you choose Associate Only coverage, you will have an individual out-of-pocket maximum. If you choose Associate + Spouse, Associate + Child(ren) or Associate + Family coverage you will have an out-of-pocket maximum that is two times the individual out-of-pocket maximum. In this case, the out-of-pocket maximum can be met by one or any combination of covered family members.

If you enroll in the HRA Elite 3000, HRA Elite 5000, HRA Enhanced or HRA Basic plans, you pay co-pays for your prescriptions which do not count toward your annual deductible but do count toward your out-of-pocket maximum.

Example:

Associate John Doe is married with one child. John Doe enrolls in the HRA Enhanced Plan, which has a \$3,500 annual deductible which includes a \$500 company provided HRA. 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 \$500 of expenses, leaving \$3,000 to be paid by John Doe. After he pays the \$3,000, his annual deductible is met.

Or, if only one family member has a covered medical expense of \$3,500, the HRA will pay \$500 of the expense, and John Doe will pay \$3,000. The family's annual deductible is met.

Crossover claims

If you receive services in one year, but the claim is processed by the claims administrator the following year, the following provisions will apply:

- **Date of service.** The Third Party Administrator will use the date of service to determine if the claim will apply to the annual deductible, if coinsurance will apply, or if the out-of-pocket maximum has been met for the Plan year in which the services were received or the prescription drug was purchased.
- **Date of processing.** If the Third Party Administrator received a claim the year after the services were received, if funds are available in the HRA, available HRA dollars will be used to pay the claim, even though the HRA dollars from the previous year were used up.

How the HDP Standard plan annual deductible works

If you enroll in the HDP Standard plan and choose Associate Only coverage, you will have an individual annual deductible. If you choose Associate + Spouse, Associate + Child(ren) or Associate + Family coverage, you will have an annual deductible that is two times the individual annual deductible amount. The annual deductible may be met by one or any combination of covered family members.

You must pay your medical expenses up to the annual deductible amount before the Plan begins to pay a portion of your covered expenses.

You can choose to use money in your HSA to pay expenses that are subject to the annual deductible, or you can pay them yourself out of your own pocket and save your HSA money for future expenses.

If you enroll in the HDP Standard plan, you will pay full cost for prescriptions until you meet your annual deductible, and your pharmacy charges will apply toward your annual deductible and out-of-pocket maximum.

How coinsurance and your out-of-pocket maximum work

For the HDP Standard plan, after your annual deductible is met, the Plan pays 80 percent of covered network expenses and you pay 20 percent. If you use an out-of-network provider (except for emergency care), 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). The amount you pay for out-of-network services will apply toward your annual deductible but will not apply toward your out-of-pocket maximum.

After you've met your out-of-pocket maximum, the Plan then pays 100 percent of covered network medical expenses.

	HRA Elite 3000, HRA Elite 5000, HRA Enhanced and HRA Basic	HDP Standard
Paying from your account	Covered expenses are automatically paid from your HRA until it is used up (except prescriptions). Any money left in your HRA at the end of the Plan year will roll over and remain in your account for the next Plan year as long as you continue to enroll in an HRA plan.	You can choose to pay your covered medical expenses from your HSA, or you can pay them out of your own pocket and save your HSA money. Any money left in your HSA at the end of the Plan year will roll over and remain in your account.
You pay 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 HSA until your annual deductible is met.
The Plan pays a percentage of covered expenses	After your annual deductible is met, the Plan pays 80 percent of your covered network expenses — you pay 20 percent. The Plan pays 50 percent of covered out-of-network expenses up to the maximum allowable charge. You are responsible for paying all amounts above the maximum allowable charge.	After your deductible is met, the Plan pays 80 percent of your covered network expenses — you pay 20 percent yourself or from your HSA. The Plan pays 50 percent of covered out-of-network expenses up to the maximum allowable charge. You are responsible for paying all amounts above the maximum allowable charge.
Your out-of-pocket maximum – the Plan pays 100 percent of covered network services	After you have paid your out-of-pocket maximum, the Plan pays 100 percent of covered network expenses for the rest of the calendar year. (If you go to an out-of-network provider, the Plan pays 50 percent of covered out-of-network expenses up to the maximum allowable charge. You are responsible for paying all amounts above the maximum allowable charge, even if you've already reached your out-of-pocket maximum.)	After you have paid your out-of-pocket maximum, the Plan pays 100 percent of covered network expenses for the rest of the calendar year. (If you go to an out-of-network provider, the Plan pays 50 percent of covered out-of-network expenses up to the maximum allowable charge. You are responsible for paying all amounts above the maximum allowable charge, even if you've already reached your out-of-pocket maximum.)

The expenses you pay that apply toward your out-of-pocket maximum include:

- Your annual deductible
- Your coinsurance when using a network provider
- Pharmacy charges before your annual deductible is met
- Pharmacy co-pays

Your out-of-pocket maximum may be met by any combination of covered medical services.

If you choose Associate Only coverage, you will have an individual out-of-pocket maximum. If you choose Associate + Spouse, Associate + Child(ren) or Associate + Family coverage you will have an out-of-pocket maximum that is two times the individual out-of-pocket maximum. In this case, the out-of-pocket maximum can be met by one or any combination of covered family members.

What is covered by the Associates' Medical Plan?

The Associates' Medical Plan pays benefits for covered expenses. Covered expenses are charges for procedures, services, equipment and supplies that are:

- 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 under 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 twelve 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 as a late enrollee.

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 these time limits, your newly enrolled dependent also is considered to have satisfied the requirements.

Certificates of Creditable Coverage

The 12-month limitation period 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. 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 Programs (CHIP)
- A health benefit plan of the Peace Corps Act

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 (COCC). You may also request a COCC from your prior plan for yourself or your dependent at any time.

If you need to obtain a COCC, please contact:

Benefits Customer Service
508 SW 8th Street
Bentonville, AR 72716-3500
[\(800\) 421-1362](tel:(800)421-1362)

You also have the right to demonstrate creditable coverage through documentation other than a COCC, 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 COCC 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 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 BlueCross BlueShield as payment in full, subject to the annual deductible and coinsurance amounts. An out-of-network provider may charge you for the amount over and above what the Plan allows for covered expenses (for example, amounts above the maximum allowable charge).

Note: For information on benefits for localized associates, see **Localized associates** in the **Eligibility and enrollment** chapter.

Associates' Medical Plan participants are enrolled in the BlueAdvantage Administrators of Arkansas BlueCard PPO network (the network):

- The network:** The Plan has contracted with a Third Party Administrator to provide a network of providers (for example, doctors and hospitals) for participants to receive medical goods and services covered under the Associates' Medical Plan at discounted prices. 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 (for example, amounts above the maximum allowable charge).

Your choice of provider is completely up to you. Neither the Plan nor the Third Party Administrator will interfere with 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 an out-of-network provider 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 out-of-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;
- 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.

Utilizing network providers and network exceptions

	In network and network exceptions or out-of-network benefits:		
	Network	Out-of-network	Network Exceptions
Doctor's visit, outpatient services and inpatient hospitalization	80 percent of covered expenses	50 percent of the covered expense's maximum allowable charge. You are responsible for your 50 percent share plus any amount above the maximum allowable charge.	80 percent of the maximum allowable charge. You are responsible for any amount above the maximum allowable charge.
Behavioral Health (inpatient and outpatient)	80 percent of covered expenses	50 percent of the covered expense's maximum allowable charge. You are responsible for your 50 percent share plus any amount above the maximum allowable charge.	80 percent of the maximum allowable charge. You are responsible for any amount above the maximum allowable 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.

Preventive care program

Associates enrolled in an HRA plan or HDP Standard plan will have 100 percent coverage for the cost of eligible preventive care services when network providers are used. When an out-of-network provider is used, the Plan reduces the benefit to 50 percent, and coinsurance amounts will not apply toward your out-of-pocket maximum. Covered preventive care services are those required by regulations issued under the Affordable Care Act. As of the date this Summary Plan Description was prepared, covered services include those shown in the following charts. Diagnostic exams and services beyond those listed in the following charts are not covered expenses for the preventive care benefit, but may be covered under the Plan benefits if they are accompanied by a diagnosis for a covered condition or disease.

For the most up-to-date list of covered preventive services, go to the [WIRE](#) or [mywalmart.com](#) or call the Third Party Administrator.

¹ Bright Futures and the U.S. Preventive Services Task Force (USPSTF) recommendations for well-child physician visits for babies and children age newborn to age 18

Birth through 11 months	7 visits
12 months through 36 months	5 visits
Age 3 years to age 18 years	Annual visit

¹Well-child physician visits include the screenings, procedures, assessments and other services included in the Bright Futures recommendations of the American Academy of Pediatrics and USPSTF, including newborn metabolic screening and hemoglobin screening, screening newborns for sickle cell disease, PKU, hearing loss and congenital hypothyroidism; applying prophylactic ocular medication for gonorrhea to newborns; and vision screenings for children younger than 5 years, visual acuity screening for children age 5 and over, hematocrit or hemoglobin screening, lead screening, tuberculin test, dyslipidemia screening, sexually transmitted infection screening, cervical dysplasia screening, alcohol and drug use assessment and pregnancy screening. For a complete listing of the services covered and provided in well-child visits, go to http://brightfutures.aap.org/clinical_practice.html and scroll down to "Bright Futures / AAP Periodicity Schedule." There, you'll find a PDF called "Recommendations for Preventive Pediatric Health Care," which is a chart listing all of the well-child services.

USPSTF preventive prescription medications for children (see Pharmacy chapter for details)

Oral fluoride supplementation	By prescription for children age 6 months to age 6
Iron supplementation	By prescription for children age 6-12 months

Immunizations for babies and children through age 18 according to the recommendations from the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP)

Please see the CDC website at <http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm> for a detailed listing of the recommended ages and requirements for immunizations.

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| <ul style="list-style-type: none"> • Hepatitis B • Rotavirus • Diphtheria, tetanus, pertussis (DPT) • Haemophilus influenzae type b • Pneumococcal • Poliovirus | <ul style="list-style-type: none"> • Influenza (flu shot) • Measles, mumps, rubella • Varicella (chicken pox) • Hepatitis A • Meningococcal • Human papilloma virus (for girls age 9 through 18) |
|---|--|

USPSTF screenings and counseling for children and adolescents

Screening for major depressive disorder	Adolescents age 12 to 18
Screening for HIV infection	Adolescents at increased risk for HIV infection
Counseling to prevent sexually transmitted infections	For adolescents at increased risk of STIs - one counseling session per week for 30-60 minutes for six weeks per year
Obesity counseling and behavioral interventions to promote sustained weight loss	For children and adolescents - one counseling session per week for one month, then one session every two weeks for one month, then one session per month for six months. Counseling should be with the primary care physician, a registered dietitian or certified health educator

USPSTF preventive care for women age 18 and older

Screening mammogram, with or without clinical breast exam	Every one to two years, beginning at age 40, or earlier if a personal or family history of breast cancer
Pap test for cervical cancer	Yearly
Human papilloma virus vaccination	For women age 18 through 26
Screening for chlamydial infection	Yearly
Screening for gonorrhea	Yearly
Screening for osteoporosis	For women age 65, or at age 60-64 if at risk of osteoporotic fracture
Chemoprevention for breast cancer	For women at high-risk for breast cancer and at low-risk for adverse effects of chemoprevention

USPSTF preventive prescription medication for women (see Pharmacy chapter for details)

Supplementation with folic acid	By prescription for all women planning or capable of pregnancy
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USPSTF preventive care for pregnant women

Screening for bacteriuria	At 12 to 16 weeks gestation or at the first prenatal visit, if later
Interventions to promote and support breast feeding	During pregnancy and after birth
Screening for hepatitis B	One per pregnancy
Screening for iron deficiency anemia	All pregnant women
Screening for Rh incompatibility	During a prenatal visit, and at 24–28 weeks gestation for all unsensitized Rh negative women unless the biological father is known to be Rh negative
Screening for chlamydia	All pregnant women
Screening for syphilis	All pregnant women
Counseling for pregnant smokers	One counseling session of 20 minutes per week for four months during pregnancy. Counseling should take place in the primary care setting. Additional support is available for participants in the Life with Baby maternity program.

Preventive care for adults age 18 and older

Routine physician visit ¹	Yearly
Cholesterol screening	Yearly for men at age 35 and over, and for women age 45 and over. Yearly for men and women age 20 and over if at increased risk for coronary heart disease
Fecal occult blood testing	Yearly for adults beginning at age 50 and ending at age 75. Screening may begin earlier than age 50 if there is a personal or family history of colorectal cancer, or for those at high risk
Colonoscopy	Every ten years, beginning at age 50 and ending at age 75. Screening may begin earlier than age 50 if there is a personal or family history of colorectal cancer, or for those at high risk
Sigmoidoscopy or double-contrast barium enema	Every five years, beginning at age 50 and ending at age 75. Screening may begin earlier than age 50 if there is a personal or family history of colorectal cancer, or for those at high risk
Ultrasound screening for abdominal aortic aneurysm	Once per lifetime for men age 65 to 75
Screening for high blood pressure	Adults age 18 and older
Screening for depression	For all adults
Screening for type 2 diabetes	For asymptomatic adults with sustained blood pressure (treated or untreated) greater than 135/80 mm Hg
Screening for HIV	For adults at increased risk for infection
Screening for obesity	For all adults
Screening for syphilis	For all adults at increased risk of infection
Screening for tobacco use	For all adults
Screening for alcohol misuse	For all adults

¹ Preventive physician visits include a history and physical, including discussion with the doctor about recent health changes, blood pressure, weight and age-appropriate tests and screenings listed under the preventive care services for adults or women. Preventive visits may also include counseling listed under preventive counseling, where appropriate for delivery by the primary care provider.

USPSTF preventive prescription medication for adults (see Pharmacy chapter for details)

Aspirin therapy

By prescription for men age 45-79 and women age 55-79

Immunizations for adults age 19 and over according to the recommendations from the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP)

Please see the CDC website at <http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm> for a detailed listing of the recommended ages and requirements for immunizations. For 18 year old adults, please refer to the immunization chart for children at <http://www.cdc.gov/vaccines/recs/schedules/child-schedule.htm>.

- Tetanus, diphtheria, pertussis
- Human papilloma virus
- Varicella (chicken pox)
- Zoster
- Measles, mumps, rubella
- Influenza (flu shot)
- Pneumococcal
- Hepatitis A
- Hepatitis B
- Meningococcal

USPSTF preventive counseling for adults

Genetic counseling and evaluation for BRCA testing	Women whose family history is associated with an increased risk for deleterious mutation in BRCA1 or BRCA2 genes. Testing once per lifetime in the primary care setting.
Dietary counseling (by primary care provider or other specialist) for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease	One counseling session per week for four weeks, followed by one counseling session per month for four months with a registered dietitian, certified health educator or physician.
Obesity counseling and behavioral interventions to promote sustained weight loss	For adults - one counseling session per week for one month, then one session every two weeks for one month, then one session per month for six months with a registered dietitian, certified health educator or physician.
Counseling to prevent sexually transmitted infections (STIs)	For adults at increased risk of STIs - one counseling session per week for 30-60 minutes for six weeks per year in the primary care setting.
Tobacco cessation interventions	For adults who use tobacco products - three counseling sessions of 30 minutes per year for non-pregnant adults in the primary care setting.
Behavioral counseling interventions to reduce alcohol misuse	For adults at increased risk of alcohol misuse - one counseling session per year in the primary care setting.
Screening for depression	For all adults ad adolescents - one screening in the primary care setting per year in the primary care setting.
Discussion of chemoprevention	For women at high risk for breast cancer and low risk for adverse side effects in the primary care setting.

Flu vaccine program

Walmart provides an annual flu vaccination for Associates' Medical Plan participants covered at 100 percent between the September and 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 insurance 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.

Questions? Log on to mywalmart.com or the WIRE, or call Benefits Customer Service at (800) 421-1362

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 an out-of-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 annual deductible but will not apply toward your 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 services may be voluntarily pre-approved by BlueAdvantage Administrators of Arkansas. Call the telephone number on the back of your insurance ID card, **(866) 823-3790**.

Coverage for behavioral health services may be voluntarily pre-approved by New Directions Behavioral Health L.L.C. Call New Directions at the telephone number on the back of your insurance ID card, **(877) 709-6822**.

Note: Prior approval does not guarantee payment or assure coverage; it means that the information furnished to BlueAdvantage Administrators of Arkansas or New Directions 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 non-payment of premium, out-of-network limitations apply, or that any other basis exists for denial of the claim under the terms of the Plan. There is no penalty or reduction in benefits if you don't obtain prior approval.

There is no penalty or reduction in benefits if you don't obtain prior authorization. However, prior authorization may be required to comply with certain procedures following a pre-approval treatment plan or procedures for making referrals.

Helping you manage your health

24-hour: Ask Mayo Clinic nurse line

The *Ask Mayo Clinic* nurse line is available to all associates and their dependents enrolled. *Ask Mayo Clinic* is a free 24-hour nurse line that provides you with answers to questions about illnesses, injuries or medical concerns any time, day or night. If you're not sure whether your symptoms or a family member's symptoms mean you should wait and call your doctor in the morning or go to the emergency room immediately, a quick call to the experienced registered nurses at *Ask Mayo Clinic* may help you decide what to do.

Whether your medical situation is routine or serious, *Ask Mayo Clinic* is a place to turn for reliable health information. However, it is not a substitute for emergency response services. In a medical emergency, dial 911.

Keep the *Ask Mayo Clinic* nurse line phone number—**(800) 418-0758**—in your cell phone, near your home phone as well as in your wallet or purse so you can call toll-free any time from anywhere. Keep in mind that you and the doctor have the final decision on how to treat your medical condition.

Quit Tobacco programs

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 or HDP Standard 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.
- **E-mail 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 working in AL, FL, GA, LA, MS, SC, TN or TX should call **(866) 577-7169**. Associates working in all other states should call **(888) 363-1655**.

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, Life with Baby Maternity Program can help you have a safe, successful pregnancy. Enrollment is not automatic. Enroll by calling toll-free **(888) 659-8936**, and talk confidentially to a registered nurse. The program assists with pre-conception, pregnancy, delivery (including three lactation visits) and child development. Enroll in 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.

Walmart case management

Through your medical insurance you have the benefit of your own personal nurse case manager. This service is voluntary, free, and your participation is confidential. The service is available to you and your dependents, who are enrolled in the medical plan (not including HMO), and may help lower your out-of-pocket medical expenses.

A case manager is a registered nurse that has special training to help you, the associate, and your dependents when:

- You are sick or injured and hospitalized;
- You are scheduled for surgery;
- You find out you have a chronic illness;
- You have an ongoing chronic illness; or
- You have a behavioral health/substance abuse condition.

You and your special needs are the focus of your nurse case manager. The nurse case manager will work with you, your physicians and the facility as a part of your health care team providing information on your benefits.

If you need to be transferred from one facility to another facility, your nurse case manager will assist the facility in finding network providers, keeping your out-of-pocket expenses as minimal as possible. Your nurse case manager works for you and with the other members of the health care team to help you get through difficult times associated with illness or injury. The primary objective of the nurse case manager is to identify and coordinate cost effective medical care alternatives while meeting accepted standards of medical practice. When you are hospitalized and transferred from one facility to another (such as hospital to a skilled nursing facility, hospital to a long-term acute care facility, etc.) call the medical pre-notification line located on your insurance ID card.

Your health management program

	Alere:	Avivia Healthy Solutions:
Phone	(877) 863-7407	(888) 204-9080
Web site	AlerePersonalHealthSupport.com/Walmart	yourhealthctr.com/walmart

You may receive a call from your nurse case manager. Please return the call at your earliest convenience so that your nurse case manager can begin to help you with your special needs. Your nurse is available from 8:00 a.m. to 4:30 p.m. CT Monday through Friday. Call **(800) 225-1891** and ask for the Walmart Case Management Department.

Health management program

Walmart offers a special health management program to all enrolled associates and their enrolled dependents in the HRA Elite 3000, HRA Elite 5000, HRA Enhanced, HRA Basic or HDP Standard plan. This program helps you manage chronic health conditions, such as diabetes, coronary artery disease, heart failure, chronic obstructive pulmonary disease and asthma. Participation in a health management program is free and voluntary and does not affect an individual's eligibility to participate in the Associates' Medical Plan or any benefits payable under the Associates' Medical Plan. Participant information is shared only as required or allowed by state and federal law.

The health management program is designed to help improve patient health. The program can benefit you by targeting and applying some of the best known clinical guidelines for your specific health condition. Plan participants who are selected by the program will receive one-on-one education specific to their own health care condition, including ways to better manage and improve their condition.

The program available to you is determined by the state in which you work. For more information, contact your health management program.

When limited benefits apply to the Associates' Medical Plan

Some services are also subject to specific restrictions and limitations in addition to the 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 insurance 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.

You should also review the list of items not covered 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

Services and devices covered under the contraceptive benefit:

- 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)

Services and/or devices that are not included in the contraceptive benefit are:

- Abortion
- Male or female sterilization
- Over-the-counter birth control, including but not limited to: male condoms, female condoms, vaginal sponges, ovulation predictor kits, basal thermometers and spermicides
- Prescriptions for RU-486 and Plan B, or the "Morning After" pill

Durable medical equipment/Home Medical Supplies (DME)

Durable medical equipment (DME) that satisfies all of the following criteria is covered under the Plan unless listed below under **DME Not Covered**. Durable medical equipment (DME) is equipment which:

- 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 and tracheotomy supplies. Supplies must be prescribed by a medical doctor (M.D.) or doctor of osteopathy (D.O.) to be covered. Surgical stockings are limited to six pairs 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. The maximum per calendar year DME and home medical supplies benefit is \$750,000 in paid benefits. 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 the result of malicious damage, culpable neglect or wrongful disposition 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, ultra-violet 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 by the Associates' Medical Plan.

Foot care

For nonsurgical foot care in connection with treatment for the following conditions, the Plan allows three provider visits per calendar year:

- 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 one pair of orthopedic 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

Inpatient and outpatient hospice care are covered up to 180 days per illness.

Nutritional counseling

Nutritional counseling for children is covered if it is medically necessary for a chronic disease in which dietary adjustment has a therapeutic role when it is prescribed by a physician and furnished by a provider (e.g., a registered dietitian, 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.

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:

- Prescriptions
- 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; 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
- Nondental cutting procedures in the oral cavity
- Medical complications which 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.

Outpatient physical/occupational therapy

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 or occupational therapist or by one of the types of doctors listed above.

This benefit is payable up to a maximum of 20 visits per calendar year when appropriate. If an enrolled associate or an enrolled dependent requires physical or occupational therapy for a second or subsequent illness/injury or for rehabilitation following a subsequent surgical procedure, consideration may be given for coverage of an additional 20 visits when appropriate. An exacerbation or flare-up of a chronic disease or condition is not considered a new illness, and is not covered beyond the initial 20 visit maximum.

Pregnancy benefits

Pregnancy expenses are covered the same as any other medical condition.

Only one routine ultrasound per pregnancy is covered.

Benefits will be paid for pregnancy-related expenses of dependent children, however, the newborn will only be covered if the newborn is a legal dependent of the plan participant.

Note: Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with child-birth 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).

Prosthesis

Replacement prosthesis will be allowed only with a change of prescription. A licensed prosthetist 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.

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 insurance ID card for coverage details. Coverage outside the United States may vary.
- Always carry your insurance 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 insurance ID card.

Coverage for transplants and lung volume reduction (LVR)

To be eligible for transplants and lung volume reduction benefits, participants (whether donor or recipient) must be continuously enrolled in the Associates' Medical Plan or an HMO offered through the Plan for at least 12 months. Any period of time that you are enrolled in critical illness and accident insurance does not 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 LVR

All transplants (except kidney, cornea and intestinal) and LVR

- All transplant recipients (except for kidney, cornea and intestinal recipients) must undergo a pre-transplant evaluation at the Mayo Clinic. In performing this evaluation, the Mayo Clinic is not an agent of the Plan. It is the Plan's intent that this evaluation be made pursuant to the doctor-patient relationship between the Mayo Clinic and the participant. Travel, lodging and a daily allowance will be provided for the recipient and a caregiver for required evaluations at the Mayo Clinic.

- Liver, heart, lung, pancreas, simultaneous kidney/pancreas, multiple organ, LVR and bone marrow transplants must be performed at the Mayo Clinic or an approved facility, or no benefits will be paid unless travel will result in death.
- Claims for eligible transplants performed at the Mayo Clinic (including pediatric) are covered at 100 percent with no annual deductible. However, if you are enrolled in the HDP Standard plan you must meet your annual deductible prior to any Plan 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 experimental and/or investigational transplant-related services unless those services are recommended and performed by the 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 the 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, then 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, the 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 the 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 appropriate, the Independent Review Panel will reverse the Mayo Clinic's determination and approve the transplant. The Independent Review Panel then will provide you with a list of acceptable 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 services or 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 an out-of-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 annual deductible but will not apply toward your out-of-pocket maximum.
- No travel, lodging or daily allowance will be provided for these transplants (even if performed at the 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 LVR Coverage

- Claims for transplants and LVR 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 LVR benefits, other than coordination with Medicare, or as otherwise required by law. If any portion of a transplant or LVR 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 LVR benefit claim.

Transplant donor expenses

- Covered when the recipient is an Associate's 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 only covered when the expenses are part of the provider's base contracted rate with the Plan's Third Party Administrator.
- 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 **Limited benefits** section, 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 HDP Standard plan, you may be able to use your HSA funds for these and other qualified medical expenses. For more information, contact your HSA administrator.

If you have a question regarding whether a particular service is covered under the Plan, please call the Third Party Administrator on your insurance 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.
- **Beyond the Scope of Licensure or Unlicensed:** Services rendered by a non-credited or a non-licensed physician, health care worker, 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 below), or unless the Plan conducts a medical review and determines that the procedure is medically necessary.

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

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

Such coverage may be subject to annual deductibles and co-insurance 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**.

- **Chiropractic Care:** Any services performed by a chiropractor.
- **Complications of Noncovered Devices or Procedures**
- **Co-pays 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 Act (see Breast Reconstruction/Reduction above), 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**
- **Elective Inpatient and Outpatient Stays or Services Outside U.S.**
- **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.
- **Family Planning and Infertility Services:** Any services or supplies provided for, in preparation for, or in conjunction with the following are not covered:
 - Elective or voluntary termination of pregnancy and complications for these procedures (also see termination of pregnancy)
 - Sterilization or the reversal of sterilization (male or female)
 - Surrogate parenting services
 - Medical care or treatment to facilitate a pregnancy
- **Freestanding substance abuse or psychiatric residential treatment center:** Residential treatment received at a freestanding residential substance abuse treatment center or at a freestanding psychiatric residential treatment facility is not covered. For assistance in locating a provider as a possible alternative to a free-standing center, contact New Directions at **(877) 709-6822**.
- **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 psycho-social factors potentially impacting physical health problems and treatments.
- **Hearing Devices to Enhance/Aid Senses:** Charges for routine hearing tests and any electrical device to enhance any one or more of the senses, including but not limited to hearing aids, except for newborn hearing screening.
- **HMO co-pays**
- **Homeopathic/Naturopathic Medicine and Services**
- **Hypnosis**
- **Illegal Occupation, Assault, Felony, Riot or Insurrection:** Charges for medical services, supplies or treatments which 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.
- **Judgments/Settlements**
- **Late Claims:** Charges received more than 12 months past the date of service, or 18 months past the date of service if the Plan is coordinating benefits with other plans. 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 these time periods, 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 Education Disorders:** i.e., reading disorder, 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.
- **Massage Therapy, if Provided by a Massage Therapist**
- **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 SPD
 - 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

- **Nonstandard Medical Treatment**
- Off-label use for cancer chemotherapy or other drugs for the treatment of cancer 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 for non-cancer chemotherapy injectable drugs will be considered to meet coverage criteria when recommended by 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 for any drug when the FDA has determined its use to be contra indicated or not advisable.

- **Out-of-Pocket Expenses**
- **Over-the-Counter Medications and Equipment:** 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 **Enrolling in the Associates' Medical Plan for the first time** 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 sex therapy or pharmaceuticals for the treatment of sexual dysfunction, even if prescribed for other medical conditions, except in the event of restoration due to an accident or treatment of illness, effective October 1, 2011.
- **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 (such as Delta Talker) 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 non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, 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**
- **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.
- **Vision Care:** Charges for routine eye care including but not limited to vision analysis, eye examinations or eye surgeries for nearsightedness or farsightedness correction of vision.

- **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 timely filed a claim for workers' compensation benefits.

Filing a medical claim

If you use a network provider, the provider will often 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 insurance 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 insurance 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 12 months from the date of service (18 months from the date of service if coordinating with another plan as described below) 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. 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 trustee 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 which 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 pended 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 co-pays 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 similarly 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 Plan coordinates with other plans

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

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 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 included coordination of benefits provision, the provision governs. If no provision, then 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 step-parent'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.

- When none of the above 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) 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 is 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 HDP Standard 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 meet 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 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 AMP. If you also have Medicare, the AMP will generally be primary and Medicare will be secondary. File your claim with the AMP first.

You may also elect to end your coverage under the AMP 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 **Enrolling in the Associates' Medical Plan for the first time** earlier in this chapter.

When coverage ends

Your coverage and your dependents' coverage terminates on your last day of employment. 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 then 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 plans 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 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.

The pharmacy benefit

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pharmacy
benefit

The pharmacy benefit

Prescription drugs play a crucial role in treating illnesses and, for many of us, maintaining good health. When HRA and HDP Standard plan participants purchase prescription drugs from network retail or mail-order pharmacies, they take advantage of discounted network prices. A 30-day supply (retail) or 34-day supply (mail order) of eligible generic drugs is only a \$4 co-pay for participants enrolled in the HRA plans, and is only a \$4 co-pay for participants enrolled in the HDP Standard plan once their medical annual deductible is met.

Pharmacy benefit resources		
Find What You Need:	Online:	Other Resources:
<ul style="list-style-type: none">• Find a 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 medco.com/walmart	Call Medco at (800) 887-6194

What you need to know about the pharmacy benefit

- The pharmacy benefit applies to the HRA and HDP Standard plans. Associates enrolled in an HMO plan receive pharmacy benefits through their HMO.
- You must use a network pharmacy or no benefits will be paid.

The pharmacy benefit for HRA and HDP Standard plan participants

The Associates' Medical Plan covers eligible prescriptions from both retail and mail-order network pharmacies. You and your eligible dependents are entitled to prescription coverage the date your medical coverage is effective.

You should present your insurance ID card at a network pharmacy. You must use a network pharmacy or no benefits will be paid. Visit mywalmart.com to find information about:

- Retail network pharmacies;
- Mail-order network pharmacies; and
- Covered generic, brand name and specialty drugs.

You can also call Medco at **(800) 887-6194**.

How the pharmacy benefit works

The pharmacy benefit covers only the prescription drugs that are specifically listed on the closed formulary list maintained by Medco. You can view this list on the **WIRE** or at mywalmart.com or you may call Medco at **(800) 887-6194**.

- As an HRA participant, you can purchase eligible prescriptions by paying the co-pays shown in **The HRA pharmacy benefit chart** out of your own pocket. Money in your HRA cannot be used to purchase prescriptions.
- As an HDP Standard plan participant, you will pay full price for your prescriptions until you meet your medical annual deductible. Once you have met your medical annual deductible, you will pay the co-pays shown in **The HDP Standard plan pharmacy benefit chart**.

For HRA and HDP Standard plan participants, once the medical out-of-pocket maximum is reached, eligible prescriptions will be paid at 100 percent.

Under its agreement with Medco, 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 the discounted price available at the time your prescription is filled is lower than the co-pay, you will be charged the lower amount, which may include a dispensing fee. Participants in an HRA plan will never pay more than the co-pay, and participants in the HDP Standard plan

will pay full retail for their prescriptions until the annual deductible is met, and will not pay more than the co-pay once their annual deductible is met. (Please note that the co-pay for a compound prescription will be determined by the primary ingredient of the compound.)

Types of drugs

To be covered under the Plan, prescription drugs must be on the Plan's formulary list. The formulary list is reviewed quarterly and can change. You can find the list on the WIRE or at mywalmart.com or you may call Medco at (800) 887-6194.

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 FDA. For more information, visit mywalmart.com.

Covered brand name drug — 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

HRA plan participants can purchase eligible prescriptions by paying the co-pays below. Your HRA dollars may not be used to purchase prescriptions. You will be required to pay pharmacy co-pays out of your own pocket.

The co-pays will be applied toward the annual out-of-pocket maximum. Once your out-of-pocket maximum is met, eligible prescriptions will be paid at 100 percent.

Retail Prescriptions

Each co-pay covers up to a 30-day supply of an eligible prescription unless otherwise noted. Refills are available after 75 percent of your previous prescription for the same drug has been used.

Generic Drugs	Retail generic prescriptions — allow up to a 90-day supply with the following co-pays: 1- to 30-day supply: \$4 co-pay 31- to 60-day supply: \$8 co-pay 61- to 90-day supply: \$12 co-pay
Covered Brand Name Drugs	\$30 or 20 percent of the allowed cost ¹ , whichever is greater
Specialty Drugs	\$50 or 20 percent of the allowed cost ¹ , whichever is greater
Mail-Order Prescriptions	
If you order 1 to 34 days of medication through the mail, you will pay the 1- to 30-day supply retail co-pay amounts. If you order 35 to 90 days of medication through the mail, you will pay the mail-order co-pay amounts.	
Generic Drugs	\$8
Covered Brand Name Drugs	\$60 or 20 percent of the allowed cost ¹ , whichever is greater
Specialty Drugs	\$100 or 20 percent of the allowed cost ¹ , whichever is greater

¹The allowed cost of a drug is determined by Medco.

The HDP Standard plan pharmacy benefit

HDP Standard plan participants pay full retail/mail price for prescriptions until the medical annual deductible is met. Once you have met your annual deductible, you will pay the co-pays shown in the chart below. The co-pays will be applied toward the out-of-pocket maximum. Once your out-of-pocket maximum is met, eligible prescriptions will be paid at 100 percent.

Retail Prescriptions

Each co-pay covers up to a 30-day supply of an eligible prescription unless otherwise noted. Refills are available after 75 percent of your previous prescription for the same drug has been used.

Generic Drugs	Retail generic prescriptions — allow up to a 90-day supply with the following co-pays: 1- to 30-day supply: \$4 co-pay 31- to 60-day supply: \$8 co-pay 61- to 90-day supply: \$12 co-pay
Covered Brand Name Drugs	\$30 or 20 percent of the allowed cost ¹ , whichever is greater
Specialty Drugs	\$50 or 20 percent of the allowed cost ¹ , whichever is greater
Mail-Order Prescriptions	
If you order 1 to 34 days of medication through the mail, you will pay the 1 to 30-day supply retail co-pay amounts. If you order 35 to 90 days of medication through the mail, you will pay the mail-order co-pay amounts.	
Generic Drugs	\$8
Covered Brand Name Drugs	\$60 or 20 percent of the allowed cost ¹ , whichever is greater
Specialty Drugs	\$100 or 20 percent of the allowed cost ¹ , whichever is greater

¹The allowed cost of a drug is determined by Medco.

Preventive over-the-counter medications

Associates enrolled in the Associates' Medical Plan will have 100 percent coverage of the cost of certain prescribed over-the-counter (OTC) medications when retail network pharmacies are used. Covered OTC preventive care medications are those required by regulations issued under the Affordable Care Acts as of the date this SPD was prepared. The Plan's coverage of OTC preventive care medications may change as additional regulations are issued. You must have a prescription from your doctor in order for the covered OTC medication to be covered at 100 percent. For the most up-to-date list of covered preventive care OTC medications, please go to the [WIRE](#) or [mywalmart.com](#), or call Medco.

USPSTF Preventive over-the-counter medications

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, pre-authorization will be required on some medications in order for them to be covered by the pharmacy benefit. In that case, your medical provider may need to provide more information (a coverage review).

If a coverage review is necessary, Medco may contact your provider requesting additional information than that which appears on the prescription. After receiving the necessary information, Medco will notify you and your doctor (usually within two business days) to confirm whether or not coverage has been authorized. If the prescription is denied coverage, you can still elect to fill the prescription, but you will be responsible for the full retail cost. The medication will not be covered under your pharmacy benefit.

For questions about pre-authorization call Medco at **(800) 887-6194**.

Medications with quantity limits

Certain medications have quantity limits on the amount you can receive per prescription. These limits are based upon the approved FDA dosage guidelines for the medication. Prescriptions written for no more than the designated quantity of the drug will process through your pharmacy benefit plan at the appropriate co-pay. Prescriptions written for quantities greater than the FDA approved quantity limit will not process on your pharmacy benefit plan and you will be responsible for 100 percent of the cost of the product. A list of these medications can be found on the [WIRE](#) or [mywalmart.com](#).

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 of the Associates' Medical Plan. The retail pharmacy discount provides discounts off the pharmacy's retail price on virtually all prescriptions not covered under the pharmacy benefit. The amount of the discount will vary depending on the drug prescribed. Keep in mind, any prescription not covered by the pharmacy benefit, including those purchased with the retail pharmacy discount, will not count toward your annual deductible or out-of-pocket maximum.

To use the retail pharmacy discount, present your insurance ID card to the pharmacy when picking up your prescription. If the prescription is covered by the pharmacy benefit, the corresponding co-pay will apply. If the prescription is not covered by the pharmacy benefit, the retail pharmacy discount 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. Contact Medco at **(800) 887-6194** for more information.

Filing a pharmacy benefit claim

When you use a network pharmacy, including a mail-order pharmacy, you will 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 in writing to Medco. If it is an eligible prescription, it will be paid in accordance with Plan terms through the pharmacy benefit. Please call Medco 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 set out in the **Claims and appeals** chapter.

You will have a right to appeal a denied claim. Your appeal will be processed according to the terms set out in the **Claims and appeals** chapter.

The pharmacy plan does not coordinate benefits with respect to 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.

Health Savings Account (HSA)

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health
savings
account

Health Savings Account for HDP Standard plan participants

The Health Savings Account (HSA) offers HDP Standard 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 HDP Standard plan annual deductible you choose, Walmart contributes 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 HSA	Log on to the WIRE , mywalmart.com , hsamember.com or myhsa.usbank.com to complete an electronic signature	Call your HSA Solution Contact Center: The Bank of New York Mellon (BNY Mellon) or U.S. Bank at (800) 358-3494 , or contact your tax advisor
Get a list of qualified medical expenses (I.R.C. § 213(d)) Get eligibility and tax return reporting responsibilities associated with an HSA	mywalmart.com or hsamember.com or myhsa.usbank.com irs.gov or treasury.gov	Call your HSA Solution Contact Center: The Bank of New York Mellon (BNY Mellon) or U.S. Bank at (800) 358-3494 , or contact your tax advisor

What you need to know about the HSA

- You must be enrolled in the HDP Standard plan in order to open and contribute to an HSA.
- 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 HSA by December 1st of the Plan year.
- The HSA 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 HSA which will automatically open the account upon the effective date of your HDP Standard plan coverage.
- You will receive a welcome kit mailed to your home address directly from your HSA custodian.
- No payroll withholding or employer contributions will be deposited to your HSA account until it is open. Your account will not be considered "open" until you have signed the Master Signature Card or electronic signature and complete any other steps required by your HSA 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 HSA offers HDP Standard 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 and the 20 percent additional tax may apply.
- Amounts paid for over-the-counter drugs will no longer be qualified medical expenses eligible for reimbursement unless prescribed by a doctor.
- The opportunity to select an HSA custodian — either BNY Mellon or U.S. Bank. Both are established financial institutions. ACS provides the administration for both custodians.
- 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 HSA 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 HSA 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 HSA withdrawals for qualified medical expenses are tax-free.

The balance in your HSA 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 HSA custodian if you have questions about either the federal or state tax implications of an HSA.

Health Savings Account eligibility

As an HDP Standard plan participant, you are eligible to open an HSA. Please see **Opening your Health Savings Account** section of this chapter. If you are enrolled in the HDP Standard plan, you are not eligible for the HSA if you are:

- Covered under any other health plan that is not a qualified high deductible health plan (exception — some disease-specific and accident policies are allowed, such as the critical illness insurance and accident insurance);
- 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 HDP Standard plan.

Other restrictions may apply. For further information, please contact your HSA custodian at **(800) 358-3494**.

During the Plan year, you may be required to confirm account eligibility to continue contributions (example: becoming Medicare age eligible).

The HDP Standard plan is a qualified high deductible health plan (HDHP) subject to ERISA and to requirements of federal law that allow you to contribute to an HSA. However, Walmart intends for the HSA to be exempt from ERISA by complying with the terms of the Department of Labor Field Assistance Bulletin No. 2004-1 and 2006-02. Accordingly, the HSA is not established or administered by Walmart or the Associates' Health and Welfare Plan. Instead, an HSA is established by the associate and administered by ACS on behalf of BNY Mellon or U.S. Bank.

If you have non-qualified 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 HSA contributions. There are exceptions to this rule for "limited purpose" FSAs/HRAs, which can only be used for dental or vision coverage, or for "post-deductible" FSAs/HRAs, which only provide coverage after you satisfy the deductible under an HDHP. For additional information please contact your HSA custodian at **(800) 358-3494** or contact your HSA custodian BNY Mellon online at hsamember.com or U.S. Bank online at myhsa.usbank.com.

Opening your Health Savings Account

When you enroll online in the HDP Standard plan through the **WIRE** or mywalmart.com, you will choose:

- Your HSA 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 **Establishing and changing your contribution amount** later in this chapter.

You'll receive a welcome kit at your home address directly from the HSA 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 HDP Standard 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 HSA 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, myhsa.usbank.com, the **WIRE** or mywalmart.com by completing electronic signature.

After your initial enrollment, any address change will need to be submitted to your HSA custodian. Updating your address with Walmart will not update it with the custodian.

No payroll withholding or employer contributions will be deposited to your HSA 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 HSA 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 HSA 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 ACS, the HSA administrator, 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 HSA custodian that your account has been opened and you have completed your HSA 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 for more information.

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

If you do not open your HSA through BNY Mellon or U.S. Bank by December 1st of the Plan year, you will forfeit your right to the company's contributions for that year, even if you are covered by an HDP Standard 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 HSA custodian when you enroll. However, you may move your funds to another HSA custodian at any time. If you move your HSA custodian to a bank other than BNY Mellon or U.S. Bank, pre-tax payroll deductions will not be available, you will not receive the company matching contributions and all HSA account fees will be your responsibility.

Health Savings Account fees

The company will pay the account set-up fee for one custodian if you are newly enrolled in the HDP Standard plan and do not have an existing HSA account established with either BNY Mellon Bank or U.S. Bank.

The company also will pay the monthly maintenance fees for either BNY Mellon or U.S. Bank if you are enrolled in the HDP Standard plan. The fee will be paid to whichever custodian payroll contributions are directed.

The company will not pay overdraft fees, excess contributions, lost card or replacement check fees, or any setup 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 HDP Standard plan, all associated fees will become your responsibility. These fees will be deducted automatically from your HSA balance if any of these events occur. You may contact your HSA custodian or call **(800) 358-3494** to determine the fees for various HSA account services.

Your contributions and the company's contributions to the Health Savings Account

Your HDP Standard plan Annual Deductible:	Company Matching Contribution Limit—\$1 for \$1 up to:	Maximum Annual Contribution Limit (Associate and Company Contributions Combined):
\$3,000 (Associate Only)	\$300	\$3,100
\$6,000 (Family coverage)	\$600	\$6,250

Contributions to your Health Savings Account

Once you have opened your HSA, as long as your account remains open and you are enrolled in the HDP Standard 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.
- 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 tax and 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 HSA 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 adviser to determine if you can deduct them from your federal or state tax return.
- In the event your requested HSA contribution for a specific pay period exceeds the amount of your paycheck after deductions, no contribution or company match will be made to your HSA for that pay period.
- With respect to your final paycheck, your HSA salary reductions and corresponding employer match may be reduced because of state law restrictions on salary reduction or because your requested HSA 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. Therefore, due to IRS guidelines, you may have an excess contribution to your account that will need to be withdrawn by your tax filing deadline to avoid additional taxes.

Associates who are actively enrolled in the HDP Standard 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 2012, \$3,100 for individual coverage; or
- For 2012, \$6,250 for family coverage.

These amounts are indexed annually by the federal government and will likely change each year. Please contact your HSA 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 HSA—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.

Earning interest on your Health Savings Account

The balance in your HSA earns interest. For interest rate information on your account, contact your HSA 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 HSA shortly after the payroll deduction period ends. Walmart will initiate authorized payroll deductions once your HSA custodian confirms that your HSA is open and you complete your payroll deduction selection online.

Establishing and changing your contribution amount

You may change your contribution amount online at any time during the year on a going-forward basis.

To establish 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 and older, you can make additional contributions to your HSA. These are called catch-up contributions and can be made by payroll deductions just like your normal contribution. For 2012, the catch-up contribution is \$1,000. Please call the HSA Solution Contact Center at (800) 358-3494 for information on catch-up contributions.

If you also cover your spouse under the HDP Standard plan and your spouse is age 55 or older, he or she may also be eligible to open a second HSA and contribute catch-up contributions. The company will not contribute funds or pay any fees associated with the HSA for your spouse. Please call the HSA Solution Contact Center at (800) 358-3494 for information on how to open a second HSA for your spouse.

Paying expenses through your Health Savings Account

While the funds in your HSA 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. If you are 65 or older and use the money for non-qualified expenses, you will be required to report the distribution as ordinary income on your federal and state tax return. Qualified medical expenses generally include medical, dental and vision expenses, chiropractic care and acupuncture. 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 HSA 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 HSA for the previous calendar year. Form 1099-SA reports the distributions from your HSA in the previous calendar year. Form 5498-SA reports the contributions to your HSA 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. Please consult your tax advisor or HSA 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 HSA. Once your account has reached a particular balance, any amount over that balance can be invested in the selected mutual funds. You may be charged an investment fee. Contact your HSA custodian for more information.

If you leave the company or are no longer enrolled in the HDP Standard plan

The funds in your HSA belong to you as the account holder, even if you enroll in COBRA, change plans (are no longer enrolled in the HDP Standard 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 HSA belong to you and you may use these funds for whatever you choose. If you choose to no longer maintain the account, it is your responsibility to contact the HSA custodian to close your account (for example, if you are no longer enrolled in the HDP Standard plan).

The dental plan

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dental

The dental plan

The dental plan provides coverage for a wide range of dental services. The 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 call Delta Dental Customer Service	Go to deltadentalar.com and select "Subscriber" to create your account	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 insurance ID card. Your insurance 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, 2012, your coverage must remain in effect until December 31, 2014. 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. Self-insured means that there is no insurance company to collect premiums or pay bills. Instead, participating associates make contributions each pay period to cover a portion of the cost of the dental benefit and the company or the plan's Trust pays the rest. 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.
- **General 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.

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 co-insurance 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 pretreatment estimate to Delta Dental. Delta Dental will inform you of the amount that will be covered under the plan and suggest an alternate treatment plan if a part of your dentist's initial treatment plan is ineligible for coverage. Mail pretreatment estimates to:

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, AR 72231-5965

You still must file a claim under the procedures set out in the **Claims and appeals** chapter. This is not a guarantee of payment.

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.

Dental plan benefits that apply to your annual deductible or lifetime maximum

Annual deductible	\$50 per person/\$150 maximum annual deductible per family		
Maximum benefits	\$2,500 per covered person per calendar year. This does not apply to orthodontia assistance.		
	Delta Dental Preferred (PPO) dentists	Delta Dental Premier dentists	Non-network dentists
Preventive and diagnostic care	100 percent covered; no annual deductible applies	100 percent covered; no annual deductible applies	80 percent of maximum plan allowance; no annual deductible applies
General care	80 percent of maximum plan allowance after annual deductible is met		
Major care (12-month wait)	50 percent of maximum plan allowance after annual deductible is met		
Orthodontia assistance (12-month wait)	80 percent of maximum plan allowance up to \$1,500 lifetime maximum orthodontia benefit per person; no annual deductible applies		

It pays to use network dentists

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

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.

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.

General care

After you meet the annual deductible, the plan pays 80 percent of the maximum plan allowance for general care.

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

Composite Resin Fillings: Restorations that involve either the mesial or distal surface will be considered single-surface restorations unless the incisal angle is also involved. 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 for eligible participants:

- Patient suffers from a medical condition that prevents the patient from holding still (including but not limited to dystonia, Parkinson's disease, autism);
- Patient is under age six; or
- In connection with certain covered oral surgical procedures.

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.

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: Implant and the surgical placement of an implant body is 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.

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 **Prosthetics and Alternative Treatment Plan limitations 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 co-insurance 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 postdelivery 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 is 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 which 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 FMLA or Military Leave of Absence.

See the **Eligibility and enrollment** chapter for details.

When dental coverage ends

Your coverage and your eligible dependents' coverage ends on your last day of employment. 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 then 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.

COBRA

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COBRA

COBRA

It's important to maintain the financial protection your health care coverage provides for you and your family. If you leave Walmart or a covered family member is no longer eligible, you can continue medical and dental coverage through the continuation provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). The Plan contracts with CONEXIS to administer COBRA. Take advantage of this one-time coverage continuation opportunity by carefully reading the COBRA notification and noting enrollment deadlines. Uninterrupted medical coverage prevents you from being subject to pre-existing condition limitations in a medical plan you may have access to in the future.

COBRA resources		
Find What You Need:	Online:	Other Resources:
Contact Benefits Customer Service within 60 calendar days of a divorce, legal separation, annulment or dependent(s) ineligibility		Call Benefits Customer Service at (800) 421-1362
Contact CONEXIS, the COBRA administrator, for questions regarding eligibility, enrollment, premiums and notification of a second qualifying event.	Go to mybenefits.conexis.com	Call CONEXIS at (800) 570-1863

What you need to know about COBRA

- If you or your eligible dependent's coverage ends, you and/or your eligible dependent(s) may be able to continue medical and dental coverage under COBRA.
 - You and/or your eligible dependent(s) must contact Benefits Customer Service by calling (800) 421-1362 within 60 calendar days of the following COBRA qualifying events to request COBRA continuation coverage or COBRA eligibility will be lost: divorce, legal separation, annulment or dependent(s) ineligibility (for instance, your dependent(s) no longer satisfies the requirements for coverage, such as attainment of age 26).
 - If you leave the company or lose medical and/or dental coverage due to a reduction in hours, you will automatically receive a letter offering you the opportunity to enroll in COBRA coverage.
 - To enroll in COBRA immediately after receiving your letter:
 1. Go online at mybenefits.conexis.com to enroll; and
 2. Make your premium payment online at mybenefits.conexis.com or call (800) 570-1863.
- If you have any questions or need assistance with enrollment, please call CONEXIS at (800) 570-1863.

COBRA — Medical and dental continuation after coverage ends

If you or your eligible dependent's medical or dental coverage under the Plan ends, you and/or your eligible dependent(s) may be able to continue medical and dental coverage under the continuation provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). This coverage is called "COBRA coverage." An event that makes you and/or your eligible dependent(s) eligible for COBRA coverage is called a "qualifying event."

You must have had medical or dental coverage on the day prior to your qualifying event date to be eligible for COBRA coverage.

Unless otherwise provided in the Plan, if you add a spouse or eligible dependent due to a status change event, they will be subject to the same plan limitations that apply to you at that time, if any (for example, limits concerning transplant coverage). If you change from an HRA plan to the HDP Standard plan, or from the HDP Standard plan to an HRA plan, or from an HMO to either the HDP Standard plan or an HRA plan due to a status change event, your annual deductible and out-of-pocket maximum will reset. If you change to an HRA plan, your HRA amount will be prorated. If you change from an HRA plan, your HRA balance will be forfeited. See **The medical plan** chapter for more information.

Your coverage tier level change must be consistent with the status change event and gain or loss of coverage.

If your coverage is cancelled due to nonpayment of premiums while you are still an active associate and then you terminate from the company, you and any eligible dependent(s) are not eligible for COBRA, except for special circumstances involving FMLA, described below.

For more information, please call Benefits Customer Service at **(800) 421-1362**.

If you have HMO coverage at the time your coverage as an active associate ends, state coverage continuation rules may apply. If you have both state and COBRA continuation rights, those continuation periods will run at the same time. For more information on state continuation rights, you should contact your HMO provider.

COBRA does not apply to critical illness insurance, accident insurance, company-paid life insurance, optional life insurance, dependent life insurance, short-term disability, short-term disability plus, long-term disability, truck driver long-term disability or accidental death and dismemberment (AD&D) benefits. See the **Critical illness insurance**, **Accident insurance**, **Company-paid life insurance**, **Optional life insurance**, **Dependent life insurance** and **Accidental death and dismemberment (AD&D)** insurance chapters in this book for more information.

If you are on FMLA

Generally, if your FMLA leave ends and you do not return to work, you and any eligible dependent(s) enrolled in medical or dental coverage under the Plan will be offered COBRA, which will run from the date following your employment termination date.

Note: If you and any eligible dependent(s) were enrolled in medical or dental coverage under the Plan on the day before your FMLA leave began but you dropped coverage or your coverage was cancelled due to nonpayment of premiums during the leave, COBRA coverage will still run from the date following your employment termination date. This means that even if COBRA is elected, you and any eligible dependent(s) will not have coverage for the period beginning on the date coverage was dropped or cancelled and ending on the date your employment ended.

COBRA qualifying events

You are eligible for COBRA if your medical or dental coverage ends because:

- Your employment with Walmart ends for any reason; or
- You are no longer eligible for medical and/or dental coverage because the number of hours you regularly work for Walmart has decreased.

Your eligible dependent(s) are eligible for COBRA if their coverage ends because:

- Your employment with Walmart ends for any reason;
- They are no longer eligible for medical and/or dental coverage because the number of hours you regularly work for Walmart has decreased;
- You and your spouse divorce or legally separate, or your marriage is annulled;

- Your dependent child(ren) no longer meets eligibility requirements; or
- Your death.

If you or your eligible dependent(s) has a qualifying event of divorce, legal separation, annulment or dependent(s) ineligibility, you or your eligible dependent(s) must contact Benefits Customer Service by calling (800) 421-1362 within 60 calendar days of the event to notify Benefits Customer Service of the occurrence of the event. You or your eligible dependents must provide the following information:

- Name of the covered associate
- Address of the covered associate
- Type of qualifying event
- Date of qualifying event
- Name of dependent(s) losing coverage
- Address of the dependent(s) losing coverage (if different from the covered associate)

You or your eligible dependents may also contact Benefits Customer Service by writing to:

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

CONEXIS will send a letter to your eligible dependents at the address you or they provide within 44 calendar days of receiving this notice. This letter will offer your eligible dependents the opportunity to continue medical and/or dental coverage. If your eligible dependent(s) do not receive the letter within 44 days, call CONEXIS at (800) 570-1863.

FEDERAL LAW PLACES RESPONSIBILITY UPON YOU OR YOUR ELIGIBLE DEPENDENT(S) TO NOTIFY BENEFITS CUSTOMER SERVICE WITHIN 60 CALENDAR DAYS OF A DIVORCE, LEGAL SEPARATION, ANNULMENT OR DEPENDENT(S) INELIGIBILITY. IF YOU OR YOUR ELIGIBLE DEPENDENT(S) DO NOT NOTIFY BENEFITS CUSTOMER SERVICE, YOUR DEPENDENT(S) WILL NOT BE ELIGIBLE FOR COBRA. YOU MUST ALSO NOTIFY THE COBRA ADMINISTRATOR, CONEXIS, OF A SECOND QUALIFYING EVENT OR DISABILITY IN ORDER TO EXTEND THE PERIOD OF COBRA COVERAGE. OTHER FORMS OF NOTICE WILL NOT BIND THE PLAN. IF TIMELY NOTICE IS NOT PROVIDED, COBRA CONTINUATION RIGHTS WILL EXPIRE ON THE DATE THAT YOUR INITIAL COBRA PERIOD EXPIRES.

For termination of employment, reduction in hours that results in the loss of medical and/or dental coverage, or death of an associate, the company will notify CONEXIS, the COBRA Administrator, within 30 calendar days of the event.

CONEXIS will send a letter to you and your eligible dependent(s) at your last known address within 44 calendar days of the event. This letter will offer you the opportunity to continue medical and/or dental coverage. If you or your eligible dependent(s) do not receive the letter within 44 days, call CONEXIS at (800) 570-1863.

You must notify CONEXIS within 60 calendar days from the date on the letter if you want to continue coverage under COBRA. You can contact CONEXIS by logging on to mybenefits.conexis.com. Failure to elect COBRA continuation coverage during the 60-day period will waive any right to elect COBRA coverage. Note: You may be asked to provide documentation of the qualifying event in order to receive COBRA coverage. Notify CONEXIS of any change of address if you elect COBRA coverage.

Once you elect and timely pay your premium under COBRA, you may not change or add to your COBRA coverage without a status change event outside annual enrollment. For information about status change events, see **Changing your benefits during the year: Status change events in the Eligibility and enrollment chapter**. If a status change event occurs (such as a child is born), you must notify CONEXIS by submitting the change in writing within 60 calendar days of the event. Supporting documentation may be required. As long as you are on COBRA, you will have the right to make changes to your coverage during any annual enrollment period.

You and your eligible dependent(s) each have separate election rights. You may elect COBRA coverage for all of your family members who lost coverage because of the qualifying event. A parent may elect COBRA coverage on behalf of an eligible dependent's child(ren). A child born to or placed for adoption with you while you are on COBRA also has COBRA rights.

If you do not want to continue coverage, you may cancel COBRA coverage at any time by ceasing to pay the premiums. No further action is required.

COBRA is provided subject to your eligibility for coverage under the law and the Associates' Health and Welfare Plan. The Plan Administrator reserves the right to terminate your continuation coverage retroactively if you are later determined to be ineligible.

Paying for COBRA coverage

You and/or your eligible dependent(s) will be responsible for both the associate portion of the premium and the amounts that were previously paid by the company, plus a 2 percent administrative fee (50 percent administrative fee in cases of the 11-month disability extension). The letter sent to you and your eligible dependent(s) following notice of a qualifying event will include the actual cost for COBRA coverage.

- **Initial COBRA Premium:** You have 45 days from the date of your COBRA election to pay premiums for:
 - Coverage provided between the date of the qualifying event and the end of the month in which the election is made; and
 - Any premiums that become due during the 45-day period.

If your initial premium payment is not received in the allowed time frame, you will not be eligible for COBRA coverage.

- **Continuing Premiums:** Monthly premiums are due on the first day of each month following the initial premium due date. If you make your payment on or before the first day of each month, your coverage under the Plan will continue for that month without any break.

You will be allowed a 30-day grace period. However, if you make your payment later than the first day of the month, any claims incurred, including pharmacy benefits, will not be paid until coverage is paid through the current month. If you do not pay this premium, you will be responsible for claims incurred. If the 30th day falls on a weekend or holiday, you will have until the next business day to have your payment postmarked.

As a courtesy, CONEXIS will send you a COBRA premium payment invoice. Attach your payment to the invoice and mail to:

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

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

Duration of COBRA coverage		
Conditions:	Associate:	Dependent(s):
• Your employment with the company ends for any reason • You are no longer eligible due to a reduction in hours	18 months	18 months
• Your death • Your marital status changes • Dependent(s) no longer meets eligibility requirements	Not applicable	36 months
Disability extension is obtained	29 months	29 months
Second qualifying event — You must notify CONEXIS within 60 days of the second qualifying event	Not applicable	Up to 36 months

Your COBRA coverage ends on the last day for which you paid your full COBRA premium on time. If your coverage ends due to nonpayment of premiums, it will not start again.

How long COBRA coverage lasts

The duration of your COBRA coverage depends on the reason for the COBRA coverage, as shown in the Duration of COBRA coverage chart.

If you are entitled to Medicare

If you are entitled to Medicare before your employment terminates or your hours of employment are reduced, your eligible dependent(s) who lose medical and/or dental coverage may receive COBRA coverage for the longer of the following:

- Thirty-six months from the date you enrolled in Medicare; or
- Eighteen months from the date of the qualifying event (the date of your termination of employment or reduction in hours of employment).

If you are entitled to Medicare prior to your COBRA election date, you or your eligible dependent(s) must notify CONEXIS of your Medicare status in order to ensure your maximum coverage period is properly calculated.

If you or an eligible dependent is disabled

If you and/or your eligible dependent(s) elect COBRA coverage due to your termination of employment or reduction in hours of employment and one of you is disabled, all of you may be entitled to up to 29 months of COBRA coverage. The 29-month COBRA coverage period begins on the date of your termination of employment or reduction in hours of employment. The disability extension only applies if all of the following conditions are met:

- The Social Security Administration determines that you or your eligible dependent is disabled;
- The disability exists at any time during the first 60 calendar days of COBRA coverage; or
- You and/or your eligible dependent(s) notify CONEXIS of the Social Security Administration's disability determination by submitting a copy of the Social Security Administration Disability Determination award letter to CONEXIS within your initial 18 month COBRA period and within 60 days of the later of:
 - the date of your qualifying event; or
 - the date of your Social Security Administration Disability Determination award letter.

CONEXIS will determine if you and/or your eligible dependent(s) qualify for the disability extension. If the extension is given, a new invoice will be mailed to you and/or your eligible dependent(s) before the end of the initial 18-month COBRA coverage period.

The COBRA premium for the 18th through the 29th month of COBRA coverage generally is the amount you were paying before the qualifying event, plus the amount the company was paying, plus a 50 percent administrative fee, or 150 percent of the full premium amount.

However, if the disability extension applies, but the disabled qualified beneficiary family member is not enrolled in COBRA coverage, the COBRA premium for the covered family members for the extended period is limited to 102 percent.

You or your eligible dependent(s) must notify CONEXIS no later than 30 days after the Social Security Administration determines that you or your eligible dependent(s) is no longer disabled.

If you have a second qualifying event while on COBRA

While an associate cannot get an extension of COBRA coverage due to a second qualifying event, your eligible dependent(s) who have COBRA coverage due to your termination of employment or reduction in hours of employment may receive COBRA coverage for up to a total of 36 months of COBRA coverage if a second qualifying event occurs.

The following are second qualifying events:

- Your death;
- Your divorce, legal separation or annulment; or
- Your child is no longer eligible for medical and/or dental coverage.

If a second qualifying event occurs while your eligible dependent(s) have COBRA coverage, their COBRA coverage may last up to 36 months from the date of the first qualifying event (the date of your termination of employment or reduction in hours of employment).

TO RECEIVE THE EXTENSION OF THE COBRA COVERAGE PERIOD, YOU OR YOUR ELIGIBLE DEPENDENT(S) MUST NOTIFY CONEXIS OF THE SECOND QUALIFYING EVENT WITHIN 60 CALENDAR DAYS OF THE DATE OF THE EVENT. IF CONEXIS IS NOT NOTIFIED OF THE SECOND QUALIFYING EVENT DURING THE 60-DAY PERIOD, YOUR ELIGIBLE DEPENDENT(S) CANNOT GET THE COBRA COVERAGE EXTENSION AND THE COVERAGE WILL BE TERMINATED AS OF THE DATE YOUR INITIAL COBRA PERIOD EXPIRED.

When COBRA coverage ends

Usually, COBRA coverage ends after the 18-month, 29-month or 36-month COBRA coverage period. See **How long COBRA coverage lasts** to find out which COBRA coverage period applies to you. COBRA coverage may be terminated before the end of the 18th, 29th or 36th month if:

- The company no longer provides medical or dental coverage to any of its associates;
- COBRA payment is not made within 30 calendar days of the due date (if the 30th day falls on a weekend or postal holiday, you will have until the next business day in order to have your payment postmarked);

- The participant becomes covered by another group health or dental plan after electing COBRA coverage unless the other plan excludes or limits coverage for a pre-existing condition, other than a pre-existing condition exclusion that does not apply (or is satisfied) due to the requirements of HIPAA;
- The participant becomes covered by Medicare after electing COBRA coverage (only medical may be terminated early); or
- The participant or other family member submits a fraudulent claim or fraudulent information.

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

Filing an appeal

You have the right to appeal an enrollment or eligibility status decision or a claim denial. See the **Claims and appeals** chapter for more information.

Resources For Living® (RFL)

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resources
for living

Resources For Living®

Resources For Living® (RFL) is a valuable confidential counseling and well-being information service that's free to all Walmart associates from your date of hire. You and your family members can call a professional counselor any time, day or night, for help with stress management, family relationships, career issues and other daily challenges. RFL also provides services for assistance with childcare, eldercare, education and more.

Resources For Living resources		
Find What You Need:	Online:	Other Resources:
Speak with a professional counselor Need help in a different language?	N/A	Call (800) 825-3555 TDD (800) 827-3707 for the hearing impaired
Access articles, tools and resources across a wide range of topics	Go to rfl.com	
Access monthly Healthy Living Tips and webinars on a variety of topics	Go to rfl.com or mywalmart.com	

What you need to know about Resources For Living

- All Walmart associates are automatically enrolled in Resources For Living as of their date of hire.
- Walmart or the Plan pays the entire cost for Resources For Living benefits for you and your family.
- Resources For Living is a professional and confidential counseling and information service available 24 hours a day, seven days a week.

Using Resources For Living

Resources for Living is a professional and confidential counseling and information service that helps in a variety of areas that are important to your overall health and well-being, including emotional stress, relationships, financial, setting and reaching your goals, and everyday needs. Professional counselors are available 24 hours a day, seven days a week, 365 days a year at **(800) 825-3555 (other languages available upon request)**.

Counseling services are available in English and Spanish. Walmart or the Plan's Trust pays these benefits — there is no cost to associates.

All U.S. associates and their family members are automatically enrolled in Resources For Living. Coverage begins on your first day of employment with Walmart. All benefits under this program are provided and administered by Resources For Living.

When you log on to RFL's Web site at rfl.com, you have access to information, tools and resources on a variety of topics related to mental and emotional health, physical well-being, relationships and career success.

Resources For Living provides a gateway to personalized support, encouragement, guidance and helpful information. For major challenges or everyday needs, RFL can help. Resources For Living offers resources and counseling for issues related to:

- **Emotional/Social:** Take advantage of counseling and resources to manage relationships with your family and friends, tap into your creative potential, manage stress ... even stay motivated.
- **Career:** Learn how to lead and live a rewarding career with helpful resources for building your resume, getting that raise or promotion and managing workplace relationships.
- **Financial:** Tap into resources to help you set up a budget, buy a house, manage credit card debt, save for the future and much more.
- **Community:** Get help with finding important resources in your area, like housing, child care, seniors, pet care, legal aid and more.
- **Physical:** Find ways to keep your mind and body healthy, with helpful information and counseling on issues like nutrition, weight management, disease and chronic conditions and overall well-being.

Resources For Living provides a gateway to personalized support, encouragement, guidance and helpful information. For major challenges or everyday needs, RFL can help.

RFL WorkLife Services

RFL has expanded its services to help you with practical resources and solutions to address everyday needs like:

- Locating childcare
- Learning about money management and overcoming debt
- Military family resources
- Understanding eldercare options and identifying community resources for seniors
- Finding housing and buying a home

Using RFL's WorkLife services means more balance in your life by having a specialist do the research and make the phone calls for you. If you are looking for a particular resource or provider of services, if you are looking for a particular resource or provider of services, RFL will provide you with detailed information on those identified as a match. You'll also receive a follow-up call to make sure your needs are met. This enhanced service is available by calling the same toll-free number: **(800) 825-3555 (other languages available upon request)**.

Calling Resources For Living

Call RFL any time at **(800) 825-3555 (other languages available upon request)**. Services are available in Spanish and English, and provided 24 hours a day, seven days a week. As a Walmart associate this service is free to you and/or your family members. Services are confidential — no one will know about your call unless you tell them.

You also may visit the Resources For Living Web site rfl.com, or mywalmart.com for articles, tools and resources across a wide range of topics available to help you live well.

When Resources For Living benefits end

Your Resources For Living benefit (and your family's Resources For Living benefit) ends upon your termination of employment for any reason, but your Resources For Living benefit will automatically be continued, at no cost, for you and your family throughout the applicable COBRA period under the Associates' Medical Plan.

Filing a claim for Resources For Living benefits

You do not have to file a claim for Resources For Living benefits. You may access the Resources For Living Web or contact Resources For Living at any time. However, if you have a question about your benefits, or disagree with the benefits provided, you may contact Benefits Customer Service at **(800) 421-1362** or file a claim by writing to the following address:

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

Claims, and any appeals, will be determined under the time frames and requirements set out in the procedures for filing a claim for medical benefits in the **Claims and appeals** chapter.

Critical illness insurance

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critical illness

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Allstate Benefits, the terms of the policy will govern. You may obtain a copy of this policy by contacting the plan. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company, the underwriting company and subsidiary of The Allstate Corporation.

Critical illness insurance

When you and your dependents elect to participate in critical illness insurance, you receive benefits in the form of direct lump sum payments that can be used to help pay for expenses related to covered critical illnesses and diseases. Covered illnesses and diseases include invasive cancer, carcinoma in situ, heart attack, stroke, coronary artery bypass surgery, end stage renal failure, Alzheimer's disease and many others. You and your dependents will not need to answer any medical questions to receive coverage up to \$20,000 during your initial enrollment period.

Critical illness insurance resources

Find What You Need:

For detailed information on critical illness insurance

Online:

The WIRE, mywalmart.com or allstateatwork.com/walmart

Other Resources:

Call Allstate at (800) 514-9525

What you need to know about critical illness insurance

- All associates (except for temporary associates) and their eligible dependents (except for spouses of part-time associates and part-time truck drivers) can enroll in critical illness insurance when they are eligible. If you enroll after your initial enrollment period, you will be required to provide Proof of Good Health.
- For additional information about critical illness insurance, view the critical illness video or brochure available online at allstateatwork.com/walmart, the WIRE or mywalmart.com.
- To view your Certificate of Insurance, visit allstateatwork.com/walmart, the WIRE or mywalmart.com.

Critical illness insurance

Critical illness insurance provides a direct benefit if you or any covered dependents are diagnosed with a covered illness or disease. The policy pays benefits for covered critical illnesses and diseases regardless of any other insurance you may have. During your initial enrollment period, coverage is guaranteed issue up to \$20,000, meaning no medical questions are required.

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

Pre-existing condition and previous diagnosis limitations and exclusions apply. Visit the [WIRE](#), [mywalmart.com](#) or [allstateatwork.com/walmart](#) for more details.

Critical illness insurance is underwritten by American Heritage Life Insurance Company, a subsidiary of The Allstate Corporation. For complete information about critical illness insurance, call Allstate Benefits or go to [allstateatwork.com/walmart](#).

Eligibility and application for critical illness insurance

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

- Full-time hourly associate (including full-time hourly pharmacists, field Logistics associates and field supervisor positions in stores and clubs, full-time hourly Vision Center managers and [walmart.com](#) functional non-exempt associates);
- Full-time truck driver; or
- Management associate (including management trainees and California pharmacists).

When applying for critical illness insurance, you may choose:

- Associate Only
- Associate + Spouse
- Associate + Child(ren)
- Associate + Family

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

- Part-time hourly associate
- Part-time truck driver

You may choose:

- Associate Only; or
- Associate + Child(ren)

For complete information about eligibility and when you can apply for critical illness insurance, see the [Eligibility and enrollment](#) chapter.

The cost for coverage under critical illness insurance is based on the coverage amounts you choose, the eligible dependents you choose to cover and whether you (and/or your covered spouse) are eligible for tobacco-free rates.

Naming a beneficiary

If a covered person dies, the covered person's beneficiary(ies) will receive the benefits due at the time of the covered person's death.

You must name a beneficiary(ies) to receive your critical illness insurance benefit if you die. You may do this by going to the [WIRE](#) or [mywalmart.com](#), or by calling Allstate Benefits at (800) 514-9525.

You can name anyone you wish. If the beneficiary(ies) you have listed with Allstate Benefits differs from those named in your will, the list that Allstate Benefits has prevails.

The following information is needed when naming your beneficiary(ies):

- Beneficiary(ies) name
- Beneficiary(ies) current address
- Beneficiary(ies) phone number
- Beneficiary(ies) relationship to you
- Beneficiary(ies) Social Security number
- Beneficiary(ies) date of birth
- The percentage you wish to designate per beneficiary, up to 100 percent

If two or more beneficiary(ies) are designated and their shares are not specified, they will share the insurance benefit equally.

You can name a minor as a beneficiary; however, Allstate Benefits may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult with an attorney before naming a minor as a beneficiary.

It's important to keep your beneficiary information up-to-date. Proceeds will go to whomever is listed on your beneficiary form on file with Allstate Benefits, regardless of your current relationship with that person unless required by state law.

Changing your beneficiary

Your beneficiary(ies) can be changed at any time on the [WIRE](#) or [mywalmart.com](#), or by calling Allstate Benefits at (800) 514-9525.

If you do not name a beneficiary

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to your surviving family member(s) in the following order:

1. Your spouse; if not surviving, then
2. Your children, in equal shares; if not surviving, then
3. Your parents, in equal shares; if not surviving, then
4. Your siblings, in equal shares; if not surviving, then
5. Your estate.

Proof of Good Health for critical illness insurance

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

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

Proof of Good Health may be required for the following:

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

When your critical illness insurance coverage begins

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

If you enroll outside of annual enrollment, your coverage will become effective on your status change event date or the end of your eligibility waiting period, whichever is later. If you should die before your effective date (as indicated above) and Allstate Benefits approves your coverage, no critical illness insurance benefit will be paid to your beneficiary(ies).

Your critical illness insurance will begin whether or not you are actively-at-work, as long as you have reported for your first day of work and enrolled for the benefit. See the [Eligibility and enrollment](#) chapter for details.

Filing a claim

Within 60 days of the occurrence or commencement of any covered critical illness, or as soon as reasonably possible, send a notice of claim to:

Allstate Benefits
Attn: Walmart Claims Unit
P.O. Box 41488
Jacksonville, FL 32203-1488

and provide the following information for the covered person:

- Name;
- Social Security number; and
- Date the covered illness occurred or commenced.

You may request a claim form from Allstate Benefits or visit the [WIRE](#), [mywalmart.com](#) or [allstateatwork.com/walmart](#) to obtain an online copy. If you do not receive a claim form within 15 days of your request, you may send a notice of the claim to Allstate Benefits by providing Allstate Benefits with a statement of the nature and extent of the loss.

Claims will be determined under the time frames and requirements set out in the [Claims and appeals](#) chapter. You or your beneficiary has the right to appeal a claim denial. See the [Claims and appeals](#) chapter for details.

Critical illness benefits

Plan benefits continue until a maximum of 200 percent of your approved coverage election amount is reached, subject to limitations for pre-existing conditions.

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

- Invasive cancer
- Alzheimer's disease
- Coronary artery bypass surgery
- End stage renal failure
- Heart attack
- Stroke
- Advanced Parkinson's (requires loss of 3 ADLs)
- Loss of sight or hearing (due to illness)
- Quadriplegia (due to illness)
- Two eyes, feet, hands, arms or legs (due to illness)
- Coma (lasting 7 days) due to illness
- Major organ transplant rider (does not count toward 200 percent maximum)

Note: If you are enrolled in an HDP Standard plan, you are not eligible for the major organ transplant rider included in critical illness insurance.

The following benefits are payable at 50 percent of your coverage election:

- Benign brain tumor
- Paraplegia (due to illness)
- One eye, foot, hand, arm or leg (due to illness)

Other payable benefits include:

- Carcinoma in situ — 25 percent of coverage amount
- One or more fingers and/or one or more toes (due to illness) — 25 percent of coverage amount
- Specified diseases — 25 percent of coverage amount
 - Addison's Disease
 - Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
 - Cerebrospinal Meningitis (bacterial)
 - Cerebral Palsy
 - Cystic Fibrosis
 - Diphtheria
 - Encephalitis

- Huntington's Chorea
- Legionnaire's Disease (confirmation by culture or sputum)
- Malaria
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Necrotizing Fasciitis
- Osteomyelitis
- Poliomyelitis
- Rabies
- Sickle Cell Anemia
- Systemic Lupus
- Systemic Sclerosis (Scleroderma)
- Tetanus
- Tuberculosis
- Skin Cancer Benefit — \$250
 - Positive diagnosis of skin cancer means a diagnosis by a licensed Doctor of Medicine certified by the American Board of Pathology to practice Pathological Anatomy, or an Osteopathic Pathologist. Diagnosis is based on microscopic examination of skin biopsy samples.
 - Skin cancer means basal cell carcinoma and squamous cell carcinoma. For the purposes of this policy, skin cancer does not include malignant melanoma. It also does not include any conditions which may be considered pre-cancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; non-malignant melanoma; moles; or similar diseases or lesions.
 - Recurrence Benefit — 50 percent of original coverage amount for heart attack, stroke, coronary artery bypass surgery, invasive cancer, carcinoma in situ and rabies
 - National Cancer Institute (NCI) and Walmart Center of Excellence Evaluation — \$500 for evaluation; \$250 for transportation and lodging
 - Lodging Benefit — \$60 per day

- Transportation Benefit — \$0.50 per mile for personal vehicle, up to \$1,500, or up to \$1,500 round trip transportation for coach fare on a common carrier
- Waiver of premium during a period of the associate's disability

For more information, see your Certificate of Insurance or call Allstate Benefits.

Your Certificate of Insurance will contain complete information on the benefits payable through this coverage. To obtain a copy, visit the [WIRE](#) or [mywalmart.com](#). You can also call Allstate Benefits at (800) 514-9525 for a copy. You can view a brochure and video online at [allstateatwork.com/walmart](#).

When benefits are not paid

This policy does not pay benefits for any critical illness due to or resulting from (directly or indirectly):

- Any act of war, whether or not declared or participation in a riot, insurrection or rebellion;
- Intentionally self-inflicted injuries;
- Engaging in an illegal occupation or committing or attempting to commit a felony;
- Attempted suicide, while sane or insane;
- Being under the influence of narcotics or any other controlled chemical substance, unless administered upon the advice of a physician;
- Participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
- Alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.

If you go on a leave of absence

For information about making payments while on a 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, you will be required to provide Proof of Good Health for all coverage plans. Your coverage will be effective on the first day of the pay period that you meet the actively-at-work requirement or upon approval by Allstate Benefits.

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 FMLA or Military Leave of Absence.

See the **Eligibility and enrollment** chapter for details.

When coverage ends

Coverage under critical illness insurance for you and/or your dependent will end on the earliest of the following:

- At termination of your employment;
- Upon failure to pay your premiums;
- On the date of death of you or your dependent;
- On the date you or a dependent spouse or child loses eligibility;
- On the last day of an approved leave of absence (unless you return to work); or
- When the benefit is no longer offered by the company.

Critical illness insurance coverage ends for your covered spouse upon a valid decree of divorce, your death or you changing status to a part-time associate or part-time truck driver.

Critical illness insurance coverage ends for your covered dependent children upon the next anniversary date of your coverage after the child loses eligibility for such coverage as described in the **Eligibility and enrollment** chapter. However, coverage for such a child will not terminate if the child is unmarried, is incapable of self-sustaining employment because of mental or physical incapacity, became so incapacitated before losing his or her eligibility status, and depends chiefly upon you for support and maintenance.

Continuation of coverage at termination

If your coverage under critical illness insurance terminates as described in the **When coverage ends** section, you may continue to receive critical illness insurance directly from Allstate Benefits through portability coverage. To receive portability coverage, you must notify Allstate Benefits that you wish to receive portability coverage and send the first premium for such coverage within 60 days of the date your coverage under critical illness insurance terminated.

The premiums for portability coverage are due in advance of each month's coverage, on the first day of the calendar month. The premiums for the first 36 months of portability coverage will be at the same rate that is in effect under critical illness insurance for active associates with the same coverage. After the first 36 months, your portability coverage premiums may change on any premium due date. You will be given at least 31 days notice before any change in premium takes effect.

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

When your dependent becomes ineligible

Any eligible dependent who was covered under critical illness insurance at the time such coverage terminated may also receive portability coverage, under the terms described in the **Continuation of coverage at termination** section earlier in this chapter.

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

If you leave the company and then 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 plan 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.

See the **Eligibility and enrollment** chapter for details.

Accident insurance

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accident insurance

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Allstate Benefits, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company, the underwriting company and subsidiary of The Allstate Corporation.

Accident insurance

An accident can cause unexpected expenses along with the injury. If you enroll in accident insurance and are involved in a covered accident while you're off the job, this benefit helps you pay for services necessary as a result of the accident, such as emergency room treatment, hospitalization, physical therapy, transportation and lodging. You'll receive benefits from accident insurance in addition to any benefits you receive from other plans, such as medical and other accident plans, and benefits are paid directly to you unless you elect to have them paid directly to the provider.

Accident insurance resources

Find What You Need:

For detailed information on accident insurance

Online:

The [WIRE](#), [mywalmart.com](#) or [allstateatwork.com/walmart](#)

Other Resources:

Call Allstate at [\(800\) 514-9525](#)

What you need to know about accident insurance

- All associates (except for temporary associates) and their eligible dependents (except for the spouses of part-time associates and part-time truck drivers) can enroll in accident insurance when they are eligible. Proof of Good Health is not required for any level of coverage.
- For additional information about accident insurance, view the accident insurance video or brochure available online at [allstateatwork.com/walmart](#), the [WIRE](#) or [mywalmart.com](#).
- To view your Certificate of Insurance, visit [allstateatwork.com/walmart](#).

Accident insurance

Accident insurance provides benefits to you if you or any covered dependents receive a covered treatment related to an off-the-job accident. The benefits under this policy are not reduced by any other benefits you may receive.

Accident insurance is underwritten by American Heritage Life Insurance Company, a subsidiary of The Allstate Corporation. For complete information about accident insurance, call Allstate Benefits or go to allstateatwork.com/walmart.

Eligibility and application for accident insurance

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

- Full-time hourly associate (including full-time hourly pharmacists, field Logistics associates and field supervisor positions in stores and clubs, full-time hourly Vision Center managers and walmart.com functional non-exempt associates);
- Full-time truck driver; or
- Management associate (including management trainees and California pharmacists).

When applying for accident insurance, you may choose:

- Associate Only
- Associate + Spouse
- Associate + Child(ren)
- Associate + Family

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

- Part-time hourly associate; or
- Part-time truck driver

You may choose:

- Associate Only; or
- Associate + Child(ren).

For complete information about eligibility and when you can enroll in accident insurance, see the **Eligibility and enrollment** chapter.

The cost for coverage under accident insurance is based on the eligible dependents you choose to cover.

Naming a beneficiary

If a covered person dies, the covered person's beneficiary(ies) will receive the benefits due at the time of the covered person's death.

You must name a beneficiary(ies) to receive your accident insurance benefit if you die. You may do this by going to the **WIRE** or mywalmart.com, or by calling Allstate at **(800) 514-9525**.

You can name anyone you wish. If the beneficiary(ies) you have listed with Allstate Benefits differs from those named in your will, the list that Allstate Benefits has prevails.

The following information is needed when naming your beneficiary(ies):

- Beneficiary(ies) name
- Beneficiary(ies) current address
- Beneficiary(ies) phone number
- Beneficiary(ies) relationship to you
- Beneficiary(ies) Social Security number
- Beneficiary(ies) date of birth
- The percentage you wish to designate per beneficiary, up to 100 percent

If two or more beneficiary(ies) are designated and their shares are not specified, they will share the insurance benefit equally.

You can name a minor as a beneficiary; however, Allstate Benefits may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult with an attorney before naming a minor as a beneficiary.

It's important to keep your beneficiary information up-to-date. Proceeds will go to whomever is listed on your beneficiary form on file with Allstate Benefits, regardless of your current relationship with that person.

Changing your beneficiary

Your beneficiary(ies) can be changed at any time on the **WIRE** or **mywalmart.com**, or by calling Allstate Benefits at **(800) 514-9525**.

If you do not name a beneficiary

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to your surviving family member(s) in the following order:

1. Your spouse; if not surviving, then;
2. Children, in equal shares; if not surviving, then;
3. Parents, in equal shares; if not surviving, then;
4. Siblings, in equal shares; if not surviving, then;
5. Your estate.

When your accident insurance coverage begins

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

If you enroll outside of annual enrollment, your coverage will become effective on the status change event date or the end of your eligibility waiting period, whichever is later. If you should die before your effective date (as defined above) and Allstate Benefits approves your coverage, no accident insurance benefit will be paid to your beneficiary(ies).

Your accident insurance will begin whether or not you are actively at work, as long as you have reported for your first day of work and enrolled for the benefit. See the **Eligibility and enrollment** chapter for details.

Filing a claim

Within 60 days of the occurrence or commencement of any covered accident, or as soon as reasonably possible, send a notice of claim to:

Allstate Benefits
Attn. Walmart Claims Unit, P.O. Box 41488
Jacksonville, Florida, 32203-1488

Provide the following information for the covered person:

- Name;
- Social Security number; and
- Date the covered accident occurred.

You may request a claim form from Allstate Benefits or visit the **WIRE**, **mywalmart.com** or **allstateatwork.com/walmart** to obtain an online copy. If you do not receive a claim form within 15 days of your request, you may send a notice of the claim to Allstate Benefits by providing Allstate Benefits with a statement of the nature and extent of the loss.

Claims will be determined under the time frames and requirements set out in the **Claims and appeals** chapter. You or your beneficiary has the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

Accident insurance benefits

Accident insurance provides benefits if you or any covered dependent seeks medical treatment or is hospitalized as a result of a covered accident that happens off the job.

For a complete list of benefits and the amounts payable, visit the **WIRE**, **mywalmart.com** or **allstateatwork.com/walmart** for more details.

The following benefits for services that are required as a result of a covered off-the-job accident include:

- Emergency treatment benefit
- Initial hospitalization benefit
- Hospital confinement

- Specific benefit for injuries such as for dislocation, burns, skin grafts, eye injury, lacerations, fractures, concussions (brain), emergency dental services, coma (at least seven days), surgical procedures
- Major diagnostic exams benefit
- Physical therapy benefit
- Rehabilitation
- Appliances
- Ambulance
- Blood, plasma and platelets
- Transportation and lodging benefit
- On- and off-the-job intensive care unit (ICU)
- Confinement and step-down intensive care unit
- Follow-up treatment
- Prosthesis
- Family lodging

Your Certificate of Insurance will contain complete information on the benefits payable through this coverage. To obtain a copy, visit the **WIRE**, or **mywalmart.com**. You can also call Allstate Benefits at **(800) 514-9525** for a copy. You can view a brochure and video online at **allstateatwork.com/walmart**.

When benefits are not paid

Benefits will not be paid for an accident that is caused by or occurs as a result of:

- An injury that occurred as the result of an on-the-job accident, except as may be provided under the on- and off-the-job accident only intensive care unit benefit;
- Injury incurred prior to the covered person's effective date of coverage subject to the contestability provision;
- Any act of war whether or not declared or participation in a riot, insurrection or rebellion;
- Suicide, or any attempt at suicide, whether sane or insane;
- Any injury sustained while the covered person is under the influence of alcohol or any narcotic, unless administered upon the advice of a physician;
- Dental or plastic surgery for cosmetic purposes, except when such surgery is required to treat an injury or correct a disorder of normal bodily function that was caused by an injury;

- Participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports;
- Committing or attempting to commit an assault or felony;
- Driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway; or
- Any injury incurred while a covered person is an active member of the Military, Naval or Air Forces of any country or combination of countries. Upon notice and proof of service in such forces, Allstate Benefits will return the prorated portion of the premium paid for any period of such service.

If you go on a leave of absence

For information about making payments while on a 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 or upon approval by Allstate Benefits.

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 FMLA or Military Leave of Absence.

See the **Eligibility and enrollment** chapter for details.

When coverage ends

Coverage under accident insurance for you and/or your dependent will end on the earliest of the following:

- At termination of your employment;
- Upon failure to pay your premiums;
- On the date of death of you or your dependent;
- On the date you or a dependent spouse or child loses eligibility;
- On the last day of an approved leave of absence (unless you return to work); or
- When the benefit is no longer offered by the company.

Accident insurance coverage ends for your covered spouse upon a valid decree of divorce, your death or you changing status to a part-time associate or part-time truck driver.

Accident insurance coverage ends for your covered dependent children upon the next anniversary date of your coverage after the child loses eligibility for such coverage as described in the **Eligibility and enrollment** chapter. However, coverage for such a child will not terminate if the child is unmarried, is incapable of self-sustaining employment because of mental or physical incapacity, became so incapacitated before losing his or her eligibility status, and depends chiefly upon you for support and maintenance.

Continuation of coverage at termination

If your coverage under accident insurance terminates as described in the **When coverage ends** section, you may continue to receive accident insurance directly from Allstate Benefits through portability coverage. To receive portability coverage, you must notify Allstate Benefits that you wish to receive portability coverage and send the first premium for such coverage within 60 days of the date your coverage under accident insurance terminated. The premiums for portability coverage are due in advance of each month's coverage, on the first day of the calendar month. The premiums for the first 36 months of portability coverage will be at the same rate that is in effect under accident insurance for active associates with the same coverage. After the first 36 months, your portability coverage premiums may change on any premium due date. You will be given at least 31 days notice before any change in premium takes effect.

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

When your dependent becomes ineligible

Any eligible dependent who was covered under accident insurance at the time such coverage terminated may also receive portability coverage, under the terms described above.

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

If you leave the company and then 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 plan 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.

See the **Eligibility and enrollment** chapter for details.

Company-paid life insurance

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company-paid life insurance

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential, the terms of the policy will govern. You may obtain a copy of this policy by contacting the plan.

Company-paid life insurance

Whether you are single or married, your loved ones will have expenses as a result of your death. That's why Walmart automatically provides you with life insurance at no cost to you. Your company-paid life insurance benefit can help pay for your funeral, any credit card balances, or other debts and expenses you may leave behind.

Company-paid life insurance resources

Find What You Need:	Online:	Other Resources:
Change your beneficiary designation	The WIRE or mywalmart.com	Beneficiary changes cannot be made over the phone.
• Get more details about company-paid life insurance • Request an accelerated benefit • Continuing your insurance		Call Prudential at (877) 740-2116
File a claim		Call Prudential at (877) 740-2116

What you need to know about company-paid life insurance

- Wal-Mart Stores, Inc. provides all full-time associates (including full-time hourly pharmacists, field Logistics associates, field supervisor positions in stores and clubs, management trainees, California pharmacists, full-time Vision Center managers, and [walmart.com](#) functional non-exempt associates) and management associates (including full-time truck drivers) with company-paid life insurance — there is no cost to you.
- Your coverage amount is equal to your pay, including overtime and bonuses, during the previous 26 pay periods of active status (52 pay periods if paid weekly) prior to your death, rounded to the nearest \$1,000, up to \$50,000.
- An early payout due to terminal illness is available.

Your company-paid life insurance

Walmart provides all full-time associates and management associates with company-paid life insurance — there is no cost to you. No enrollment is necessary. Coverage will become effective after any applicable waiting period. See the **Eligibility and enrollment** chapter for details.

If you die, your beneficiary(ies) can receive a lump sum payment. The payment will be equal to your pay, including overtime and bonuses, during the previous 26 pay periods of active status (52 pay periods if paid weekly) prior to your death, rounded to the nearest \$1,000. The payment cannot exceed \$50,000. Company-paid life insurance is insured by the Prudential Insurance Company of America (Prudential).

In addition, if your death occurs outside of a 100-mile radius of your home, there is a benefit for expenses that are incurred to return your body to either a preferred location within the United States, or to your residence at the time of death. The benefit includes expenses for embalming, cremation, a coffin and transportation of the remains. The benefit is the lesser of the cost to return your remains or \$10,000.

This policy has no cash value.

Naming a beneficiary

In order to ensure your company-paid life insurance benefit is paid according to your wishes, you must name a beneficiary(ies). You may do this by going to the [WIRE](#) or [mywalmart.com](#).

You can name anyone you wish. If the beneficiary(ies) you have listed with the company differs from those named in your will, the list that the company has prevails.

The following information is needed when naming your beneficiary(ies):

- Beneficiary(ies) name
- Beneficiary(ies) current address
- Beneficiary(ies) phone number
- Beneficiary(ies) relationship to you
- Beneficiary(ies) Social Security number
- Beneficiary(ies) date of birth
- The percentage you wish to designate per beneficiary up to 100 percent

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end, and will be shared equally by any remaining beneficiary(ies), unless your beneficiary form states otherwise.

You can name a minor as a beneficiary; however, Prudential may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult with an attorney or an estate planner before naming a minor as a beneficiary. If you name a minor as a beneficiary, funeral expenses cannot be paid from the minor's beneficiary proceeds.

Please note

It's important to update your beneficiary information annually. Keep in mind, proceeds will go to whomever is listed on your beneficiary form with the company, regardless of your current relationship with that person. You can change your beneficiary(ies) at any time on the WIRE or mywalmart.com.

If you do not name a beneficiary

If no beneficiary is named, payment will be made to your surviving family member(s) in the following order:

1. Widow or widower; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares; if not surviving, then
5. Executor or administrator of your estate.

When your company-paid life insurance coverage begins

You must be actively-at-work in order for your coverage to be effective. You will be considered actively-at-work on a day that is one of your scheduled work days if you are performing in the usual way all of the regular duties of your job. See the **Eligibility and enrollment** chapter for details.

An early payout due to terminal illness

If you are terminally ill, you may elect to receive up to 50 percent of the amount your beneficiary(ies) would have received upon your death, while you are still living. Payment may be made in a lump sum or 12 equal monthly installments. Upon your death, your beneficiary(ies) will receive the remaining 50 percent (plus any amount of the early payout not yet received at the time of your death). This benefit is referred to as the accelerated benefit.

If you terminate from the company after you have received (or begun to receive) the accelerated death benefit, you will need to convert the policy in order for your beneficiary(ies) to receive the remaining balance upon your death. If you do not convert the policy upon termination of your employment, there will be no benefit payout for your beneficiary(ies). See the **Continuing your insurance** section in this chapter for details on conversion.

You are terminally ill if:

- There is no reasonable prospect of recovery;
- Death is expected within 12 months; and
- A doctor can certify the illness or injury as terminal.

There may be some circumstances when the accelerated benefit will not be paid. Contact Prudential at **(877) 740-2116** for details.

Tax laws are complex. Please consult with a tax professional to assess the impact of this benefit.

Filing a claim

Within 12 months of the covered associate's death, contact Prudential at **(877) 740-2116**, and provide the following information regarding the deceased associate:

- Name;
- Social Security number;
- Date of death; and
- Cause of death (if known).

An original or certified copy of the death certificate may be required as proof of death. Mail the death certificate to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, PA 19176

The claim will not be finalized until the death certificate is received. Acceptance of the death certificate is not a guarantee of payment.

Claims will be determined under the time frames and requirements set out in the **Claims and appeals** chapter. Your beneficiary(ies) has the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For more details, contact Prudential at **(877) 740-2116**.

When benefits are not paid

Benefits will not be paid to any beneficiary(ies) who engaged in an illegal act that resulted in the death of the associate. Instead, the benefit would go to another eligible beneficiary or to your estate.

When coverage ends

Your company-paid life insurance coverage ends:

- At termination of your employment;
- On the last day of the pay period when your job status changes to part-time;
- On the date of your death;
- On the date you lose eligibility;
- On the last day of an approved leave of absence (unless you return to work); or
- When the benefit is no longer offered by the company.

This policy has no cash value.

FinancialPoint® beneficiary financial counseling

In the event of your or your dependent's death, beneficiary financial planning guidance is available at no cost to you. Financial planning guidance is also available if you are terminally ill. Services include resources mailed to your or your beneficiary(ies) home — a data-gathering questionnaire, personal investment viewpoint questionnaire and a glossary of financial terms — a personalized financial plan, a year of 24/7 access to a financial planning hotline and support for topics such as inheritance taxes, loss of income, creditors and probate.

To request more information on resources available to you, call FinancialPoint at **(888) 327-4260**.

Estate Guidance®

Estate Guidance offers you the convenience of online will preparation from your personal computer at no cost to you. Wills ensure your assets will be distributed in accordance with your wishes and allow you to name a guardian to take care of your minor children. To complete the online will questionnaire, log on to willguidance.com, password: **WMTWILL**.

Note: If the beneficiary(ies) you have listed with the company differs from those named in your will, the list the company has prevails.

Continuing your insurance

In most circumstances if your group life coverage ends, you can continue all or a portion of your coverage. You have 31 days from the termination date of coverage to request to continue your coverage under an individual policy.

If your death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted.

To request information on all available continuation plans, call Prudential at **(877) 740-2116**.

For residents of Minnesota, you may elect to continue coverage at your expense if your employment is terminated either voluntarily or involuntarily, or if you are laid off, as long as the group policy is still in force with the employer. Coverage may be continued until you obtain coverage under another group policy or you return to work from layoff; however, the maximum period that coverage may be continued is 18 months.

If you leave the company and then are rehired

If you return to work within 30 days you will automatically be re-enrolled (or enrolled in the most similar coverage offered under the plan).

If you return to work after 30 days, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period. See the **Eligibility and enrollment** chapter for details.

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optional life insurance

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential, the terms of the policy will govern. You may obtain a copy of this policy by contacting the plan.

Optional life insurance

You protect your family every day — your paycheck keeps a roof over their heads and food on the table, you use seat belts and child safety seats, and you plan for your family's college and retirement expenses. What would happen to your family if you died? Would they be forced to deal with a desperate financial situation along with emotional devastation? In addition to your Walmart-provided life insurance, optional life insurance protects your family financially during a difficult time.

Optional life insurance resources		
Find What You Need:	Online:	Other Resources:
Change your beneficiary designation	The WIRE or mywalmart.com	Beneficiary changes cannot be made over the phone.
• Get more details about life insurance • Request an accelerated benefit • Continuing your insurance		Call Prudential at (877) 740-2116
File a claim		Call Prudential at (877) 740-2116

What you need to know about optional life insurance

- All full-time associates (including full-time hourly pharmacists, field Logistics associates, field supervisor positions in stores and clubs, management trainees, California pharmacists, full-time Vision Center managers, and [walmart.com](#) functional non-exempt associates) and management associates (including full-time truck drivers) can enroll in optional life insurance.
- Depending on the coverage amount you choose and when you enroll, you may be required to provide Proof of Good Health.
- You can enroll in, change or drop life insurance at any time, but if you enroll at any time other than your initial enrollment period, you will have to provide Proof of Good Health.
- An early payout due to terminal illness is available.
- This policy is term life insurance. Therefore, it has no cash value.

Enrolling in optional life insurance

All full-time associates and management associates can enroll in optional life insurance in addition to the company-paid life insurance provided by Walmart. Your coverage choices for optional life insurance are:

- \$25,000
- \$50,000
- \$75,000
- \$100,000
- \$150,000
- \$200,000

Depending on the coverage amount you choose and when you enroll, you may be required to provide Proof of Good Health.

This policy has no cash value.

If you die, your beneficiary(ies) may receive a lump sum payment for the coverage amount you select. Optional life insurance is insured by The Prudential Insurance Company of America (Prudential).

The cost of optional life insurance is based on the coverage amount you select, your age and whether you are eligible for tobacco-free rates.

You can enroll in optional life insurance at any time. Proof of Good Health is required if you enroll after your initial enrollment period. Also, you can change or drop coverage at any time. However, if you want to increase your coverage or re-enroll after dropping coverage, you will be required to provide Proof of Good Health.

Providing Proof of Good Health

Proof of Good Health is required for optional life insurance if:

- The coverage amount selected is above \$25,000 during your initial enrollment period;
- You enroll after your initial enrollment period for any amount; or
- You increase your coverage after your initial enrollment period.

Proof of Good Health includes completing a questionnaire regarding your medical history and possibly having a medical exam. The Proof of Good Health questionnaire is made available when you enroll.

Naming a beneficiary

In order to ensure your life insurance benefit is paid according to your wishes, you must name a beneficiary(ies) to receive your optional life insurance benefit if you die. You may do this by going to the **WIRE** or **mywalmart.com**.

You can name anyone you wish. If the beneficiary(ies) you have listed with the company differs from those named in your will, the list that the company has prevails.

The following information is needed when naming your beneficiary(ies):

- Beneficiary(ies) name
- Beneficiary(ies) current address
- Beneficiary(ies) phone number
- Beneficiary(ies) relationship to you
- Beneficiary(ies) Social Security number
- Beneficiary(ies) date of birth
- The percentage you wish to designate per beneficiary, up to 100 percent

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end, and will be shared equally by any remaining beneficiary(ies), unless your beneficiary form states otherwise.

You can name a minor as a beneficiary; however, Prudential may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult with an attorney or an estate planner before naming a minor as a beneficiary. If you name a minor as a beneficiary, funeral expenses cannot be paid from the minor's beneficiary proceeds.

Please note

It's important to update your beneficiary information annually. Keep in mind, proceeds will go to whomever is listed on your beneficiary form with the company, regardless of your current relationship with that person. You can change your beneficiary(ies) at any time on the WIRE or mywalmart.com.

If you do not name a beneficiary

If no beneficiary is named, payment will be made to your surviving family member(s) in the following order:

1. Widow or widower; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares; if not surviving, then
5. Executor or administrator of your estate.

When your optional life insurance coverage begins

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

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

If Proof of Good Health is not required, your coverage will be effective on the date you enroll or at the end of your eligibility waiting period, whichever is later.

You must be actively-at-work in order for your coverage to be effective. You will be considered actively-at-work on a day that is one of your scheduled work days if you are performing in the usual way all of the regular duties of your job. See the **Eligibility and enrollment** chapter for details.

An early payout due to terminal illness

If you are terminally ill, you may receive up to 50 percent of the coverage amount you have chosen while you are still living. Payment may be made in a lump sum or 12 equal monthly installments. Upon your death, your beneficiary(ies) will receive the remaining 50 percent (plus any amount of the early payout not yet received at the time of your death). This benefit is referred to as the accelerated benefit.

If you terminate from the company after you have received (or begun to receive) the accelerated death benefit, you will need to convert the policy to an individual policy in order for your beneficiary(ies) to receive the remaining balance upon your death. If you do not convert the policy upon termination of your employment, there will be no benefit payout for your beneficiary(ies). See the **Continuing your insurance** section in this chapter for details on conversion.

You are terminally ill if:

- There is no reasonable prospect of recovery;
- Death is expected within 12 months; and
- A doctor can certify the illness or injury as terminal.

There may be some circumstances when the accelerated benefit will not be paid. Contact Prudential at **(877) 740-2116** for details.

Tax laws are complex. Please consult with a tax professional to assess the impact of this benefit.

Filing a claim

Within 12 months of the covered associate's death, contact Prudential at **(877) 740-2116**, and provide the following information regarding the deceased associate:

- Name;
- Social Security number;
- Date of death; and
- Cause of death (if known).

A copy of the death certificate is required as proof of death. Mail the death certificate to:

**The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, PA 19176**

The claim will not be finalized until the death certificate is received. Acceptance of the death certificate is not a guarantee of payment.

Claims will be determined under the time frames and requirements set out in the **Claims and appeals** chapter. Your beneficiary(ies) has the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For more details, contact Prudential at **(877) 740-2116**.

When benefits are not paid

Benefits will not be paid to any beneficiary(ies) who engaged in an illegal act that resulted in the death of the associate. Instead, the benefit would go to another eligible beneficiary or to your estate.

No benefits will be paid to your beneficiary(ies) if you die as a result of a self-inflicted injury or suicide while sane or insane during the first two years of coverage. If you increase your coverage and you die as a result of a self-inflicted injury or suicide within two years of the date you increase your coverage, your beneficiary(ies) will receive the prior coverage amount.

If your beneficiary(ies) files a claim within the first two years of your approval date, Prudential has the right to re-examine your Proof of Good Health questionnaire. If material facts about you were stated inaccurately, the true facts will be used to determine what amount of coverage should have been in effect, if any, and:

- The claim may be denied; and
- Premiums paid may be refunded.

If you go on leave of absence

For information about making payments while on a 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, you may re-enroll for the same coverage in effect prior to the cancellation.

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 can enroll for optional life insurance coverage within the applicable waiting period described in the **Eligibility and enrollment** chapter. Proof of Good Health will be required for coverage above \$25,000.

Special rules may apply if you are on or return from a FMLA or Military Leave of Absence.

See the **Eligibility and enrollment** chapter for details.

When coverage ends

Your optional life insurance coverage ends:

- At termination of your employment;
- On the last day of the pay period when your job status changes to part-time;
- Upon failure to pay your premiums;
- On the date of your death;
- On the date you lose eligibility;
- On the last day of an approved leave of absence (unless you return to work);
- When the benefit is no longer offered by the company; or
- On the day after you drop coverage.

This policy has no cash value.

FinancialPoint® beneficiary financial counseling

In the event of your or your dependent's death, beneficiary financial planning guidance is available at no cost to you. Financial planning guidance is also available if you are terminally ill. Services include resources mailed to your or your beneficiary(ies) home — a data-gathering questionnaire, personal investment viewpoint questionnaire and a glossary of financial terms — a personalized financial plan, a year of 24/7 access to a financial planning hotline and support for topics such as inheritance taxes, loss of income, creditors and probate.

To request more information on resources available to you, call FinancialPoint at (888) 327-4260.

Estate Guidance®

Estate Guidance offers you the convenience of online will preparation from your personal computer at no cost to you. Wills ensure your assets will be distributed in accordance with your wishes and allows you to name a guardian to take care of your minor children. To complete the online will questionnaire, log on to willguidance.com, password: **WMTWILL**.

Note: If the beneficiary(ies) you have listed with the company differs from those named in your will, the list the company has prevails.

Continuing your insurance

In most circumstances if your group life coverage ends, you can continue all or a portion of your coverage. You have 31 days from the termination date of coverage to request to continue your coverage under an individual policy.

If your death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted.

To request information on all available continuation plans, call Prudential at **(877) 740-2116**.

For residents of Minnesota, you may elect to continue coverage at your expense if your employment is terminated either voluntarily or involuntarily, or if you are laid off, as long as the group policy is still in force with the employer. Coverage may be continued until you obtain coverage under another group policy or you return to work from layoff; however, the maximum period that coverage may be continued is 18 months.

If you leave the company and are then rehired

If you return to work within 30 days, you will automatically be re-enrolled for the same coverage in effect prior to leaving the company (or the most similar coverage offered under the plan).

If you return to work after 30 days, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period. Proof of Good Health is required for coverage plans above \$25,000. See the **Eligibility and enrollment** chapter for details.

If you drop or decrease your coverage and re-enroll

If you drop or decrease your coverage and re-enroll within 30 days, you may re-enroll for the same coverage in effect prior to dropping or decreasing coverage.

If you re-enroll more than 30 days after dropping or decreasing your coverage, you may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter. Proof of Good Health will be required.

Dependent life insurance

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dependent life insurance

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential, the terms of the policy will govern. You may obtain a copy of this policy by contacting the plan.

Dependent life insurance

The loss of your spouse could mean the loss of an income or a need for childcare. The loss of a child could mean medical bills and funeral expenses. While you and your family are dealing with the emotional burden the loss of a family member brings, you can receive help for the financial consequences through dependent life insurance. Think about the expenses you would have if your spouse or child died. Dependent life insurance could ease your financial situation, helping your family get through a difficult time.

Dependent life insurance resources		
Find What You Need:	Online:	Other Resources:
Get more details about life insurance	The WIRE or mywalmart.com	Call Prudential at (877) 740-2116
Continuing your insurance		Call Prudential at (877) 740-2116
File a claim		Call Prudential at (877) 740-2116

What you need to know about dependent life insurance

- All full-time associates (including full-time hourly pharmacists, field Logistics associates, field supervisor positions in stores and clubs, management trainees, California pharmacists, full-time Vision Center managers and [walmart.com](#) functional non-exempt associates) and management associates (including full-time truck drivers) can enroll their spouse and/or children in dependent life insurance.
- Proof of Good Health for your spouse is required if you enroll for a coverage amount above \$5,000 during your initial enrollment period or for any coverage amount if you enroll at any other time.

Enrolling in dependent life insurance

All full-time and management associates can enroll their spouse and/or child(ren) in dependent life insurance. If your spouse and/or legal dependent dies, you may receive a lump sum payment for the coverage amount you select. Dependent life insurance is insured by The Prudential Insurance Company of America (Prudential).

Your coverage choices for dependent life insurance are:

- **Spouse:**

- \$5,000
- \$15,000
- \$25,000
- \$50,000
- \$75,000
- \$100,000

- **Child:**

- \$2,000 per child
- \$5,000 per child
- \$10,000 per child

Depending on the coverage amount you choose and when you enroll, your spouse may be required to provide Proof of Good Health. You do not have to provide Proof of Good Health for your child(ren).

You (the associate) are automatically assigned as the primary beneficiary of your dependent's life insurance coverage. If you and your covered dependent(s) die at the same time, benefits will be paid to your dependent's estate or at Prudential's option to a surviving relative of the dependent.

The cost of dependent life insurance for your spouse is based on the coverage amount you select, your (the associate's) age and whether your spouse is eligible for the tobacco-free rates. The cost of coverage for your child(ren) is based on the coverage amount you select.

This policy has no cash value.

You can enroll in dependent life insurance at any time. Proof of Good Health is required for your spouse if you enroll after your initial enrollment period. Also, you can change or drop coverage at any time. However, if you want to increase your spouse's coverage or re-enroll after dropping coverage, you will be required to provide Proof of Good Health for your spouse.

Proof of Good Health

Proof of Good Health is required for your spouse's dependent life insurance coverage if:

- The coverage amount selected is above \$5,000 during your initial enrollment period;
- You enroll after your initial enrollment period for any amount; or
- You increase your coverage after your initial enrollment period.

Proof of Good Health includes completing a questionnaire regarding your spouse's medical history and possibly requiring your spouse to have a medical exam. The Proof of Good Health questionnaire is made available when you enroll your spouse. Proof of Good Health is not required for children.

When your dependent life insurance coverage begins

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

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

If **Proof of Good Health is not required**, your spouse's coverage will be effective on the date you enroll or at the end of your eligibility waiting period, whichever is later.

If **your spouse or dependent child is confined to a hospital or home**, coverage will be delayed until the spouse or child has a medical release (does not apply to a newborn child).

If **a dependent child is born alive and dies within 60 days of birth and**:

- Was enrolled in dependent life insurance prior to the loss, Prudential will pay the enrolled benefit.

- Was not enrolled in dependent life insurance prior to the loss — with a live birth certificate and a death certificate — Prudential will pay a \$2,000 benefit only. (Premium owed will be payroll deducted.)

If a dependent child is stillborn, Prudential will pay a \$2,000 benefit. A stillborn child is defined as an eligible associate's natural born child, whose death occurs before expulsion, extraction or delivery and whose fetal weight is 350 grams or more; or, if fetal weight is unknown, whose duration in utero was 20 or more complete weeks of gestation. If both the mother and father of the stillborn work at Walmart, each associate is eligible to submit a claim for this benefit separately for a total of \$4,000.

You must be actively-at-work in order for your dependent coverage to be effective. You will be considered actively-at-work on a day that is one of your scheduled work days if you are performing in the usual way all of the regular duties of your job. See the **Eligibility and enrollment** chapter for details.

Filing a claim

Within 12 months of the covered dependent's death, contact Prudential at **(877) 740-2116**, and provide the following information regarding the deceased:

- Name;
- Social Security number;
- Date of death; and
- Cause of death (if known).

An original or certified copy of the death certificate may be required as proof of death. Mail the death certificate to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, PA 19176

The claim will not be finalized until the death certificate is received. Acceptance of the death certificate is not a guarantee of payment.

Claims will be determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For more details, contact Prudential at **(877) 740-2116**.

When benefits are not paid

Benefits will not be paid to you if you engage in an illegal act that resulted in the death of the insured. Instead, the benefit may go to another eligible beneficiary or to the insured's estate.

No benefits will be paid to you if your spouse or dependent dies as a result of a self-inflicted injury or suicide while sane or insane during the first two years of coverage. If you increase your dependent's coverage and your spouse or dependent child dies as a result of a self-inflicted injury or suicide within two years of the increase in coverage, you will receive the prior coverage amount.

If you file a claim for your spouse within the first two years of your approval date, Prudential has the right to re-examine your Proof of Good Health questionnaire. If material facts about your spouse were stated inaccurately, the true facts will be used to determine what amount of coverage should have been in effect, if any, and:

- The claim may be denied; and
- Premiums paid may be refunded.

If you go on a leave of absence

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

If your dependent 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, you may re-enroll for the same coverage plan in effect prior to the cancellation.

If your dependent 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 can enroll for dependent life insurance coverage within the applicable waiting period described in the **Eligibility and enrollment** chapter. Proof of Good Health will be required for dependent spouse coverage plans above \$5,000.

Special rules may apply if you are on or return from a FMLA or Military Leave of Absence.

See the **Eligibility and enrollment** chapter for details.

When coverage ends

Your dependent life insurance coverage ends:

- At termination of your employment;
- On the last day of the pay period when your job status changes to part-time;
- Upon failure to pay your premiums;
- On the date of your death;
- On the date you or a dependent spouse or child loses eligibility (see the **Eligibility and enrollment** chapter);
- On the last day of an approved leave of absence (unless you return to work);
- When the benefit is no longer offered by the company; or
- The day after you drop your coverage.

This policy has no cash value.

Continuing your dependent life insurance

In most circumstances if your dependent life coverage ends, you can continue all or a portion of the coverage. You have 31 days from the termination date of coverage to request to continue coverage.

If your dependent's death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted.

To request information on all available continuation plans, call Prudential at **(877) 740-2116**.

For residents of Minnesota, you may elect to continue coverage at your expense if your employment is terminated either voluntarily or involuntarily, or if you are laid off, as long as the group policy is still in force with the employer. Coverage may be continued until you obtain coverage under another group policy or you return to work from lay off; however, the maximum period that coverage may be continued is 18 months.

If you leave the company and then are rehired

If you return to work 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 after 30 days, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period. Proof of Good Health is required for spouse coverage plans above \$5,000.

See the **Eligibility and enrollment** chapter for details.

If you drop or decrease your coverage and re-enroll

If you drop or decrease your coverage and request to re-enroll within 30 days, you may re-enroll for the same coverage plan you had prior to dropping or decreasing coverage.

If you re-enroll more than 30 days after dropping or decreasing coverage, you may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter. Proof of Good Health will be required for spouse coverage plans.

Accidental death and dismemberment (AD&D) insurance

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AD&D

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential, the terms of the policy will govern. You may obtain a copy of this policy by contacting the plan.

Accidental death and dismemberment (AD&D) insurance

Accidents are unpredictable and unavoidable. But you don't have to be unprepared for the financial consequences of a serious injury or death. Accidental death and dismemberment insurance is available to you and your family, and Proof of Good Health is not required. If you choose coverage and experience a covered loss, accidental death and dismemberment benefits can help pay the cost of medical care, childcare and education expenses.

AD&D insurance resources		
Find What You Need:	Online:	Other Resources:
Change your beneficiary designation	The WIRE or mywalmart.com	Beneficiary changes cannot be made over the phone.
Get more details about AD&D insurance		Call Prudential at (877) 740-2116
File a claim		Call Prudential at (877) 740-2116

What you need to know about AD&D insurance

- All full-time associates (including full-time hourly pharmacists, field Logistics associates, field supervisor positions in stores and clubs, management trainees, California pharmacists, full-time Vision Center managers and [walmart.com](#) functional non-exempt associates) and management associates (including full-time truck drivers) can enroll in AD&D.
- Proof of Good Health is not required for AD&D insurance, regardless of the coverage amount you choose.
- AD&D insurance pays a lump sum benefit for loss of life, limb, sight, speech, hearing or paralysis, due to an accident.

Enrolling in AD&D insurance

All full-time associates and management associates can enroll in accidental death and dismemberment (AD&D) insurance. AD&D insurance pays a lump sum benefit to you or your beneficiary(ies) if you or your covered dependent(s) has a loss of life, limb, sight, speech or hearing, or becomes paralyzed, due to an accident.

You have two AD&D coverage decisions. You choose whom you want to cover and your coverage amount.

You choose to cover:

- Associate Only
- Associate + Family

The coverage amount for your family will be a percentage of the coverage amount you choose for yourself (see **AD&D coverage amount** later in this chapter). The amounts available for you to choose as your associate coverage amount are:

- \$25,000
- \$50,000
- \$75,000
- \$100,000
- \$150,000
- \$200,000

The amount of your benefit depends on the type of loss. See **When AD&D benefits are paid** later in this chapter for more detail.

You can enroll in or make changes to your AD&D insurance during your initial enrollment period, during annual enrollment or when you have a status change event. For more information, see the **Eligibility and enrollment** chapter.

The cost of AD&D insurance is based on the coverage amount you select and whether you choose Associate Only or Associate + Family coverage.

Naming a beneficiary

In order to ensure your AD&D benefit is paid according to your wishes, you must name a beneficiary(ies). You may complete your beneficiary form by going to the **WIRE** or **mywalmart.com**. You (the associate) will receive any benefits payable for your covered dependents.

You can name anyone you wish. If the beneficiary(ies) you have listed with the company differs from those named in your will, the list that the company has prevails.

The following information is needed when naming your beneficiary(ies):

- Beneficiary(ies) name
- Beneficiary(ies) current address
- Beneficiary(ies) phone number
- Beneficiary(ies) relationship to you
- Beneficiary(ies) Social Security number
- Beneficiary(ies) date of birth
- The percentage you wish to designate per beneficiary up to 100 percent

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally.

You can name a minor as a beneficiary. However, Prudential may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult with an attorney before naming a minor as a beneficiary. If you name a minor as a beneficiary, funeral expenses cannot be paid from the minor's beneficiary proceeds.

It is important to keep your beneficiary information up-to-date. Proceeds will go to whomever is listed on your beneficiary form on file with the plan, regardless of your current relationship with that person.

Changing your beneficiary

Your beneficiary(ies) can be changed at any time on the **WIRE** or **mywalmart.com**.

If you do not name a beneficiary

If there is no beneficiary designated or no surviving beneficiary at the time of your death, Prudential will determine the beneficiary to be one or more of the following surviving you:

1. Widow or widower; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares, if not surviving, then
5. Executor or administrator of your estate.

When your AD&D coverage begins

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

If you enroll outside of annual enrollment, your coverage will become effective on the event date or the end of your eligibility waiting period, whichever is later.

Your AD&D coverage will begin whether or not you are actively at work, as long as you have reported for your first day of work and enrolled for the benefit. See the **Eligibility and enrollment** chapter for details.

AD&D coverage amount

The coverage amount you enroll in is the coverage amount that applies to you, the associate. If you enroll in family coverage, your family members' coverage amount is a percentage of your associate coverage amount. The coverage amount for your family members depends on your family unit. See the chart **Full benefit amount** for information on the coverage amount for your family members.

When AD&D benefits are paid

If you or your dependent (if you choose family coverage) sustains an accidental injury that is the direct and sole cause of a covered loss, proof of the accidental injury and covered loss must be sent to Prudential.

Prudential will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

Direct and Sole Cause: The covered loss occurs within 12 months of the date of the accidental injury and was a direct result of the accidental injury, independent of other causes.

Paralysis: Loss of use, without severance, of a limb. A doctor must determine that the loss is complete and not reversible. Severance means complete separation and dismemberment of the limb from the body.

Covered losses paid at full benefit

The following covered losses are payable at the full benefit:

- **Loss of life.**
—It will be presumed that you have suffered a loss of life if your body has not been found within one year of disappearance, stranding, sinking or wrecking of any vehicle in which you were an occupant.

Full benefit amount

Associate coverage amount:	If family unit includes spouse only:	If family unit includes a spouse and children:		If family unit includes children only:
Associate - 100 percent	Spouse - 50 percent	Spouse - 40 percent	Children - 10 percent	Children - 25 percent
\$25,000	\$12,500	\$10,000	\$2,500	\$6,250
\$50,000	\$25,000	\$20,000	\$5,000	\$12,500
\$75,000	\$37,500	\$30,000	\$7,500	\$18,750
\$100,000	\$50,000	\$40,000	\$10,000	\$25,000
\$150,000	\$75,000	\$60,000	\$15,000	\$37,500
\$200,000	\$100,000	\$80,000	\$20,000	\$50,000

- Both hands, both feet or sight in both eyes—Severance through or above the wrists or ankle joints, or total and irrecoverable loss of sight.
- One hand and one foot—Severance through or above the wrist or ankle joint.
- One arm or one leg.
- Speech and hearing in both ears—Complete inability to communicate audibly in any degree, with irrecoverable loss of hearing which cannot be corrected by any hearing aid or device.
- Hand or foot and sight in one eye—Severance through or above the wrist or ankle joint, with total and irrecoverable loss of sight in one eye.
- Quadriplegia—Total paralysis of both upper and lower limbs.
- Paraplegia—Total paralysis of both lower limbs.
- Hemiplegia—Total paralysis of upper and lower limbs on one side of the body.

50 percent of full benefit

- Brain damage—Brain damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least five days and persist for 12 consecutive months after the date of the accidental injury.
- Hand or foot—Permanent severance through or above the wrist but below the elbow or permanent severance at or above the ankle but below the knee.
- Sight in one eye—Total and irrecoverable loss of sight in one eye.
- Speech or hearing in both ears—Complete inability to communicate audibly in any degree, or irrecoverable loss of hearing which cannot be corrected by any hearing device.

25 percent of full benefit

- Loss of hearing in one ear.
- Thumb and index finger of the same hand—Permanent severance of each through or above the joint closest to the wrist.
- Uniplegia—Total paralysis of one arm or leg.

Coma benefit

If you or your covered dependent(s) is comatose or become comatose within 31 days as the result of an accident, a coma benefit equal to one percent of the insured's coverage amount will be paid for 11 consecutive months to you, your spouse, your children or a legal guardian. The benefit is payable after 31 consecutive days of being comatose. If you or your covered dependent(s) remains comatose beyond 11 months, the full sum of the coverage, less any AD&D benefit already paid, will be made to you or your designated beneficiary.

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 31 days of the accidental injury and continue for 31 consecutive days.

Additional AD&D benefits

Additional benefits may be payable by the plan:

- Seat belt benefit: If you and/or your covered dependents suffer a loss of life as a result of a covered accident that occurs while wearing a seat belt, an additional benefit may be payable.
- Safe motorcycle rider benefit: If you and/or your covered dependents suffer a loss of life as a result of a covered accident that occurs while wearing a helmet, an additional benefit may be payable.
- Education and childcare benefit: If you (the associate) suffer a loss of life, a childcare benefit, child education benefit and/or spouse education benefit may be payable.
- Felonious assault benefit: If you (the associate) suffer a covered loss while at work due to a physical attack by another person resulting in bodily harm because of your employment, an additional benefit may be payable.
- Home alteration and vehicle modification benefit: If you and/or your covered dependents suffer a covered loss that requires home alteration or vehicle modification, an additional benefit may be payable.
- COBRA monthly medical premium benefit: If you (the associate) suffer a covered accidental bodily injury, which results in a termination after a leave of absence, an additional benefit may be payable to assist with the continuation of your Associate Health and Welfare medical plan.
- Monthly rehabilitation benefit: If you and/or your covered dependents suffer a covered accidental bodily injury that requires medically necessary rehabilitation, an additional benefit may be payable.

When benefits are not paid

AD&D benefits will not be paid for any loss caused or contributed to by the following:

- Suicide or attempted suicide, while sane or insane;
- Intentionally self-inflicted injuries, or any attempt to inflict such injuries;
- Sickness, whether the loss results directly or indirectly from the sickness;
- Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment;
- Any bacterial or viral infection. But, this does not include:
 - pyogenic infection resulting from an accidental cut or wound; or
 - bacterial infection resulting from accidental ingestion of a contaminated substance
- Taking part in any insurrection;
- War, or any act of war. War means declared or undeclared war, and includes resistance to armed aggression;
- An accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces. But this does not include Reserve or National Guard active duty for training;
- Travel or flight in any vehicle used for aerial navigation (includes getting in, out, on or off any such vehicle), if: the person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
- Commission of or attempt to commit an assault or a felony; or
- While operating a land, water or air vehicle, being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a doctor.

Filing a claim

Within 90 days of the loss, call Prudential at (877) 740-2116 and provide the following:

- Name;
- Associate's Social Security number;
- Date of death or injury; and
- Cause of death or injury (if known).

Prudential will send a claim packet to your address on file. The required information must be completed and returned with the claim forms and an original or certified copy of the death certificate, when applicable, to:

The Prudential Insurance Company of America
Group Claim Life Division
P.O. Box 8517
Philadelphia, PA 19176

Benefits are paid in a lump sum. If you or a covered dependent sustains more than one covered loss due to an accidental injury, the amount paid, on behalf of any such injured person, will not exceed the full amount of the benefit.

Claims will be determined under the time frames and requirements set out in the **Claims and appeals** chapter. You or your beneficiary has the right to appeal a claim denial.

If you go on a leave of absence

For information about making payments while on a 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, you will automatically be re-enrolled for the same coverage plan you had prior to your leave of absence. Your coverage will be effective the first day of the pay period that you meet the actively-at-work requirement.

If your coverage 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 can enroll for AD&D coverage within the applicable waiting period described in the **Eligibility and enrollment** chapter.

Special rules may apply if you are on or return from a FMLA or Military Leave of Absence.

See the **Eligibility and enrollment** chapter for details.

When coverage ends

Your AD&D coverage ends:

- At termination of your employment;
- On the last day of the pay period when your job status changes to part-time;
- Upon failure to pay your premiums;
- On the date of your death;
- On the date you or a dependent spouse or child loses eligibility;
- On the last day of an approved leave of absence (unless you return to work); or
- When the benefit is no longer offered by the company.

AD&D coverage cannot be converted to individual coverage after coverage ends.

If you leave the company and then are rehired

If you return to work within 30 days, you will automatically be re-enrolled for the same coverage plan in effect prior to leaving the company (or the most similar coverage offered under the plan).

If you return to work after 30 days, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period.

See the **Eligibility and enrollment** chapter for details.

Business Travel Accident insurance

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business
travel
accident

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by the applicable insurer under this chapter, the terms of the policy will govern. You may obtain a copy of this policy by contacting the plan.

Business Travel Accident insurance

While you are traveling on authorized company business, Walmart's Business Travel Accident insurance protects you financially if you have an accident that results in certain types of injury or death. This coverage costs you nothing, and is effective on your first day of work.

Business Travel Accident insurance resources		
Find What You Need:	Online:	Other Resources:
Change your beneficiary designation	The WIRE or mywalmart.com	Beneficiary changes cannot be made over the phone.
Get more details about Business Travel Accident insurance		Call Prudential at (877) 740-2116
File a Business Travel Accident insurance claim		Call Prudential at (877) 740-2116

What you need to know about Business Travel Accident insurance

- Wal-Mart Stores, Inc. provides all associates with Business Travel Accident insurance — at no cost to you.
- Business Travel Accident insurance pays a lump sum benefit for loss of life, limb, sight, speech or hearing, or paralysis, due to an accident you were involved in while traveling on authorized company business.
- Your coverage amount is three times your Base Annual Earnings—maximum of \$1 million, minimum of \$200,000 (unless otherwise specified).

Your Business Travel Accident insurance

Walmart provides all associates with Business Travel Accident insurance. The company pays for this coverage in full — there is no cost to you. No enrollment is necessary. Coverage will become effective on your first day of active-work. See the **Eligibility and enrollment** chapter for details.

Business Travel Accident insurance pays a lump sum benefit to you or your beneficiary(ies) if you have a loss of life, limb, sight, speech or hearing or become paralyzed, due to an accident while traveling on authorized company business. Business Travel Accident insurance is insured by The Prudential Insurance Company of America (Prudential).

The full benefit amount of Business Travel Accident insurance is three times your Base Annual Earnings—maximum of \$1 million, minimum of \$200,000 (unless otherwise specified).

Base Annual Earnings* is defined as:

- For Hourly associates—Annualized Hourly rate as shown in the Walmart payroll system as of date of death.
- For Management associates and Officers—Base Salary as shown in the Walmart payroll system as of date of death.
- For Truck Drivers—Annualized Average Day's pay as of date of death as determined by Logistics Finance.

*Base Annual Earnings shall exclude bonus.

Naming a beneficiary

In order to ensure your Business Travel Accident insurance benefit is paid according to your wishes, you must name a beneficiary(ies). You (the associate) will receive any benefits payable for the injuries listed in **When Business Travel Accident insurance benefits are paid** later in this chapter.

You can name anyone you wish. If the beneficiary(ies) you have listed with the company differs from those named in your will, the list that the company has prevails.

The following information is needed when naming your beneficiary(ies):

- Beneficiary(ies) name
- Beneficiary(ies) current address
- Beneficiary(ies) phone number

- Beneficiary(ies) relationship to you
- Beneficiary(ies) Social Security number
- Beneficiary(ies) date of birth
- The percentage you wish to designate per beneficiary, up to 100 percent

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end, and it will be shared equally by any remaining beneficiary(ies), unless your beneficiary form states otherwise.

You can name a minor as a beneficiary. However, Prudential may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult with an attorney or an estate planner before naming a minor as a beneficiary. If you or an estate planner names a minor as a beneficiary, funeral expenses cannot be paid from the minor's beneficiary proceeds.

Please note

It's important to update your beneficiary information annually. Keep in mind, proceeds will go to whomever is listed on your beneficiary form with the company, regardless of your current relationship with that person. You can change your beneficiary(ies) at any time on the WIRE or mywalmart.com.

If you do not name a beneficiary

If no beneficiary is named, payment will be made to your surviving family member(s) in the following order:

1. Widow or widower; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares; if not; surviving, then
5. Executor or administrator of your estate.

Filing a claim

Within 12 months of the covered associate's injury or death or within 90 days of the onset of a coma, contact Prudential at **(877) 740-2116**, and provide the following regarding the associate:

- Name;
- Social Security number;
- Date of injury or death; and

- Cause of injury or death (if known).

An original or certified copy of the death certificate is required as proof of death. Mail the death certificate to:

**The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, PA 19176**

The claim will not be finalized until the death certificate is received, where applicable. Acceptance of the death certificate is not a guarantee of payment.

Benefits can be paid in a lump sum or, upon written request, in monthly installments. Only one benefit, the highest, will be paid if you suffer more than one loss resulting from a single accident.

When Business Travel Accident insurance benefits are paid

If you are involved in an accident while traveling on authorized company business and the injuries result in death or a loss listed below, the plan will pay the benefit outlined in this section.

Paralysis means loss of use, without severance, of a limb. A doctor must determine that the loss is complete and not reversible. Severance means complete separation and dismemberment of the limb from the body.

Exposure to the elements: It will be presumed that you (the associate) have suffered a loss of life if your body has not been found within one year of the disappearance, stranding, sinking or wrecking of any vehicle in which you were an occupant.

If one or more associates suffer a common loss as a result of the same accident, the maximum the Business Travel Accident Insurance Policy will pay for all loss is \$10 million per accident. This includes any means of transportation owned and operated by the company.

Full benefit — three times your Base Annual Earnings—maximum of \$1 million, minimum of \$200,000 (unless otherwise specified)

- Loss of life;
- Quadriplegia — Total paralysis of both upper and lower limbs;
- Paraplegia — Total paralysis of both lower limbs;
- Hemiplegia — Total paralysis of upper and lower limbs on one side of the body;

- Both hands, both feet, or sight in both eyes — Severance through or above the wrists or ankle joints, or total and irrecoverable loss of sight;
- One hand and one foot — Severance through or above the wrist or ankle joint;
- Speech and hearing in both ears — Complete inability to communicate audibly in any degree, with irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; or
- Hand or foot and sight in one eye — Severance through or above the wrist or ankle joint, with total and irrecoverable loss of sight in one eye.

50 percent of full benefit

- Hand or foot — Permanent severance through or above the wrist but below the elbow or permanent severance at or above the ankle but below the knee;
- Brain damage—Brain damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all of the substantial and material functions and activities of everyday life. Such damage must manifest itself within 30 days of the accidental injury, require hospitalization of at least five days and persist for 12 consecutive months;
- Sight in one eye — Total and irrecoverable loss of sight in one eye; or
- Speech or hearing in both ears — Complete inability to communicate audibly in any degree, or irrecoverable loss of hearing which cannot be corrected by any hearing aid or device.

25 percent of full benefit

- Thumb and index finger of the same hand — Severance of each through or above the joint closest to the wrist.
- Uniplegia — Total paralysis of one limb.

Additional Business Travel Accident insurance benefits

Business Travel Accident insurance also provides these additional benefits:

- Seat belt benefit;
- Air bag benefit;
- Coma benefit;
- Funeral expenses benefit;
- Medical evacuation benefit;

- Family relocation and accompaniment; and
- Specific activity hazard—traveling to, from or while attending Walmart's Annual Shareholders Meeting.

When Business Travel Accident insurance benefits are not paid

Business Travel Accident insurance benefits will not be paid for the following:

- Intentionally self-inflicted injuries while sane or insane;
- Suicide or attempted suicide;
- Sickness, whether the loss results directly or indirectly from the sickness;
- Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the sickness;
- Any bacterial or viral infection, except a pyogenic infection resulting from an accidental cut or wound or a bacterial infection resulting from accidental ingestion of a contaminated substance;
- Losses resulting from war or act of war (declared or undeclared), including resistance to armed aggression or an accident while on full-duty with the armed services for more than 30 days (this does not include Reserve or National Guard active duty for training);
- Losses resulting from riding in an unlicensed aircraft;
- Losses resulting from flying as a crew member of an airplane, except one owned and operated by the company; or
- Injuries that arise during an attempt to commit an assault or the commission of a felony.

When coverage ends

Your Business Travel Accident insurance coverage ends on your last day of employment.

If you leave the company and then are rehired

Your Business Travel Accident insurance coverage (or the most similar coverage offered under the plan) will be reinstated.

Short-term disability

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short-term disability

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by The Hartford, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Short-term disability

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

Short-term disability resources		
Find What You Need:	Online:	Other Resources:
Get more details about short-term disability	E-mail your question to askhartford@hartfordlife.com or visit mywalmart.com	Call The Hartford at (800) 492-5678
If you work in California	edd.ca.gov	Call the state of California at (800) 480-3287
If you work in Hawaii		Call The Hartford at (808) 534-7073
If you work in New Jersey		Call The Hartford at (800) 492-5678
If you work in New York		Call The Hartford at (800) 492-5678
If you work in Rhode Island		Call the state disability carrier at (401) 462-8420
File a claim within 90 days of the date your disability began	Go to mywalmart.com or the WIRE	Call The Hartford at (800) 492-5678

What you need to know about short-term disability

- All full-time hourly associates (including full-time hourly pharmacists, field Logistics associates, field supervisor positions in stores and clubs, full-time hourly Vision Center managers, and walmart.com functional non-exempt associates) can enroll in short-term disability coverage. Enrollment in short-term disability is required to enroll in long-term disability.
- If you enroll after your initial eligibility period, your short-term disability coverage will not begin until you complete a 12-month waiting period. Once coverage begins, benefits will be reduced during your first five continuous years of coverage.
- While you are disabled, the short-term disability plan replaces 40 or 50 percent of your income, depending on when you enroll for coverage.

Enrolling in short-term disability and when coverage is effective

All full-time hourly associates are eligible to enroll in short-term disability coverage. Short-term disability coverage is insured by The Hartford in all 50 states except California and Rhode Island, which have state plans. In addition, coverage in Hawaii, New York and New Jersey is different, as required by state law, but is still insured by The Hartford. For information on coverage in these states, call the phone number listed in **Short-term disability resources** at the beginning of this chapter.

You must be enrolled in short-term disability coverage in order to enroll in long-term disability coverage.

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

The date your coverage begins and the amount of your short-term disability benefit depend on when you enroll for coverage:

- If you enroll during your initial enrollment period, your coverage begins on your effective date. See the **Eligibility and enrollment** chapter for information on your initial enrollment period and your effective date.
- If you enroll at any time after your initial enrollment period as a late enrollee, you are required to finish a 12-month waiting period from the date you enroll before your coverage is effective. You will not pay short-term disability premiums during your 12-month waiting period. Your coverage will become effective on the day you meet the 12-month waiting period, provided you have been actively-at-work for the previous six-month period.

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

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

- If you enrolled during your initial enrollment period:
 - 50 percent of your average weekly wage up to the maximum benefit.
- If you are a late enrollee:
 - First five continuous years of coverage - 40 percent of your average weekly wage up to the maximum benefit.
 - After five continuous years of coverage - 50 percent of your average weekly wage up to the maximum benefit. Note: The five years of continuous coverage does not include the 12-month waiting period.

Short-term disability benefits are different in the following states: California, Hawaii, New Jersey, New York and Rhode Island. For information about benefits in these states, call the number listed in **Short-term disability resources** at the beginning of this chapter.

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

Your short-term disability benefit

If You Enrolled:	Your Benefit Is:
During your initial enrollment period or as a late enrollee after five years of continuous coverage	50 percent of your average weekly wage For example, 50 percent of \$400 is a \$200 weekly benefit
As a late enrollee and have been covered for less than five continuous years	40 percent of your average weekly wage For example, 40 percent of \$400 is a \$160 weekly benefit

The cost of short-term disability coverage

Your cost for short-term disability is based on your biweekly earnings and your age. Premiums are deducted from all wages including bonuses. You will not be required to pay short-term disability premiums while you are receiving short-term disability benefits.

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

- California
- Hawaii
- New Jersey
- New York
- Rhode Island

Coverage during a temporary layoff or leave of absence

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

When you qualify for short-term disability benefits

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

- Submit medical evidence provided by a qualified doctor that you are totally disabled as defined by the Plan; and
- Receive approval by The Hartford of your claim.

The Hartford may require written proof of your disability or additional information before making a decision on your claim. A statement by your physician(s) that "you are unable to work" does not in and of itself qualify you for short-term disability benefits. Also note that approval of a Medical Leave of Absence does not constitute approval for short-term disability benefits.

As defined by the Plan, total disability means:

- You are unable to perform the essential duties of your occupation according to the medical evidence provided by a qualified doctor other than you or a family member (failure to meet requirements necessary to maintain a license to perform the duties of your occupation does not mean you are totally disabled);
 - You are under the continuous care of a qualified doctor; and
 - The disability is due to injury, sickness or pregnancy.
- If your total disability is the result of more than one cause, you will be paid as if they were one. The maximum benefit for any one period of disability is limited to 26 weeks.

When benefits are not paid

Short-term disability benefits will not be paid for:

- Any illness or injury that is not treated by a qualified doctor;
- Any loss caused by war or act of war (declared or not), insurrection, rebellions or taking part in a riot or civil disorder;
- Any loss caused by illness or injury while in the armed services of any country engaged in war or other armed conflict;
- Any injury caused by your commission of or attempt to commit an assault, a battery, or felony;
- Any injury caused or contributed to by your being engaged in an illegal occupation or activity;
- Any loss caused by any illness or injury for which workers' compensation benefits are paid, or may be paid, if properly claimed; and/or
- Any injury sustained as a result of doing any work for pay or profit.

Filing a claim for short-term disability

For all states except California and Rhode Island, you must submit your short-term disability claim within 90 days of the date your disability begins to assure benefits.

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

STEP 1: Notify your supervisor as soon as you know you will be absent from work due to an illness or injury.

STEP 2: On or after your last day worked, call The Hartford at **(800) 492-5678** to report the disability. You may also report your disability online by going to mywalmart.com. Processing of your claim cannot begin until you have stopped working.

STEP 3: Ask your doctor's office to call The Hartford to provide medical information, including the following:

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

STEP 4: Follow up with your doctor to ensure information was forwarded to The Hartford.

Claims will be determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

The Hartford may require written proof of your disability or additional medical information before your benefit payments begin.

Call The Hartford the date you return to work.

California associates — You must:

- File a claim with the state of California by calling **(800) 480-3287** within 41 days of the date of your disability.
- Contact Benefits Customer Service at **(800) 421-1362**.

Rhode Island associates — You must:

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

When short-term disability benefits begin

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

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

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

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

You will not accumulate illness protection time, vacation, personal time or other types of benefit hours while you are receiving short-term disability benefits.

Your short-term disability benefit

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

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

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

Total gross pay includes:

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

Your short-term disability benefit is 40 percent or 50 percent of your average weekly wage, depending on whether you enrolled during your initial enrollment period and whether you have been covered for five continuous years.

Average weekly wage	
Length of Employment:	How Average Weekly Wage Is Determined:
Employed 12 months or more	Total gross pay ÷ prior 52 weeks For example, the average weekly wage for an associate with a total annual gross pay of \$20,800 is \$400 (\$20,800 ÷ 52).
Employed less than 12 months	Total gross pay ÷ number of weeks worked For example, the average weekly wage for an associate with a total gross pay of \$4,800 for 12 weeks of work is \$400 (\$4,800 ÷ 12).

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

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

Please refer to the policy for a complete list of offsets. The policy can be obtained by calling Benefits Customer Service at **(800) 421-1362**.

The Hartford has the right to recover from you any amount that is overpaid to you for short-term disability benefits under this plan.

Continuing benefit coverage while disabled

If you wish to continue medical, dental, AD&D, short-term disability plus, optional life insurance, dependent life insurance and accident insurance coverage while you are receiving short-term disability benefits, you must make premium payments each pay period for each of these benefits. These amounts will not be deducted from your short-term disability benefit payments. If you fail to pay your premiums for your other benefit plan(s), your benefits may be cancelled. See the **Eligibility and enrollment** chapter for details. You may be eligible for a waiver of premium for critical illness insurance. See the **Critical illness Insurance** chapter for details.

The company offers additional disability coverage — short-term disability plus — that pays your payroll contributions for medical, dental, AD&D, short-term disability plus, optional life insurance and dependent life insurance for up to eight weeks while you are disabled and receiving short-term disability benefits. See the **Short-term disability plus** chapter for more information.

Your short-term disability and long-term disability coverage will not be cancelled if you are receiving payments under this policy. You will not be required to pay short-term disability or long-term disability premiums while you are receiving short-term disability benefits.

When short-term disability benefits end

Short-term disability benefit payments will end on the earliest of:

- The date you are no longer totally disabled;
- The date you fail to furnish proof that is satisfactory to The Hartford that you are totally disabled;
- The date you are no longer under the regular care of a physician;
- The date you refuse to be examined, if The Hartford requires an examination;
- The last day of the maximum period for which benefits are payable (end of 26 weeks);
- The date no further benefits are payable under any provision in the short-term disability plan that limits benefit duration, which would include refusal to work in a similar position offered to you by Walmart that you are medically able and qualified to perform, with a rate of pay 50 percent or greater of your pre-disability earnings;
- The date of your death; or
- The day after you drop coverage.

If you return to work within 30 days of the end of your approved disability claim, you will be reinstated to the disability coverage you had prior to your disability. If you do not return to work within 30 days of the end of your disability, your coverage will lapse until you return to work and meet the actively-at-work requirement.

If you return to work and become disabled again

If you return to work for 30 calendar days or less of full-time active-work and become totally disabled again from the same or a related condition that caused the first period of disability, your short-term disability benefits will pick up where they left off before you came back to work. There will be no additional waiting period. The combined benefit duration will not exceed 26 weeks.

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

If you have returned to full-time active work for any number of calendar days and then become totally disabled from a new and unrelated cause, it will be considered a new disability and you will be able to receive up to 26 weeks of benefits. A new 14-day benefit waiting period will apply.

If you are on a leave of absence

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

If you return to actively-at-work status within one year of cancellation, you will automatically be enrolled for the same coverage you had prior to your leave of absence. Your coverage will be effective the first day of the pay period that you meet the actively-at-work requirement.

If you return to work on a full-time basis after one year of cancellation, you will be considered newly eligible, and you can enroll for short-term disability coverage (including short-term disability plus) within the applicable waiting period described in the **Eligibility and enrollment** chapter.

Special rules may apply if you are on or return from a FMLA or Military Leave of Absence. See the **Eligibility and enrollment** chapter for more information.

When coverage ends

Your short-term disability coverage ends:

- At termination of your employment;
- On the last day of the pay period when your job status changes to part-time;
- Upon failure to pay your premiums;
- On the date of your death;
- On the date you lose eligibility;
- On the 91st day of an approved leave of absence (unless you return to work);
- When the benefit is no longer offered by the company; or
- The day after you drop your coverage.

If you leave the company and are rehired

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

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

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

Short-term disability plus

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short-term disability plus

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by The Hartford, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Short-term disability plus

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

Short-term disability plus program resources

Find What You Need:

Get more details about short-term disability plus

Online:

E-mail your question to askhartford@hartfordlife.com or visit mywalmart.com

Other Resources:

Call The Hartford at (800) 492-5678

What you need to know about short-term disability plus

- All full-time hourly associates (including full-time hourly pharmacists, field Logistics associates, field supervisor positions in stores and clubs, full-time hourly Vision Center managers and [walmart.com](#) functional non-exempt associates) can enroll in short-term disability plus during their initial enrollment period or at any other time. However, late enrollees will have a 12-month waiting period before coverage is effective.
- You must be enrolled in the Walmart short-term disability plan or be covered by a state-mandated plan (Hawaii, New Jersey or New York) in order to enroll in the short-term disability plus program.
- Short-term disability plus pays your premiums for your company-sponsored medical, dental, life insurance and other specified benefits for up to 56 calendar days while you are receiving short-term disability benefits.

Enrolling in short-term disability plus and when coverage is effective

All full-time hourly associates who have enrolled in the short-term disability plan or who are covered in a state-supplied plan in New York, New Jersey and Hawaii are eligible to enroll in short-term disability plus. Short-term disability plus is not available in California or Rhode Island. Short-term disability plus coverage is insured by The Hartford.

The date your coverage begins depends on when you enroll for coverage:

- If you enroll during your initial enrollment period, your coverage begins on your effective date. See the **Eligibility and enrollment** chapter for information on your initial enrollment period and your effective date.
- If you enroll at any time after your initial enrollment period as a late enrollee, you are required to finish a 12-month waiting period from the date you enroll before your coverage is effective. You will not pay short-term disability plus premiums during your 12-month waiting period. Your coverage will become effective on the day you meet the 12-month waiting period.
- If at any time you drop your short-term disability plus coverage and later decide to re-enroll, you will be treated as a late enrollee with a 12-month waiting period.

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

The cost of short-term disability plus coverage

The cost of short-term disability plus is based on the coverage you select.

Coverage during a temporary layoff or leave of absence

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

Your short-term disability plus benefits

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

You are responsible for your biweekly benefits payments even if there are delays in processing your short-term disability claim.

The Hartford will forward your benefit payments directly to the Plan. The Plan will apply this amount toward your premiums.

Filing a claim

You do not have to file a claim for short-term disability plus benefits; a claim is automatically generated by The Hartford when you file a claim for short-term disability benefits.

In order to receive short-term disability plus benefits:

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

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

When short-term disability plus benefits begin

The short-term disability plus program begins paying benefits after a 14-calendar-day benefit waiting period.

Continuing benefits coverage while disabled

Because the short-term disability plus program pays your premiums for your company-sponsored medical, dental, optional life insurance, dependent life insurance, AD&D and short-term disability plus benefits, your coverages will remain in force. However, if you are enrolled in accident insurance, you must continue to pay your premiums or your coverage may be cancelled. You may be eligible for a waiver of premium in the critical illness insurance. See the **Critical illness insurance** chapter for details.

If you are receiving short-term disability benefits, you are not required to pay short-term disability or long-term disability premiums.

When short-term disability plus benefits end

The short-term disability plus program pays your premiums for 56 calendar days after your 14-day benefit waiting period. You are responsible for your premiums after that time. If you do not pay your premiums, your coverage will be cancelled. Benefit payments will end on the earliest of:

- The day you are no longer receiving short-term disability;
- At the end of 56 calendar days for which short-term disability plus benefits are payable; or
- The day of your death.

If you are on a leave of absence

For information about making payments while on a 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, you will automatically be enrolled for the same coverage you had prior to your leave of absence. Your coverage will be effective the first day of the pay period that you meet the actively-at-work requirement.

If your coverage is cancelled for failure to pay premiums and you return to work on a full-time basis after one year of cancellation, you will be considered newly eligible, and you can enroll for short-term disability plus coverage within the applicable waiting period described in the **Eligibility and enrollment** chapter.

Special rules may apply if you are on or return from a FMLA or Military Leave of Absence. See the **Eligibility and enrollment** chapter for more information.

When coverage ends

Your short-term disability plus coverage ends:

- At termination of your employment;
- On the last day of the pay period when your job classification changes to part-time;
- Upon failure to pay your premiums;
- On the date of your death;
- On the date you lose eligibility;
- On the 91st day of an approved leave of absence (unless you return to work);
- When the benefit is no longer offered by the company; or
- On the day after you drop coverage.

If you leave the company and are rehired

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

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

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

Long-term disability

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long-term disability

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by The Hartford, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Long-term disability

Your paycheck is the foundation of your financial health. Think about how you would survive financially if you became disabled and were unable to work. Your bills would keep coming, even if your paychecks stopped. When you enroll, Walmart's long-term disability plan works with other benefits you receive during a disability to replace part of your paycheck.

Long-term disability resources

Find What You Need:	Online:	Other Resources:
Get more details about long-term disability	E-mail your question to askhartford@hartfordlife.com or visit mywalmart.com	Call The Hartford at (800) 492-5678
File a claim		Call The Hartford at (800) 492-5678

What you need to know about long-term disability

- All full-time associates (including full-time hourly pharmacists, field Logistics associates, field supervisor positions in stores and clubs, management trainees, California pharmacists, full-time hourly Vision Center managers and [walmart.com](#) functional non-exempt associates) enrolled in the short-term disability plan or participating in New York, New Jersey, Hawaii, California or Rhode Island state-sponsored plans and management associates (including management trainees and California pharmacists) are eligible to enroll in the long-term disability plan.
- If you enroll after your initial eligibility period, your long-term disability coverage will not begin until you complete a 12-month waiting period. Once coverage begins, benefits will be reduced during your first five continuous years of coverage.
- The long-term disability plan works with any other benefits you receive while disabled to replace 40 percent or 50 percent of your income, depending on when you enroll for the coverage.
- Long-term disability benefits are paid at the end of each month.

Enrolling in long-term disability and when coverage is effective

You are eligible to enroll in long-term disability coverage if you are:

- A full-time hourly associate who is enrolled in the short-term disability plan;
- Located in a state that has a state-sponsored short-term disability plan (California, Hawaii, New Jersey, New York and Rhode Island); or
- A management associate.

Long-term disability is insured by The Hartford and provides up to 50 percent of your average monthly wage after your waiting period if you become totally disabled as defined by the Plan. For more information about your waiting period, see **When long-term disability benefits begin** later in this chapter. The maximum monthly benefit under the long-term disability plan is \$15,000. For more information about your average monthly wage, see **Your long-term disability benefit** later in this chapter.

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

- **If you enroll during your initial enrollment period,** your coverage begins on your effective date. See the **Eligibility and enrollment** chapter for information on your initial enrollment period and your effective date.
- **If you enroll at any time after your initial enrollment period as a late enrollee,** you are required to finish a 12-month waiting period from the date you enroll before your coverage is effective. You will not pay long-term disability premiums during your 12-month waiting period. Your coverage will become effective on the day you meet the 12-month waiting period, provided you have been actively-at-work for the previous six-month period.
- **If at any time you drop long-term disability and later decide to re-enroll,** you will be treated as a late enrollee with a 12-month waiting period.

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

- If you enrolled during your initial enrollment period:
 - 50 percent of your average monthly wage up to the maximum benefit.
- If you are a late enrollee:
 - First five continuous years of coverage — 40 percent of your average monthly wages up to the maximum benefit.
 - After five continuous years of coverage — 50 percent of your average monthly wage up to the maximum benefit. Note: The five years of continuous coverage does not include the 12-month waiting period.

The cost of long-term disability coverage

Your cost for long-term disability is based on your biweekly earnings and your age. Premiums are deducted from all wages including bonuses. You will not be required to pay long-term disability premiums while you are receiving long-term disability benefits.

Coverage during a temporary layoff or leave of absence

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

When you qualify for long-term disability benefits

In order to qualify for long-term disability benefits, you must:

- Submit medical evidence provided by a qualified doctor that you are totally disabled as defined by the Plan; and
- Receive approval by The Hartford of your claim.

As defined by the Plan, total disability means:

- You are unable to perform the essential duties of your occupation (or any occupation after 12 months of benefit payments) according to the medical evidence provided by a qualified doctor other than you

or a family member (failure to meet requirements necessary to maintain a license to perform the duties of your occupation does not mean you are totally disabled). Your occupation includes similar job positions with the company with a rate of pay 50 percent or greater of your indexed pre-disability earnings;

- You are under the continuous care of a qualified doctor; and
- The disability is due to injury, sickness, substance abuse or pregnancy.

A statement by your physician(s) that "you are unable to work" does not in and of itself qualify you for long-term disability benefits.

When benefits are not paid

Long-term disability benefits will not be paid for:

- Any illness or injury that is not treated by a qualified doctor;
- Any loss caused by war or act of war (declared or not), insurrection, rebellions or taking part in a riot or civil disorder;
- Any loss caused by illness or injury while in the armed services of any country engaged in war or other armed conflict;
- Any injury caused by your commission of or attempt to commit an assault, a battery or felony;
- Any injury caused or contributed to by your being engaged in an illegal occupation or activity; or
- Due to, or contributed to, by a pre-existing condition.

Pre-existing condition limitation

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

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

When long-term disability benefits begin

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

- **For full-time hourly associates:** your waiting period is 26 weeks or the end of your short-term disability benefits—whichever is longer.
- **For management associates:** your waiting period is 90 days or the end of your employer-sponsored salary continuation program—whichever is longer.
- If you are approved for long-term disability benefits, any illness protection time, vacation days or personal days may not be used while receiving long-term disability benefits.

If you return to work during your waiting period and become disabled again

- **For full-time hourly associates:** If you cease to be totally disabled and return to work for a total of 30 calendar days or less during a waiting period, the waiting period will not be interrupted.
- **For management associates:** If you cease to be totally disabled and return to work for a total of six months or less during a waiting period, the waiting period will not be interrupted.

Filing a long-term disability claim

Full-time hourly associates — You will receive a claim form from The Hartford if the medical information provided indicates your total disability is expected to last longer than 195 calendar days. The Hartford will transfer the claim from short-term disability to long-term disability on the 17th week of disability.

Management associates — Call The Hartford at **(800) 492-5678** by the 45th day of your salary continuance if you believe you will need to use your long-term disability benefits. The Hartford will provide additional information on how to complete your claim.

Associates receiving workers' compensation benefits and enrolled for long-term disability insurance may be eligible for disability benefits after their waiting period is expired. Call The Hartford at **(800) 492-5678** to verify your eligibility for these benefits.

Claims will be determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

Your long-term disability benefit

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

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

Your long-term disability benefit is shown below.

Your long-term disability benefit	
If You Enrolled:	Your Benefit Is:
During your initial enrollment period	50 percent of your average monthly wage minus the amount of other benefits or income you (or your family) are eligible to receive For example, Social Security disability benefits*
As a late enrollee and have been covered for less than five continuous years	40 percent of your average monthly wage minus the amount of other benefits or income you (or your family) are eligible to receive For example, Social Security disability benefits*

*See **Other benefits or income that reduce long-term disability benefits** later in this chapter for more information.

Average monthly wage

Length of Employment:	How Average Monthly Wage Is Determined:
Employed 12 months or more	Total gross pay ÷ prior 12 months For example, the average monthly wage for an associate with a total annual gross pay of \$20,800 is \$1,733.33 (\$20,800 ÷ 12).
Employed less than 12 months	Total gross pay ÷ number of months worked For example, the average monthly wage for an associate with a total gross pay of \$11,900 for seven months of work is \$1,700 (\$11,900 ÷ 7).

Total gross pay includes:

- Overtime;
- Bonuses;
- Vacation;
- Illness protection (not including any previous disability benefits); and
- Personal pay for the 26 pay periods (52 if paid weekly) prior to the total disability.

If you have been employed less than 12 months, an annualized average of earnings will be used, excluding reimbursed expenses.

The maximum monthly benefit under the long-term disability plan is \$15,000. Your benefit will be no less than \$50 for any month that you are receiving long-term disability benefits. The total of your monthly disability payment, plus all earnings, cannot exceed 80 percent of your average monthly wage prior to your disability.

Long-term disability benefits are paid at the end of the month.

The Hartford has the right to recover from you any amount that is overpaid to you for long-term disability benefits under this plan.

Other benefits or income that reduce long-term disability benefits

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

- Social Security disability insurance;
- Social Security retirement that begins after the date of total disability;
- Workers' compensation;
- Employer-related individual policies;

- No-fault automobile insurance;
- Employer retirement plan that begins after the date of the total disability; and
- Settlement or judgment, less associated costs of a lawsuit, that represents or compensates for your loss of earnings.

Please refer to the policy for a complete list of offsets. The Hartford policy can be obtained by calling Benefits Customer Service at **(800) 421-1362**.

Reduction of long-term disability benefit example

Average monthly wage	\$1,800
Benefit amount (50 percent of average monthly wage, subject to the \$15,000 max)	- \$900
Less Social Security disability benefit	- \$500
Less dependent's Social Security benefits	- \$250
Long-term disability payment	\$150

Applying for Social Security disability benefits

You may be eligible to receive Social Security disability benefits after you have been disabled for five months. If your disability is expected to last, or has already lasted, 12 consecutive months, the long-term disability policy terms may require you to apply for Social Security disability benefits. If the Social Security Administration denies you benefits, you will be required to follow the Social Security Administration's appeal process.

Failure to file for Social Security disability benefits could result in your Social Security retirement benefits being reduced when you reach the age of retirement. If you qualify for Social Security disability benefits while on long-term disability and your approval date is retroactive, you must reimburse The Hartford for any long-term disability benefits paid to you as a result of an award of Social Security disability benefit payments.

If you are disabled and working

If you are disabled and working, and are currently earning less than 80 percent of your indexed pre-disability earnings, the following calculation is used to determine your monthly benefit:

Disabled and working benefit calculation

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

A	Your indexed pre-disability monthly earnings
B	Your current monthly earnings
C	The monthly benefit payable if you were otherwise totally disabled
D	The disabled and working benefit payable

Indexed pre-disability monthly earnings means your pre-disability earnings adjusted annually by adding seven percent.

Pre-disability monthly earnings means your regular monthly rate of pay in effect for the 26 regular pay periods immediately prior to the date you became totally disabled, divided by 12. Pre-disability earnings include overtime pay, bonuses, vacation pay, illness protection and personal pay, but not commissions or any other fringe benefits or extra compensation. If you have worked for less than 12 months with the company, your regular monthly rate of pay will be based upon the total earnings you actually received while working for the company immediately prior to the date you became totally disabled, annualized and divided by 12.

Continuing benefit coverage while disabled

If you wish to continue medical, dental, AD&D, short-term disability plus, life insurance and accident insurance coverage while you are receiving long-term disability benefits, you must make premium payments each pay period. These amounts will not be deducted from your long-term disability benefit payments. If you fail to pay

your premiums for your other benefit plan(s), your benefits may be cancelled. See the **Eligibility and enrollment** chapter for details. You may be eligible for a waiver of premium for critical illness insurance. See the **Critical illness insurance** chapter for details. You will not be required to pay short-term disability or long-term disability premiums while you are receiving disability benefits. Your coverage will not be cancelled while you are receiving disability benefits under this policy.

If you die while receiving long-term disability benefits

When you die, your coverage ends; however, if you die after satisfying the waiting period while receiving long-term disability benefits, a lump sum payment of \$5,000 will be paid to your surviving spouse. If you are not survived by a spouse, the payment will be made to your surviving children in equal shares. If you are not survived by a spouse or children, the payment will be made to your estate.

When long-term disability benefits end

Long-term disability benefit payments will end on the earliest of:

- The date you are no longer totally disabled,
- The date you fail to furnish proof that is satisfactory to The Hartford that you are totally disabled,
- The date you refuse to be examined, if The Hartford requires an examination,
- The last day of the maximum period for which benefits are payable,
- The date that you refuse a similar position offered to you by Walmart that you are medically able and qualified to perform, with a rate of pay 50 percent or greater of your pre-disability earnings,
- The date of your death, or
- The date determined in the chart below.

Duration of long-term disability benefits		Social Security normal retirement age	
Age When You Become Totally Disabled:	Benefits Termination (Months of LTD benefits):	Year of Birth:	Normal Retirement:
Prior to age 62	Normal Retirement Age (as listed to the right)	1937 or before	65
62	4 years	1938	65 + 2 months
63	3 1/2 years	1939	65 + 4 months
64	3 years	1940	65 + 6 months
65	2 1/2 years	1941	65 + 8 months
66	2 1/4 years	1942	65 + 10 months
67	2 years	1943 through 1954	66
68	1 3/4 years	1955	66 + 2 months
69 or older	1 1/2 years	1956	66 + 4 months
		1957	66 + 6 months
		1958	66 + 8 months
		1959	66 + 10 months
		1960 or after	67

If the disability is due to mental illness, alcoholism or drug addiction

In order to receive long-term disability benefits for more than 24 months for the following disabilities, you must be confined in a hospital or other facility licensed to provide medical care:

- Mental illness (excluding demonstrable, structural brain damage),
- Any condition that results from mental illness,
- Alcoholism, and
- Non-medical use of narcotics, sedatives, stimulants, hallucinogens or similar substances.

When you are not confined, there will be a 24-month lifetime benefit for these disabilities.

If you return to work and become disabled again

If you return to work for less than 180 days of active full-time work and become totally disabled again from the same or a related condition that caused the first period of disability, the recurrent disability will be part of the same disability.

If you return to work as an active full-time associate for 180 days or more, any recurrence of a disability will be treated as a new disability. A new waiting period must be completed.

If you are on a leave of absence

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

If you return to actively-at-work status within one year of cancellation, you will automatically be enrolled for the same coverage plan you had prior to your leave of absence. Your coverage will be effective the first day of the pay period that you meet the actively-at-work requirement.

If you return to work on a full-time basis after one year of cancellation, you will be considered newly eligible, and you can enroll for long-term disability coverage within the applicable waiting period described in the **Eligibility and enrollment** chapter.

Special rules may apply if you are on or return from a FMLA or Military Leave of Absence. See the **Eligibility and enrollment** chapter for more information.

When coverage ends

Your long-term disability coverage ends:

- At termination of your employment;
- On the last day of the pay period when your job status changes to part-time;
- Upon failure to pay your premiums;
- On the date of your death;
- On the date you lose eligibility;
- On the 91st day of an approved leave of absence (unless you return to work);
- When the benefit is no longer offered by the company; or
- The day after you drop coverage.

If you leave the company and are rehired

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

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

Truck driver long-term disability

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truck driver
long-term

This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by The Hartford, the terms of the policy will govern. You may obtain a copy of this policy by contacting the plan.

Truck driver long-term disability

If a disability keeps you off the road and unable to work beyond your salary continuance period, truck driver long-term disability benefits work with other benefits you receive to replace part of your paycheck. You have two truck driver long-term disability plans that pay benefits for different lengths of time.

Truck driver long-term disability resources

Find What You Need:	Online:	Other Resources:
Get more details about truck driver long-term disability	E-mail your question to askhartford@hartfordlife.com or visit mywalmart.com	Call The Hartford at (800) 492-5678
File a claim by the 45th day of your salary continuance		Call The Hartford at (800) 492-5678

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

- Full-time truck drivers have two truck driver long-term disability plans: full-duration coverage and five-year coverage.
- If you enroll after your initial eligibility period, your truck driver long-term disability benefits will be reduced to 40 percent of your average monthly wage during your first year of coverage and you'll have to submit Proof of Good Health and may be required to undergo a medical exam at your own expense before you can be approved.
- The truck driver long-term disability plan works with any other benefits you receive while disabled to replace 40 percent or 50 percent of your average monthly wage, depending on when you enroll for the coverage.
- Truck driver long-term disability benefits are paid at the end of each month.

Enrolling in truck driver long-term disability and when coverage is effective

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

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

Truck driver long-term disability begins paying benefits after a waiting period, providing you with an income. Benefits are paid if you are totally disabled as defined by the plan. The maximum monthly benefit under the long-term disability plan is \$15,000. Truck driver long-term disability coverage is insured by The Hartford. Your benefit will be no less than \$50 for any month that you are receiving long-term disability benefits. The total of your monthly disability payment plus all earnings cannot exceed 80 percent of your average monthly wage prior to your disability.

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

- **If you enroll during your initial enrollment period (from the date of your first paycheck through 60 days of your date of hire),** your coverage amount will be 50 percent of your average monthly wage. Your coverage will be effective on your date of hire.

- **If you enroll at any time after your initial enrollment period as a late enrollee:**

—Your monthly benefit will be reduced to 40 percent of your average monthly wage if you become totally disabled during your first continuous year of coverage and increases to 50 percent after the first year;

—You will be required to provide Proof of Good Health (complete a questionnaire regarding your medical history); and

—You may be required to undergo a medical exam at your own expense.

- **If at any time you drop your truck driver long-term disability coverage and later decide to re-enroll,** you will be treated as a late enrollee as described above.

As a late enrollee, your coverage will be effective the first day of the pay period after Benefits Customer Service receives approval from The Hartford.

The cost of truck driver long-term disability coverage

Your cost for truck driver long-term disability is based on your biweekly earnings. Premiums are deducted from all wages including bonuses. You will not be required to pay truck driver long-term disability premiums while you are receiving truck driver long-term disability benefits.

Coverage during a temporary layoff or leave of absence

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

When you qualify for truck driver long-term disability benefits

In order to qualify for truck driver long-term disability benefits, you must:

- Submit medical evidence provided by a qualified doctor that you are totally disabled as defined by the plan;
- Remain totally disabled beyond the waiting period; and
- Receive approval by The Hartford of your claim.

As defined by the plan, total disability means:

- You are unable to perform the essential duties of your occupation for the first 12 months (or any occupation after 12 months of benefit payments) according to the medical evidence provided by a qualified doctor other than you or a family member (failure to meet requirements necessary to maintain a license to perform the duties of your occupation does not mean you are totally disabled). Your occupation includes similar job positions with the company with a rate of pay 50 percent or greater of your indexed pre-disability earnings;
- You are under the continuous care of a qualified doctor; and
- The disability is due to injury, sickness, substance abuse or pregnancy.

A statement by your physician(s) that "you are unable to work" does not in and of itself qualify you for long-term disability benefits.

If you file a claim within the first two years of your approval date, The Hartford has the right to re-examine your Proof of Good Health questionnaire. If material facts about you were stated inaccurately, the true facts will be used to determine if and for what amount your coverage should have been in effect and your premium may be adjusted.

When benefits are not paid

Truck driver long-term disability benefits will not be paid for disabilities that are:

- Any illness or injury that is not treated by a qualified doctor;

- Any loss caused by war or act of war (declared or not), insurrection, rebellions or taking part in a riot or civil disorder;
- Any loss caused by illness or injury while in the armed services of any country engaged in war or other armed conflict;
- Any injury caused by your commission of or attempt to commit an assault, a battery or a felony;
- Any injury caused or contributed to by your being engaged in an illegal occupation or illegal activity; or
- Due to, or contributed to by, a pre-existing condition.

Pre-existing condition limitation

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

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

When truck driver long-term disability benefits begin

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

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

If you return to work during your waiting period and become disabled again

If you cease to be totally disabled and return to work for a total of six months or less during a waiting period, the waiting period will not be interrupted.

Filing a truck driver long-term disability claim

If you believe you will need to use your truck driver long-term disability benefits, call The Hartford at **(800) 492-5678** by the 45th day of your salary continuance. The Hartford will provide additional information on how to complete your claim.

Claims will be determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

Associates receiving workers' compensation benefits and enrolled for truck driver long-term disability insurance may be eligible for disability benefits after their waiting period has expired. Call The Hartford at **(800) 492-5678** to verify your eligibility for these benefits.

Your truck driver long-term disability benefit

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

- Your average monthly wage;

Average monthly wage	
Length of Employment:	How Average Monthly Wage Is Determined:
Employed 12 months or more	Your activity pay, mileage rate and bonuses, paid in the 26 pay periods prior to the total disability ÷ 12 months
Employed less than 12 months	Your activity pay, mileage rate and bonuses ÷ the number of months worked.

- Whether you enrolled for coverage during your initial enrollment period or as a late enrollee (see **Enrolling in truck driver long-term disability** and **When coverage is effective** earlier in this chapter);
- If you are approved for truck driver long-term disability benefits, any illness protection time, vacation days or personal days may not be used while receiving truck driver long-term disability benefits; and
- If you are drawing truck driver long-term disability and you are approaching your anniversary date, you can receive a payout of your vacation time the pay period before your anniversary.

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

Your truck driver long-term disability benefit	
If You Enrolled:	Your Benefit Is:
During your initial enrollment period	50 percent of your average monthly wage minus the amount of other benefits or income you (or your family) are eligible to receive For example, Social Security disability benefits*
After your initial enrollment period	40 percent of your average monthly wage for the first year minus the amount of other benefits or income you (or your family) are eligible to receive For example, Social Security disability benefits*

*See **Other benefits or income that reduce truck driver long-term disability benefits** later in this chapter for more information.

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

Truck driver long-term disability benefits are paid at the end of the month.

The Hartford has the right to recover from you any amount that is overpaid to you for truck driver long-term disability benefits under this plan.

Other benefits or income that reduce truck driver long-term disability benefits

Your truck driver long-term disability benefit amount will be reduced by other benefits or income you (or your family) receive or are eligible to receive. Examples include, but are not limited to, income from the following:

- Social Security disability insurance;
- Social Security retirement that begins after the date of total disability;
- Workers' compensation;
- Employer-related individual policies;
- No fault automobile insurance;

- Employer retirement plan that begins after the date of the total disability; or
- Settlement or judgment, less associated costs of a lawsuit, that represents or compensates for your loss of earnings

Please refer to the policy for a complete list of offsets. The Hartford policy can be obtained from Benefits Customer Service by calling **(800) 421-1362**.

Reduction of truck driver long-term disability benefit example

Average monthly wage	\$1,800
Benefit amount (50 percent of average monthly wage, subject to the \$15,000 max)	- \$900
Less Social Security benefit	- \$500
Less dependent's Social Security benefits	- \$250
Truck driver LTD payment	\$150

Applying for Social Security disability benefits

You may be eligible to receive Social Security disability benefits after you have been disabled for five months. If your disability is expected to last, or has already lasted, 12 consecutive months, the truck driver long-term disability policy terms may require you to apply for Social Security disability benefits. If the Social Security Administration denies you benefits, you will be required to follow the Social Security Administration's appeal process.

Failure to file for Social Security disability benefits could result in your Social Security retirement benefits being reduced when you reach the age of retirement. If you qualify for Social Security disability or retirement benefits while on truck driver long-term disability and your approval date is retroactive, you must reimburse The Hartford for any truck driver long-term disability benefits paid to you, regardless of when you actually start receiving Social Security disability or retirement benefit payments.

If you are disabled and working

If you are disabled and working, and are currently earning less than 80 percent of your indexed pre-disability monthly earnings, the following calculation is used to determine your monthly benefit:

Your pre-disability monthly earnings means your activity pay, mileage rate and bonus in effect for the 52 weeks immediately prior to the date you become disabled, divided by 12. Indexed pre-disability monthly earnings means your pre-disability monthly earnings increased annually by seven percent.

Disabled and working benefit calculation

$$(A - B) \times C = D$$

A

A	Your indexed pre-disability monthly earnings
B	Your current monthly earnings
C	The monthly benefit payable if you were otherwise totally disabled
D	The disabled and working benefit payable

Continuing benefit coverage while disabled

If you wish to continue medical, dental, AD&D, life insurance and accident insurance coverage while you are receiving truck driver long-term disability benefits, you must make benefits premium payments each pay period. These amounts will not be deducted from your truck driver long-term disability benefit payments. If you fail to pay your premiums for your other benefit plan(s), your benefits may be cancelled. See the **Eligibility and enrollment** chapter for details. You may be eligible for a waiver of premium for critical illness insurance. See the **Critical illness insurance** chapter for details.

You will not be required to pay truck driver long-term disability premiums while you are receiving disability benefits. Your coverage will not be cancelled while you are receiving disability benefits under this policy.

If you die while receiving truck driver long-term disability benefits

When you die, your coverage ends; however, if you die after satisfying the waiting period while receiving truck driver long-term disability benefits, a lump sum payment of \$5,000 will be paid to your surviving spouse. If you are not survived by a spouse, the payment will be made to your surviving children in equal shares. If you are not survived by a spouse or children, the payment will be made to your estate.

When truck driver long-term disability benefits end

Truck driver long-term disability benefit payments will end on the earliest of:

- The date you are no longer totally disabled;
- The date you fail to furnish proof that is satisfactory to The Hartford that you are totally disabled;
- The date you refuse an examination required by The Hartford;
- The date that you refuse a similar position offered to you by Walmart that you are medically able and qualified to perform, with a rate of pay 50 percent or greater of your pre-disability earnings;
- The date of your death; or
- The date determined from the coverage you have chosen and the following tables.

Full duration coverage	Five-year coverage
<p>Full-duration coverage pays benefits for the longer of:</p> <ul style="list-style-type: none">• The period shown in the Reducing benefit duration chart; or• The normal retirement age under the Social Security Act shown in the Social Security normal retirement age chart.	<p>Five-year coverage pays benefits for 60 months unless both the applicable period in the Reducing benefit duration chart and the Social Security normal retirement age chart are less than five years. In that case, the five-year coverage will pay for the longer of those two periods.</p>

Reducing benefit duration		Social Security normal retirement age	
Age When You Become Totally Disabled:	Benefits Termination	Year of Birth:	Normal Retirement:
Prior to age 62	Normal Retirement Age (as listed to the right)	1937 or before	65
62	4 years	1938	65 + 2 months
63	3 1/2 years	1939	65 + 4 months
64	3 years	1940	65 + 6 months
65	2 1/2 years	1941	65 + 8 months
66	2 1/4 years	1942	65 + 10 months
67	2 years	1943 through 1954	66
68	1 3/4 years	1955	66 + 2 months
69 or older	1 1/2 years	1956	66 + 4 months
		1957	66 + 6 months
		1958	66 + 8 months
		1959	66 + 10 months
		1960 or after	67

If the disability is due to mental illness, alcoholism or drug addiction

In order to receive truck driver long-term disability benefits for more than 24 months for the following disabilities, you must be confined in a hospital or other place licensed to provide medical care:

- Mental illness (excluding demonstrable, structural brain damage);
- Any condition that results from mental illness;
- Alcoholism; and
- Non-medical use of narcotics, sedatives, stimulants, hallucinogens or similar substances.

If you are confined in a hospital or other place licensed to provide medical care, benefits will be payable as long as you are confined, subject to the maximum duration of benefits and all other policy provisions.

If you return to work and become disabled again

If you return to work for less than 180 days of active full-time work and become totally disabled again from the same or a related condition that caused the first period of disability, the recurrent total disability will be part of the same disability. No additional waiting period will be required.

If you return to work as an active full-time associate for 180 days or more, any recurrence of a total disability will be treated as a new disability. A new benefit waiting period must be met.

If you are on a leave of absence

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

If you return to actively-at-work status within one year of cancellation, you will automatically be enrolled for the same coverage plans you had prior to your leave of absence. Your coverage will be effective the first day of the pay period that you meet the actively-at-work requirement.

If you return to work on a full-time basis after one year of cancellation, you will be considered newly eligible, and you can enroll for truck driver long-term disability coverage within the applicable waiting period described in the **Eligibility and enrollment** chapter.

Special rules may apply if you are on or return from a FMLA or Military Leave of Absence.

See the **Eligibility and enrollment** chapter for more information.

When coverage ends

Your truck driver long-term disability coverage ends:

- At termination of your employment;
- On the last day of the pay period when your job status changes to part-time;
- Upon failure to pay your premiums;
- On the date of your death;
- On the date you lose eligibility;
- On the 91st day of an approved leave of absence (unless you return to work);
- When the benefit is no longer offered by the company; or
- On the day after you drop coverage.

If you leave the company and are rehired

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

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

The Associate Stock Purchase Plan (ASPP)

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ASPP

The Associate Stock Purchase Plan

The Associate Stock Purchase Plan (ASPP) allows you to buy Walmart stock conveniently through payroll deductions. You can have any amount from \$2 to \$1,000 withheld from your biweekly paycheck (\$1 to \$500 if you are paid weekly) to buy stock. Walmart matches 15 cents for every dollar that you contribute to purchase stock, up to the first \$1,800 in purchases each Plan year.

The Associate Stock Purchase Plan resources		
Find What You Need:	Online:	Other Resources:
Enroll in the Plan or change your deduction amount		Associates must complete an online benefits enrollment session on the WIRE or at mywalmart.com .
<ul style="list-style-type: none"> • Access your account information • Get your account statement • Get a Form 1099 	Go to the Computershare Web site at computershare.com/walmart	Call Computershare at (800) 438-6278 (hearing impaired: (800) 952-9245)
Send money directly to Computershare		Send check to: Computershare Attn: Walmart ASPP P.O. Box 43080 Providence, RI 02940-3080 (Company contributions will not be made on money sent directly to Computershare.)
Get information about setting up a line of credit for your account		Call USBancorp (800) 771-2265

What you need to know about the Associate Stock Purchase Plan

- All eligible associates can purchase Walmart stock through convenient payroll deductions.
- Walmart matches 15 cents for every \$1 you put into the Plan through payroll deductions, up to the first \$1,800 that you contribute.
- If you have \$2,000 or more of Walmart stock in your account, you may be eligible to borrow money using the stock in your Stock Purchase Plan account to secure a line of credit.
- While you are employed, there are no fees to purchase shares of Walmart stock through the Plan. You only pay a fee when you sell shares of stock.
- Your account is maintained at Computershare. You can access your account online or by telephone to get your balance or sell stock.

Associate Stock Purchase Plan eligibility

You are eligible to enroll in the Associate Stock Purchase Plan if you are:

- Not a member of a collective bargaining unit whose benefits were the subject of good faith collective bargaining.
- At least 18 years of age or the legal age of majority (19 is the legal age of majority in Alabama and Nebraska) in your payroll state to participate. If you live in Puerto Rico, you must be 21 years of age to participate. If you have questions about the age requirement, review your state laws on age of majority.

Enrolling in the Associate Stock Purchase Plan

You can enroll in the Plan by completing an online benefits enrollment session on the **WIRE** or at mywalmart.com. Before you enroll in this plan, you should carefully review the Associate Stock Purchase Plan brochure or the Plan Prospectus.

If you are a Hawaii associate who would like to enroll in the Associate Stock Purchase Plan, you will need to contact your personnel representative for an enrollment form.

The decision to purchase company stock is an individual decision to be made solely by you and your tax or financial advisor. By offering this program, the company is not recommending, endorsing or soliciting the purchase of company stock. In making your decision, you should be aware that the past performance of the company stock is not an indication or prediction of future performance. The value of company stock may be affected by many factors including those outside the company itself, such as economic conditions.

Walmart's contribution to your company stock ownership

The Associate Stock Purchase Plan allows all eligible associates to buy Walmart stock conveniently through payroll deductions. You can have any whole dollar amount from \$2 to \$1,000 withheld from your paycheck to buy stock (\$1 to \$500 for associates with a weekly paycheck).

Walmart contributes to your stock purchase account by matching 15 cents for every \$1 you purchase through payroll deductions, up to your first \$1,800 in purchases each Plan year. The Plan year runs from April through March. The company match is reflected as income on your check stub and on your W-2 form.

In addition to your payroll deductions, you can contribute additional money to the Associate Stock Purchase Plan by sending money directly to Computershare, the Plan's administrator at:

Computershare
Attn: Walmart ASPP
P.O. Box 43080
Providence, RI 02940-3080

Money sent directly to Computershare will not receive the Walmart matching contribution. The maximum amount (payroll deductions and money sent directly to Computershare) you can purchase through the Associate Stock Purchase Plan is \$125,000 in stock per Plan year. Dividends that you earn on the stock are automatically reinvested to buy additional shares of stock for you.

The value of the stock you purchase can fluctuate and may decline. There is no way to guarantee that your stock will have the same value in the future that it had when you made the purchase. When making a decision about purchasing Walmart stock, consider all your investments, including other Walmart stock you may own. For investment questions, consult a financial advisor.

Walmart's contribution to your company stock ownership

If you contribute:	Your Plan year payroll deduction contribution is:	Walmart's matching contribution is:	Total amount used to purchase Walmart stock:
\$10 biweekly	\$260	\$39	\$299
\$20 biweekly	\$520	\$78	\$598
\$70 biweekly	\$1,820	\$270 (Walmart matches 15 cents for every \$1 up to \$1,800)	\$2,090

Military Leave of Absence

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

Stock certificates

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

Please note that any shares issued in stock certificate form are no longer part of the Plan. Once the shares are taken from your Associate Stock Purchase Plan account, the certificate will be tracked and treated as a "general shareholder" account. You may contact Computershare at **(800) 438-6278**.

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

If stock certificates in your possession are lost or stolen, you may request replacement certificates, at a cost, by completing documentation required by Computershare. Special insurance, based on a percentage of the value of the stock certificate, is required to protect you from the loss of those certificates through the mail service. For more information about replacing lost or stolen certificates or any fees that may be incurred for the replacement of a lost certificate, please contact Computershare directly at **(800) 438-6278**.

Selling stock through the Plan

No fees are charged to you for buying stock; however, when you sell stock you will be charged a fee.

If you choose to sell your stock under the market order method, your stock will be sold as soon as your request can reasonably be processed at the market price in effect at the time. If the market is closed, your order will be processed at the start of the next business day. Your fee is \$30 per sale plus 5 cents per share sold.

Unless you specifically request a market order, the sale will be completed through a batch order transaction. The price for your stock will be the average price for all Walmart shares sold that day by Computershare before 1:00 p.m. CST. Any sale request after the 1:00 p.m. CST deadline will be processed the next business day. Your fee for this type of sale will be \$20 per sale plus 5 cents per share sold.

To sell stock, call Computershare at **(800) 438-6278** or go to computershare.com/walmart. A check will be mailed to the address on your latest payroll check and you should receive it within 7 to 10 business days.

The sale fee is automatically deducted from your check. Each time you sell stock, you will receive a transaction summary form along with your check. At the end of January, you'll receive a separate 1099-B - Tax Reporting Statement at your home to use in reporting the sale of stock on your tax return.

It's important to understand the tax consequences of a stock sale. If you have tax-related questions, please consult a financial advisor or tax consultant.

Keeping track of your Computershare account

You will receive a statement from Computershare at least annually in January that shows the activity in your account. However, if you opted to receive your statements online, you will receive an e-mail informing you that your statement is ready and can be found on computershare.com/walmart. The statement you receive in January will contain important tax information. It is very important that you keep your statement so that you will know the difference between your purchase price and sale price if you sell shares of stock.

You can access your account information by phone at **(800) 438-6278** (hearing impaired: **(800) 952-9245**) or the Computershare Web site at computershare.com/walmart.

If you request replacement statements from Computershare, there is a \$5 charge per statement for previous years' statements. Or, you can obtain copies free of charge through the Web site at computershare.com/walmart.

Borrowing money using your Stock Purchase Plan account

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

The line of credit is repaid through monthly payments to USBancorp. For more information, call **(800) 771-2265** and enter **extension 9604**.

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

Naming a joint tenant for your Stock Purchase Plan account

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

Ending your participation and closing your account

To cancel your payroll deductions to the Associate Stock Purchase Plan, complete an online benefits enrollment session on the WIRE or at mywalmart.com.

After you cancel your payroll deductions, you can close your account by asking Computershare to issue you a stock certificate or by directing them to sell your stock and send you a check. To avoid paying a sales transaction twice, cancel your payroll deductions before closing your account.

If you leave the company

If you leave the company, you will have several options concerning the status of your account:

- You can keep your account open without the weekly or biweekly payroll deduction and the company match. You can make voluntary cash purchases and benefit from having no brokers' fee. There is an annual maintenance fee of \$35 per year, which will be automatically deducted from your account through the sale of an appropriate portion of a share of stock to cover the fee during the first quarter of the year.
- You can close your account and receive all full shares in certificate form and a check for any partial share ownership.
- You can close your account and sell some or all of the shares in your account.

In order to prevent any residual balances and to avoid paying a sales transaction fee twice, wait until you receive your final paycheck before closing your account.

It is very important that you update Computershare if you have an address change after you have left the company.

PROSPECTUS

This document constitutes part of a prospectus covering securities that have been registered under the Securities Act of 1933.

73,994,987 Shares

WAL-MART STORES, INC.

Common Stock
 (\$.10 par value per share)

WAL-MART STORES, INC.

2004 Associate Stock Purchase Plan

(formerly, the Wal-Mart Stores, Inc. Associate Stock Purchase Plan of 1996)

THESE SECURITIES HAVE NOT BEEN APPROVED OR DISAPPROVED BY THE SECURITIES AND EXCHANGE COMMISSION OR ANY STATE SECURITIES COMMISSION NOR HAS THE SECURITIES AND EXCHANGE COMMISSION OR ANY STATE SECURITIES COMMISSION PASSED UPON THE ACCURACY OR ADEQUACY OF THIS PROSPECTUS. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE.

No one is authorized to give any information or to make any representations other than those contained in this Prospectus and, if given or made, you should not rely on them. This Prospectus is not an offer to sell or a solicitation of an offer to buy any of the securities referred to in this Prospectus in any state where such an offer or solicitation would be unlawful. Neither the delivery of this Prospectus nor acquisition of securities described in this Prospectus implies that no change in the affairs of the company has occurred since the date of this Prospectus.

Investment in shares of the Common Stock offered hereby involves certain risks. See [Stock Ownership; fees and risks](#) later in this chapter.

The date of this Prospectus is August 31, 2009

Introduction and overview

The Wal-Mart Stores, Inc. 2004 Associate Stock Purchase Plan (the "[Plan](#)") amended and restated the Wal-Mart Stores, Inc. Associate Stock Purchase Plan of 1996.

The Plan was most recently approved by the stockholders of Wal-Mart Stores, Inc. (the "[company](#)") on June 4, 2004. Up to 142,624,272 shares of the company's common stock, par value \$.10 per share (the "[Stock](#)"), were available for delivery under the Plan as of June 4, 2004. As of the date of this Prospectus, 73,994,987 shares of Stock remain available. Those shares have been registered with the United States Securities and Exchange Commission for offer and sale on a Registration Statement on Form S-8 (Commission File No. 333-62965). Shares of the Stock are listed for trading on the New York Stock Exchange. Participating associates may be referred to as "[you](#)" in this Prospectus.

The Plan has two parts -- the Stock Purchase Program and the Outstanding Performance Award Program. The Stock Purchase Program gives eligible associates an opportunity to share in company ownership by allowing them to purchase Stock by payroll deduction. In addition, if they make or have made purchases through such payroll deductions under the Plan, they may also purchase Stock by making voluntarily contributions to the Plan out of their own funds. Under the Outstanding Performance Award Program, the company may reward associates for exceptional job performance by awarding shares of Stock to them.

The company believes that the Plan is not subject to any provisions of the Employee Retirement Income Security Act of 1974, as amended. The Plan is not qualified under Section 401(a) or 423 of the Internal Revenue Code of 1986, as amended.

Plan administration; account management

The Plan provides that the Equity Compensation Committee ("Committee"), consisting of members of the company's Board of Directors, has the overall authority for administering the Plan. The Committee may delegate (and revoke the delegation of) some or all aspects of Plan administration to the officers or managers of the company or an affiliate or to others, subject to terms as it deems appropriate. The members of the Committee are selected by the company's Board of Directors. The Board of Directors may remove a member from the Committee at its discretion, and a member will cease to be a Committee member if he or she ceases to be a director of the company for any reason. At the date of this Prospectus, the members of the Committee were Mr. Michael T. Duke, the President and Chief Executive Officer of the company; Mr. Gregory B. Penner, a director of the company; Mr. H. Lee Scott, Jr., the Chairman of the Executive Committee of the company's Board of Directors; and Mr. S. Robson Walton, the Chairman of the Board of Directors of the company. Mr. Walton is also a managing member of Walton Enterprises LLC, which, at the date of this Prospectus, owned in excess of 42 percent of the outstanding shares of the Stock.

The Committee has selected a Third Party Administrator, currently Computershare Trust Company, N.A. ("Computershare"), to maintain accounts under the Plan. Computershare also serves as the company's stock transfer agent and provides other stock-related services to the company and its shareholders.

The Committee, as administrator of the Plan, or its delegate, must follow the terms of the Plan, but otherwise has full power and discretion to administer the Plan, including but not limited to the power to: determine when, to whom and in what types and amounts contributions should be made; make contributions to eligible associates in any number and to determine the terms and conditions applicable to each such contribution; set a minimum and maximum dollar, share or other limitation on the various contributions permitted under the Plan; determine whether an affiliate should become (or cease to be) a Participating Employer (as defined below); determine whether (and which) associates of non-U.S.

Participating Employers should be eligible to participate in the Plan; make all determinations deemed necessary or advisable for the administration of the Plan; establish, amend and revoke rules and regulations for the administration of the Plan; and exercise any powers, perform any acts and make any determinations it deems necessary or advisable to administer the Plan. All decisions made by the Committee under the Plan are final and binding on all persons, including the company and its affiliates, any associate, any person claiming any rights under the Plan from or through any participant, and shareholders of the company. The members of the Committee do not act as the trustees of the participants or hold the Stock credited to the participants' Plan accounts in trust for the benefit of the participants.

Plan participation and eligibility

If you are eligible, you can become a participant in the Plan by enrolling online (where available) to authorize payroll deductions to be taken from your regular compensation and contributed to the Plan for the purchase of Stock to be held in your Plan account. You can also become a participant in the Plan if the Committee grants you an award of Stock under the Outstanding Performance Award Program.

All associates of the company and approved affiliates of the company ("Participating Employers") are eligible to participate in the Plan, except:

- If you are restricted or prohibited from participating in the Plan under the law of your state or country of residence, you may not participate in the Plan or your participation in the Plan may be limited.
- You must have attained the age of majority in your state of residence or employment to participate. It is your responsibility to ensure you are of sufficient age to participate. The company may terminate your participation if it discovers you are not of sufficient age.
- If you are a member of a collective bargaining unit whose benefits were the subject of good faith collective bargaining, you are excluded from participation in the Plan, unless your bargaining agreement requires participation.
- If your employer is a non-U.S. affiliate, you may participate only if you are an approved associate (listed by category or by individual).

- If you are an officer, including those subject to subsection 16(a) of the Securities Exchange Act of 1934, or otherwise subject to the company's Insider Trading Policy, your ability to acquire or sell shares of Stock may be restricted.

If you are on a bona fide leave of absence from the company or a Participating Employer, you will continue to be eligible to make contributions to the Plan during your leave of absence, but you will not be eligible for company matching contributions during that time. If you are on a Military Leave of Absence, please contact the Benefits Department to see whether you are eligible to receive company matching contributions during your leave. Please note that you must make contributions from your own funds if you are not receiving a paycheck while you are on a leave of absence, as payroll deduction would not be available as an option. Any other circumstances which would permit you to continue to participate in the Plan while on a leave must be approved by the Committee.

Plan contributions — Stock Purchase Program

To make payroll deduction contributions, you need to complete an online benefits enrollment session on the **WIRE** or at **mywalmart.com**. Once you have properly enrolled in the Plan, your payroll deduction contributions will continue as long as you are employed by the company or a Participating Employer, unless you change or terminate your payroll deduction authorization or the Plan itself is terminated. Please note that no deduction will be drawn from any paycheck in which your payroll deduction contribution exceeds your net pay after taxes are withheld. You can change or terminate your payroll deduction authorization by completing an online benefits enrollment session on the **WIRE** or at **mywalmart.com**. Your request will be processed as soon as practicable. Your request may be delayed or rejected if your requested change is prohibited at the time of request by any company policy, including the company's Insider Trading Policy.

Note that payroll deduction contributions are generally taken from your last paycheck. If you do not want to have payroll deduction contributions taken from your last paycheck, it is important that you timely terminate your payroll deduction authorization. If you work in a state that requires your last paycheck to be paid outside of the normal payroll cycle, payroll deduction contributions will not be taken out of your last paycheck.

Payroll deductions can be as little as \$2 or as much as \$1,000 per biweekly payroll period. Payroll deductions for associates paid on a weekly basis can be as little as \$1 or as much as \$500 per weekly pay-roll period. The amount of any biweekly or weekly deduction in excess of the minimum must be in multiples of \$0.50. Your employer will make a matching cash contribution on your behalf when you make contributions to the Plan by payroll deduction. The matching contribution is currently 15 percent of the first \$1,800 you contribute to the Plan by payroll deduction, or up to \$270 per Plan year. The match is used to buy Stock for your Plan account.

If you participate or have participated in payroll deductions under the Plan and your Plan account has not been closed as described below, you can also voluntarily contribute cash (in U.S. dollars) from your other resources to fund the purchase of Stock under the Plan to be held in your Plan account. Any voluntary contributions must be made directly to Computershare. Instructions for making such voluntary contributions are available from Computershare. Your employer will not make matching contributions on amounts you contribute directly to Computershare. In addition, you may also deposit Stock that you hold outside of the Plan to your Plan account by making arrangements directly with Computershare.

The total of your payroll deductions and voluntary cash contributions cannot exceed \$125,000 per Plan year (April 1 through March 31).

The Committee establishes and may change the maximum and minimum contributions, may change the conditions for voluntary cash or Stock contributions, and may change the amount of the matching contributions of an employer at any time.

Outstanding Performance Award Program

Under the Outstanding Performance Award component, you can be granted an award of Stock for demonstrating consistently outstanding performance in your job over the period of a month, a quarter or a year. The Committee approves all Outstanding Performance Awards, and sets maximum dollar limitations on these awards from time to time.

Your Stock under the Outstanding Performance Award component will be given to you through an account maintained for your benefit by Computershare.

Stock purchases

Your employer will send all of your payroll deductions along with any matching contributions to Computershare as soon as practicable following each pay period. Computershare will purchase Stock for your Plan account no later than five business days after it receives the funds. If you make a voluntary cash contribution outside of payroll deductions, Computershare will purchase your Stock with that voluntary cash contribution no later than five business days after it receives the funds.

Computershare may purchase Stock for the Plan accounts on a national stock exchange, from the company, or from a combination of these places. However, the Committee reserves the right to direct Computershare to purchase from a particular source, consistent with applicable securities rules and the applicable rules of any national stock exchange.

Typically, when Computershare purchases Stock for the Plan on a national stock exchange, the shares are purchased as part of a bundled group rather than individually for each participant. In some instances, the shares of Stock for a bundled group must be purchased for the Plan over more than one day. When shares of Stock are purchased for you as part of a bundled group, your purchase price for each share of Stock will be equal to the average price of all shares of Stock purchased for that group as determined by Computershare.

If Computershare buys shares of Stock from the company, whether authorized but unissued shares or treasury shares, the per-share price will be equal to the Volume Weighted Average Price (VWAP) as reported on the New York Stock Exchange - Composite Transactions on the date of purchase. The VWAP is the weighted average of all trades of the company's Stock for a day. While the Plan permits the Committee to designate another methodology for valuing Stock purchased from the company, as of the date of this Prospectus no other methodology has been designated.

The number of shares allocated to your Plan account in connection with any purchase of Stock will equal the total amount of the contributions available for your Plan account and used to fund such purchases, divided by the purchase price for each share of Stock attributable to those purchases as discussed above.

Non-U.S. Participants Please Note: All amounts contributed to the Plan by payroll deduction, all matching contributions, and any contributions made pursuant to the Outstanding Performance Award component will be converted from your local currency to U.S. dollars prior to the time the shares of Stock are purchased. The exchange rate will be set as of a date as soon as practicable prior to the date the cash is sent to Computershare. Generally, the exchange rate for the business day immediately prior to the day the funds are sent to Computershare is used, but that may not be practicable in all circumstances. All voluntary cash contributions must be converted to U.S. dollars before being sent to Computershare to purchase shares of stock.

Stock ownership, fees and risks

Stock ownership

From the time that shares of Stock are credited to your Plan account, you will have full ownership of the shares (including any fractional shares) of Stock. The Stock held in your Plan account will be registered in Computershare's name until you request to have your Stock certificates delivered to you from the Plan account or you sell the shares credited to your Plan account. You may not assign or transfer any interest in the Plan before shares are credited to your account. However, you may

sell, transfer, assign or otherwise deal with your shares of Stock credited to your Plan account once they are credited to your Plan account, just like any other stockholder of the company. There is no automatic lien or security interest on the shares of Stock held in your Plan account. However, if you pledge the Stock as collateral in connection with the company's Stock Secured Line of Credit Program, the lender will have a security interest in the shares of Stock held in your Plan account.

Dividends and voting

Dividends on shares in your account will be automatically reinvested in additional shares of Stock. You will be able to direct the vote on each full share of Stock held in your Plan account, but not fractional shares. You will receive at no cost and as promptly as practicable (by mail or otherwise) all notices of meetings, proxy statements and other materials distributed by the company to its stockholders. To vote the shares of Stock held in your Plan account, you must timely deliver signed voting instructions, also known as proxy instructions, to the company's proxy tabulator. Otherwise, your shares of Stock may be voted in the manner recommended by the company in its proxy statement or as directed by the Committee, provided that doing so would comply with applicable law and any applicable listing standard of a national stock exchange.

Fees and account statements

The company pays all fees associated with the purchase of Stock. Generally, no maintenance fees or other charges will be assessed to your Plan account as long as you are employed by the company or one of its affiliates (even if that affiliate is not a Participating Employer). However, you must pay any commissions or charges resulting from other Computershare services you request, for example, brokerage commissions and other fees applicable to the sale of Stock.

Computershare can tell you if a particular request would cause you to incur a charge. At least annually, you will receive a statement of your account under the Plan, reflecting all activity with respect to your Plan account for the period of time covered by the statement. You may also access information regarding your account at any time by logging on to computershare.com/walmart.

Risks

Many of your risks of Plan participation are the same as those of any other stockholder of the company in that you assume the risk that the value of the Stock may increase or decrease. There are no guarantees as to the value of a share of Stock. This means that you assume the risk of fluctuations in the value or market price of the Stock. Our latest Annual Report on Form 10-K filed with the SEC and, as noted below, incorporated by reference in this Prospectus, discusses, and other of our reports filed with the SEC may discuss, certain risks relating to the company, its operations and financial performance that can affect the value and market price of the Stock. The company urges you to review those discussions in connection with any determination to participate in the Plan, to change the terms of your participation in the Plan, to terminate your participation in the Plan or to make any voluntary contributions under the Plan.

If you are a non-U.S. participant, you also assume the risk of fluctuation in currency exchange rates. Also, until Stock is purchased for you, your payroll deductions (as well as the corresponding matching contributions) are considered general assets of the company or the Participating Employer and, as such, are subject to the claims of the company's or Participating Employer's creditors. No interest will be paid on any contributions to the Plan.

Stock certificate delivery and Stock sales

Computershare will send you, on request, a Stock certificate for any or all full shares of Stock held in your Plan account at no cost to you.

You may request that Computershare sell all or a portion of the shares of Stock (including any fractional interests) held in your Plan account at any time whether or not you want to close your Plan account.

You will be charged a brokerage commission, as well as any other applicable fees, if for any reason you have Computershare sell shares of Stock held in your Plan account. Any brokerage commission or fees will be at the rates posted by Computershare from time to time. These rates are available upon request from Computershare.

The Plan offers a choice of methods by which to sell your Stock -- by "market order" or "batch order."

If you choose to sell your Stock under the "market order" method, your Stock will be sold as soon as your request can reasonably be processed at the market price in effect at that time. If the market is closed when you enter the request, your sale transaction will be processed at the start of the next day that the stock market is open.

If you choose to sell your Stock under the "batch order" method, your Stock will not be sold immediately as described above. Generally, if Computershare receives your request to sell shares of Stock before 1:00 p.m. Central Time on a business day, your sale transaction will take place on the same day. If your request is received on or after 1:00 p.m. Central Time or if your request is made on a day the stock market is not open, your sale transaction will take place on the next day that the stock market is open. The sale price for a share of Stock sold in this manner will be the average price of all shares of Stock sold by Computershare on the date of your sale transaction.

The Stock will be traded in U.S. dollars. If you are employed outside the U.S. by a Participating Employer and if provided by Computershare for your country, the proceeds from the sale may be converted for a fee to another currency if you request it when you request your Stock to be sold. If the proceeds are converted to another currency, the exchange rate that will be used is the following business day's market rate on the date your sale transaction is executed. You will assume the risk of any fluctuations in currency exchange rates.

Termination of participation; account closure

Once you become a participant in the Plan, you will remain a participant until you elect to close your Plan account and all Stock and sale proceeds credited to it have been distributed out of your Plan account or until all Stock and sale proceeds have been distributed from your Plan account after your employment with the company or one of its affiliates has terminated.

If you terminate your payroll deduction authorization, or your employment with the company and all its affiliates has terminated, you may choose to continue your Plan account or you may close your Plan account, as you specify to Computershare. Specifically:

- You may keep your Plan account open (without the weekly or biweekly payroll deduction and your employer's matching contributions). If you keep your account open, you may continue to make voluntary cash contributions and no brokerage commissions will be charged on the purchase of Stock. If you cease to be employed by the company or one of its affiliates, an annual maintenance fee will be charged to your account in the first quarter of each calendar year and will be paid by means of the sale of an appropriate portion of a share of Stock. (If you are transferred to a company affiliate that is not a Participating Employer, the company may continue to pay the maintenance fee for you.)
- If you own at least one full share of Stock, you may close your Plan account by moving your Stock into a "General Shareholder" account maintained on your behalf by Computershare. You may accomplish this move either by receiving all full shares in certificate form with a check for any partial share ownership and re-depositing them in the General Shareholder account, or Computershare can move the shares electronically at your request. You should contact Computershare for more information about the fees associated with a General Shareholder account.
- You may close your Plan account by having all shares of Stock in your account sold and the proceeds paid to you, or you can have certificates for full shares (and cash proceeds of fractional shares) delivered to you instead. The proceeds of any sale of full or fractional shares will be net of brokerage commissions, sales fees and other applicable charges. Your account will be closed automatically if you have a termination of employment and there are no shares or fractional shares in your account.

If you die before your Plan account has been closed, your Plan account will be distributed per the legal documentation submitted to Computershare or to your estate, unless you had previously arranged with Computershare to have your stock held in a joint account. In the event you have a joint account, the joint account holder may either make arrangements with Computershare to move your shares into a General Shareholder account maintained by Computershare at his or her own expense or to have the Stock (or proceeds from the sale thereof) distributed, less any applicable fees or commissions.

To add or remove a joint tenant to or from your account, call Computershare at (800) 438-6278.

Plan amendment and termination

The Plan has no set expiration date. The Board of Directors of the company (or a committee designated by the Board) may amend or terminate the Plan at any time. However, if stockholder approval of an amendment is required under law or the applicable rules of a national stock exchange, the amendment will be subject to that approval. No amendment or termination of the Plan will cause you to forfeit (1) any funds you have contributed to the Plan that have not yet been used to purchase Stock; (2) any shares (or fractional interests) of Stock in your Plan account; or (3) any dividends or distributions declared with respect to Stock after you have made a contribution to the Plan but before the effective date of the amendment or termination.

Tax information

The following summary of the U. S. income tax consequences of the Plan is based on the Internal Revenue Code and any regulations thereunder as in effect as of the date of this Prospectus. The summary does not cover any state or local income taxes or taxes in jurisdictions other than the United States. You should consult your tax advisor with respect to individual tax consequences before purchasing Stock under the Plan.

Stock purchases under the Stock Purchase Plan

You have no federal income tax consequences when you enroll in the Plan or when Stock is purchased for you under the Stock Purchase Plan either by payroll deduction or voluntary contribution. The amount of your payroll deductions and any voluntarily contributions under the Plan are not deductible for purposes of determining your federal taxable income. The amount of your wages that you have deducted under the Plan and the full value of company matching contributions are ordinary income to you in the calendar year of deduction or the contribution, as the case may be, and will be reported on your pay stub and your W-2. The company deducts all applicable wage withholding and other required taxes from your other compensation (by increasing your payroll deduction for such purposes) with respect to the amount of your wages deducted under the Plan and the matching contributions to your Plan account, if any. The company is entitled to a tax deduction for the amount of the matching contribution in the same year as you recognize the income.

Outstanding Performance Awards under the Outstanding Performance Award Program

Stock grants under the Outstanding Performance Award Program are taxable as ordinary income in the calendar year of the award, regardless of whether the Stock certificates are given directly to you or the Stock is awarded to your Plan account. Your ordinary income will be the market value of a share of Stock on the date the award is granted, times the number of shares of Stock granted. The market value of any Stock awarded will be reported to you on your W-2. The company will deduct applicable wage withholding and other required taxes from your other compensation (by increasing your payroll deduction for such purposes). The company is entitled to a tax deduction in the same amount and in the same year as you recognize the ordinary income.

Stock sales or certificate distributions

You will not recognize any taxable income when you request to have certificates delivered to you for some or all of the Stock held in your Plan account. However, when you sell or otherwise dispose of your Stock - whether through Computershare or later after you have received your Stock certificates - the difference between the fair market value of the Stock at the time of sale and the fair market value of the Stock on the date you acquired it will be taxed as a capital gain or loss. The holding period to determine whether the capital gain or loss is long-term or short-term will begin running on the date you acquire the Stock. The company will have no deduction as a result of your disposition of the Stock.

Available information

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

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

Computershare may be contacted by calling **(800) 438-6278 (800 GET-MART)**, online at computershare.com/walmart, or by writing to:

Computershare
Attn: Wal-Mart ASPP
P.O. Box 43080
Providence, RI 02940-3080

for all correspondence, including transactions, Stock certificates request, Stock powers, voluntary purchases and any customer service inquiries.

Documents incorporated by reference

The following documents filed by the company with the Securities and Exchange Commission (the "Commission") (File No. 1-6991) are hereby incorporated by reference in and made a part of this Prospectus:

- The company's Annual Report on Form 10-K for the fiscal year ended January 31, 2009;
- The company's Quarterly Report on Form 10-Q for the fiscal quarter ended April 30, 2009;
- The company's Current Reports on Form 8-K filed with the Commission on February 5, 2009, March 9, 2009, March 26, 2009, May 14, 2009 (which contains disclosure under Item 8.01 of Form 8-K), May 20, 2009 and July 24, 2009;
- The company's definitive Proxy Statement for the 2009 Annual Shareholders' Meeting, filed with the Commission on April 20, 2009; and
- The company's Registration Statement on Form 8-A containing a description of company's common stock, \$0.10 par value per share.

All documents filed by the company pursuant to Sections 13(a), 13(c), 14 and 15(d) of the Securities Exchange Act of 1934 (the "Exchange Act") on or after the date of this Prospectus shall be deemed to be incorporated by reference in this Prospectus and to be a part hereof from the date of filing of such documents, except for information furnished to the Commission that is not deemed to be "filed" for purposes of the Exchange Act (such documents, and the documents listed above, being hereinafter referred to as "Incorporated Documents"). Any statement contained in an Incorporated Document shall be deemed to be modified or superseded for purposes of this Prospectus

to the extent that a statement contained herein or in any other subsequently filed Incorporated Document modifies or supersedes such statement. Any such statement so modified or superseded shall not be deemed, except as so modified or superseded, to constitute a part of this prospectus.

These documents and the company's latest Annual Report to Stockholders are available to you without charge upon written or oral request. Please direct your requests for documents to:

Wal-Mart Stores, Inc.
Benefits Department
508 SW 8th Street
Bentonville, AR 72716-0295

whose telephone number is **(800) 421-1362**.

The Walmart 401(k) Plan

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401(k)

The Walmart 401(k) Plan

The Walmart 401(k) Plan resources		
Find What You Need:	Online:	Other Resources:
Enroll in or change your 401(k) contribution and your catch-up contribution	Go to mywalmart.com , the WIRE or benefits.ml.com	Call the Customer Service Center at (888) 968-4015
<ul style="list-style-type: none"> • Request a rollover packet to make a rollover contribution • Get a fee disclosure sheet • Get information about your Plan accounts • Get a copy of your quarterly statement • Request a hardship withdrawal or a withdrawal after you reach age 59½ • Change your investment fund choices • Request a payout when you leave Walmart • Get information about your Plan investment options 	Go to benefits.ml.com	Call the Customer Service Center at (888) 968-4015
• Designate a beneficiary	Go to the WIRE or mywalmart.com	

What you need to know about the Walmart 401(k) Plan

- You are generally eligible to participate in the Plan on the first day of the calendar month after your first anniversary of employment if you are credited with at least 1,000 hours during that first year.
- You can contribute from one percent up to 50 percent of each paycheck to the Plan once you are eligible.
- Walmart will make matching contributions each payroll period to an account called the “Company Match Account.” The matching contribution will be a dollar-for-dollar match on each dollar you elect to contribute to the Plan up to six percent of your eligible annual pay for the Plan year.
- You will always be 100 percent vested in the money you contribute to Your 401(k) Account and the money Walmart contributes to your Company Match Account
- You choose how to invest all contributions to your account, including your Company Match Account.
- If you do not elect how your current contributions to the Plan will be invested, they will be automatically invested in the Plan’s default investment alternative, currently the *myRetirement Funds*.
- You pay no federal income tax on contributions or any investment earnings until you receive a payout from the Plan.

This is a summary of benefits offered under the Plan as of October 1, 2011. Should any questions ever arise about the nature and extent of your benefits, the formal language of the Plan document, not the informal wording of this summary, will govern.

Walmart 401(k) Plan eligibility

When participation begins

If you are an eligible associate, you will begin participating in the Walmart 401(k) Plan on the first day of the calendar month following your first anniversary of employment with Walmart if you are credited with at least 1,000 hours of service during that first year. For example, if your date of hire is February 15, 2011 and you are credited with 1,095 hours by February 15, 2012 (your first anniversary), then you will become a participant in the Plan on March 1, 2012. This means you can choose to contribute to the Plan from your pay and may be eligible to receive company matching contributions.

If you are not credited with 1,000 hours of service during that first year, you will begin participating on the February 1 after the first Plan year (February 1-January 31) in which you are credited with at least 1,000 hours of service. For example, if your date of hire is February 15, 2011 and you are credited with only 595 hours by February 15, 2012 (your first anniversary), but you work 1,095 hours during the February 1, 2012 - January 31, 2013 Plan year, you will become a participant in the Plan on February 1, 2013.

To begin making contributions to the Plan once you are eligible, you can enroll on [mywalmart.com](#), the **WIRE**, or through [benefits.ml.com](#) (see **Enrolling in the Plan** later in this summary).

Associates who are eligible to participate in the Plan

All associates of Wal-Mart Stores, Inc. or a participating subsidiary who satisfy the requirements are eligible to participate in the Plan, except:

- Leased employees; Non-resident aliens with no income from U.S. sources; Independent contractors or consultants;
- Anyone not treated as an employee of Walmart or its participating subsidiaries;
- Associates covered by a collective bargaining agreement, to the extent that the agreement does not provide for participation in this Plan; and
- Associates represented by a collective bargaining representative after Walmart has negotiated in good faith to impasse with the representative on the question of benefits.

For purposes of this summary plan description, all participating subsidiaries are referred to as "Walmart".

Special provisions for former employees of VUDU, Inc.

The employment of VUDU, Inc. associates was transferred to Walmart on or about June 5, 2010 and those associates became immediately eligible to participate in this Plan. In addition, these transferred associates are also entitled to credit under the Plan for prior service with VUDU, Inc. for all Plan purposes.

The VUDU, Inc. 401(k) Plan was frozen as of June 5, 2010 and no new participants will enter the plan, and no additional contributions will be made to the plan, after such date (other than contributions related to periods ending on or before June 5, 2010).

Special provisions for former employees of Kosmix Corp.

The employment of Kosmix Corp. associates will be transferred on January 1, 2012, and those associates will become immediately eligible to participate in this Plan. In addition, these transferred associates are also entitled to credit under the Plan for prior service with Kosmix Corp. for all Plan purposes.

How hours of service are credited under the Plan

For hourly associates, hours of service are credited as follows:

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

For management associates and truck drivers, hours of service are credited as follows:

- Management associates and truck drivers are credited with 190 hours per month for each month in which they work at least one hour for Walmart or a subsidiary.

- In general, you must work at least six months of the Plan year to have 1,000 hours credited for the year. (Vacation pay after you leave Walmart will not give you an additional 190 hours of credit.)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994, veterans who return to Walmart after a qualifying deployment, may be eligible to have their qualified military service considered toward their hours of service under the Plan. If you think you may be affected by this rule, call Benefits Customer Service at (800) 421-1362 for more details.

Enrolling in the Plan

Shortly before you become eligible for participation in the Plan, you will receive an enrollment packet at your home address on file. This packet tells you how you can make contributions from your pay on a pretax basis into Your 401(k) Account and explains how you can direct the investment of your Plan funds from among a menu of investment options with varying investment objectives and associated risks. Because the Plan is intended to be an important source for your financial security at retirement, you should read all information pertaining to the Plan carefully, and consult with your family, tax and financial advisors before making any decisions.

When making elections regarding your contributions to the Plan keep in mind that Walmart will match all of your contributions dollar-for-dollar up to six percent of eligible annual pay in any Plan year. You will always be 100 percent vested in Your 401(k) Account and the Company Match Account.

To begin making contributions to the Plan once you are eligible, you can enroll online at [mywalmart.com](#), the **WIRE**, or [benefits.ml.com](#) or by calling the Customer Service Center at **(888) 968-4015**. You can enroll at any time after you become eligible.

When you enroll, you can choose:

- The percent you want to contribute on a per pay period basis (see **Making contributions to Your 401(k) Account** later in this summary); and
- How to invest your account among the Plan's investment options. The Plan's investment funds and procedures are described in the enrollment packet.

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

Your contributions to the Plan will be effective as soon as administratively feasible, normally within two pay periods. No contributions will be taken from your pay before you become an eligible participant in the Plan. Only participants who elect to contribute their own funds to the Plan will have those contributions matched by the Company.

It is your responsibility to review your paychecks to confirm that your election was implemented. If you believe your election was not implemented, you must timely notify the Customer Service Center at **(888) 968-4015**, but in no event later than six months after your election, for corrective steps to be taken. If you do not timely notify the Customer Service Center, the amount that is being withheld from your paycheck will be treated as your deferral election.

Your Walmart 401(k) Plan accounts

The Walmart 401(k) Plan consists of several accounts.

You will have some or all of the following accounts:

- Your 401(k) Account — This account holds your contributions to the Plan (including your catch-up contributions, if any) adjusted for earnings or losses on those contributions.
- Company Match Account – This account holds Walmart's matching contributions adjusted for earnings or losses on those contributions.
- 401(k) Rollover Account —This account holds any contributions that you rolled over to this Plan from another eligible retirement plan adjusted for earnings or losses on those contributions.
- Company Funded 401(k) Account — This account holds the discretionary Company contributions to the 401(k) portion of the Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.

- Company Funded Profit Sharing Account —This account holds the discretionary Company contributions to the profit sharing portion of the Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.

The chart on the following page provides a summary of some of the differences between these accounts. These differences are discussed in more detail throughout this summary.

Making a rollover from a previous employer's plan or IRA

When you come to work for Walmart, you may have pretax funds owed to you from a previous employer's retirement plan (including a 401(k) plan, a profit sharing plan, a 403(b) plan of a tax-exempt employer or a 457(b) plan of a governmental employer). If so, you may be able to have that money rolled over to this Plan. You may also roll over pretax funds you have in an Individual Retirement Account (IRA). If you roll over funds to this Plan, you should keep these points in mind:

- If you are an eligible associate, you may go ahead and roll over money to the Plan even though you have not yet satisfied the 1,000 hour and 12-month waiting period requirement to become a participant in the Plan;
- Once you roll funds into the Walmart 401(k) Plan, those funds will be subject to the rules of this Plan, including payout rules, and not the rules of your former employer's plan or your IRA;
- Your rollover contribution will be placed in your 401(k) Rollover Account and will be 100 percent vested.

If you're interested in making a rollover contribution to the Plan, you should contact the Customer Service Center at **(888) 968-4015** and request a rollover packet.

Making contributions to Your 401(k) Account

After you become a participant in the Plan, you may choose to contribute from one percent up to 50 percent (in whole percentages) of each paycheck to Your 401(k) Account. Your contributions in any calendar year, however, may not exceed a limit set by the IRS. For 2011, the limit is \$16,500. This amount will be increased from time to time by the IRS. You are always 100 percent vested in all amounts contributed into Your 401(k) Account.

The IRS limits the amount of annual compensation that can be taken into account under the Plan for any participant. For 2011, this limit is \$245,000.

Your 401(k) contributions to the Plan are deducted from your pay before federal income taxes are withheld. This means that you don't pay federal income taxes on amounts you pay to the Plan. Earnings on these contributions continue to accumulate tax-free and are not taxed until they are actually distributed to you from the Plan. You may also save on state and local taxes as well, depending on your location. Please note that your contributions are subject to Social Security taxes in the year the amount is deducted from your pay. Payouts from the Plan, however, are not subject to Social Security taxes.

In addition, if you contribute your own pay to Your 401(k) Account, you may be eligible for a "Saver's Tax Credit." If you are a married taxpayer who files a joint tax return with an adjusted gross income (AGI) of \$56,500 or less (for 2011) or a single taxpayer with \$28,250 or less (for 2011) in AGI on your tax return, you are eligible for this tax credit, which can reduce your taxes. For more details, your tax preparer may refer to IRS Announcement 2001-106.

Profit Sharing and 401(k) account differences					
	Source of Contributions:	May Participants Choose Investments?:	Vesting:	Are Hardship Withdrawals Available?:	Are In-Service Withdrawals Available after Age 59½?:
Your 401(k) Account	You	Yes	100 percent	Yes	Yes
Company Match Account	Walmart	Yes	100 percent	No	Yes
401(k) Rollover Account	You	Yes	100 percent	Yes	Yes
Company Funded 401(k) Account	Walmart	Yes	100 percent	No	Yes
Company Funded Profit Sharing Account	Walmart (Except for rollovers you made to the Profit Sharing Plan)	Yes	2 years – 20 percent 3 years – 40 percent 4 years – 60 percent 5 years – 80 percent 6 years – 100 percent (Rollovers are 100 percent vested)	No	Yes (to the extent vested)

How your 401(k) contribution is determined

The percentage of pay you elect to contribute to the Plan will be applied to the following pay:

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

- Differential wage payments you receive from Walmart while you are on a qualified military leave. This means that the contribution you have in effect when you go on the leave will continue to be applied to your differential wage payments while you are on the leave unless you change your election.

Your contribution will not be withheld from:

- The 15 percent Walmart match on the Associate Stock Purchase Plan;
- Reimbursement for expenses like relocation;
- Equity income, including income from stock options or restricted stock rights; or
- A final paycheck upon your termination of employment that is paid prior to the end of a normal pay cycle (unless it is administratively practicable to withhold your contribution from that paycheck).

Changing your 401(k) contribution amount

You can increase, decrease, stop, or begin your contributions at any time by logging on to **mywalmart.com**, the **WIRE**, or **benefits.ml.com**. You may also call the Customer Service Center at **(888) 968-4015**. Your change will be effective as soon as administratively feasible, normally within two pay periods. If you change your contribution amount, a confirmation notice will be sent to your home address or you will receive an email notification when the confirmation is available if you have chosen electronic delivery of Plan documents. It is your responsibility to review your paychecks to confirm that your election was implemented. If you believe your election was not implemented, you must timely notify the Customer Service Center at (888) 968-4015, but no later than six months after your election, for corrective steps to be taken. If you do not timely notify the Customer Service Center, the amount that is being withheld from your paycheck will be treated as your deferral election.

If you are age 50 or above (catch-up contributions)

If you are age 50 or above (or will be age 50 by the end of the applicable calendar year) and you are contributing up to the Plan or legal limits, you are allowed to make additional contributions. These are called catch-up contributions and are made by payroll deduction just like your normal contributions. For 2011, your catch-up contributions may be any amount up to the lesser of \$5,500 or 75 percent of your eligible annual pay. This amount may be adjusted from time to time by the IRS. Your catch-up contributions will be credited to Your 401(k) Account.

For example, if you elect to contribute the maximum amount of \$16,500 in the 2011 calendar year, or if you elect to contribute the maximum percentage of your eligible annual pay allowed under the Plan, you could elect to contribute up to an additional \$5,500 during the 2011 calendar year. If you are interested in making catch-up contributions, you can enroll online at **mywalmart.com**, the **WIRE**, **benefits.ml.com**, or by calling the Customer Service Center at **(888) 968-4015**.

Contributing to more than one plan during the year

The total amount of contributions you can make to this Plan and to any other employer plan (including 403(b) annuity plans, simplified employee pensions or other 401(k) plans) is \$16,500 for the 2011 calendar year. (Your catch-up contributions do not count toward this limit.) This amount may be increased from time to time by the IRS. If you contribute to more than one plan during the year, it is your responsibility to determine if you have exceeded the legal limit.

If your total contributions go over the legal limit for a calendar year, the excess must be included in your income for that year and will be taxed. In addition, you may be taxed a second time when the excess amount is later paid to you (after you terminate employment). For this reason, you may wish to request that the excess amount be returned to you. If you wish to request that the excess be returned to you from this Plan, you must contact Benefits Customer Service at **(800) 421-1362** no later than March 1st following the calendar year in which the excess contributions were made. Any matching contributions related to refunded contributions will be forfeited.

If you have qualified military service

If you miss work because of qualified military service, you may be entitled under the Uniformed Services Employment and Reemployment Rights Act of 1994 to make up contributions you missed during your military service (that is, to make contributions equal to the amount you would have been eligible to make if you were working for Walmart).

Because you will only have a certain period of time after you return to work to make these contributions (generally three times the period of military service, up to five years) you should contact Benefits Customer Service at **(800) 421-1362** if you think you may be affected by these rules.

Walmart's contributions to your Company Match Account

Walmart will make matching contributions to your Company Match Account equal to 100 percent of your contributions to Your 401(k) Account, including catch-up contributions, up to six percent of your eligible annual pay for the Plan year. The company matching contribution will be made each pay period in which you make a deferral and will continue until the full amount of the company matching contribution for which you are eligible for that Plan year is made into your Company Match Account. Your eligible annual pay for this purpose is the same as outlined above for determining your 401(k) contributions to the Plan.

As previously noted, if you miss work because of qualified military service, you may be entitled under the Uniformed Services Employment and Reemployment Rights Act of 1994 to make up 401(k) contributions that you missed during your military service. If you do make-up any 401(k) contributions, Walmart is required to make-up matching contributions you would have received with respect to those contributions. If you think this rule may apply to you, you should contact Benefits Customer Service at **(800) 421-1362**.

Vesting in your Company Match Account

You are always 100 percent vested in Walmart's matching contributions to your Company Match Account.

Vesting in your Company Funded Profit Sharing Account

If you have a Company Funded Profit Sharing Account (see **Your Walmart 401(k) Plan accounts** earlier in this summary) the vested percentage of your Company Funded Profit Sharing Account is the portion that you are entitled to receive if you leave Walmart. Your account statements show your vested percentage.

You become vested in your Company Funded Profit Sharing Account (other than rollovers in that account, which are always 100 percent vested) depending on your years of service with Walmart:

Profit Sharing vesting schedule*	
Years of Service:	Vested Percentage:
Less than two	0 percent
Two	20 percent
Three	40 percent
Four	60 percent
Five	80 percent
Six or more	100 percent

* Applies to participants actively employed on or after January 31, 2008.

Note: If you terminated employment before January 31, 2008, your payout was based on the prior vesting schedule and not the vesting schedule shown above.

A year of service for this purpose is a Plan year (February 1-January 31) in which you are credited with at least 1,000 hours of service under the hours of service rules (see **How hours of service are credited under the Plan** earlier in this summary). If you are credited with less than 1,000 hours in a Plan year, your vesting does not increase. (Please note that years of service for this purpose are not determined by your anniversary date.)

If you leave Walmart because of retirement (at age 65 or older), death, or total and permanent disability, Your Company Funded Profit Sharing Account will be 100 percent vested, regardless of your years of service. Your Company Funded Profit Sharing Account will also be 100 percent vested if the Plan is ever terminated.

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

Vesting in your Company Funded 401(k) Account

You are always 100 percent vested in Walmart's contributions to your Company Funded 401(k) Account.

Investing your accounts

Your investment options

You decide how your accounts will be invested. You can choose:

- The *myRetirement Funds*. The *myRetirement Funds* are a series of customized investment options created solely for Plan participants by the Retirement Plans Committee and are commonly known as "target retirement date" funds. The *myRetirement Funds* are diversified investment options that automatically change their asset allocation over time to become more conservative as a participant gets closer to retirement. This is done by shifting the amount of money that is invested in more aggressive investments, such as stocks, and allocating those amounts to more conservative investments, such as bonds and money market funds, as a participant nears retirement. "*myRetirement Funds*" is a term developed by Walmart for describing its funds specific to the Plan and is pending proprietary protection as a registered trademark.
- From among a menu of investment options made available under the plan except that Walmart stock is not an investment option with respect to Your 401(k) Account, your Company Funded 401(k) Account, your Company Match Account and your 401(k) Rollover Account (or any rollovers in your Company Funded Profit Sharing Account). (To the extent Your 401(k) Account, your Company Funded 401(k) Account, your 401(k) Rollover Account or rollovers in your Company Funded Profit Sharing Account were invested in Walmart stock on June 15, 2007, however, they can remain invested in Walmart stock. Once the Walmart stock is sold from the accounts, it cannot be repurchased.)

You may choose one of the investment options or you may spread your money among the various investment choices. The investment gains or losses on your accounts will depend upon the performance of the investments you choose.

If you do not make an investment choice for current contributions to your account, they will be invested in one of the *myRetirement Funds* based on your age. For more information, refer to the Important Notice Regarding Your Investment Rights under the Walmart 401(k) Plan and your enrollment packet. These documents can both be obtained by going to **benefits.ml.com** or by calling the Customer Service Center at **(888) 968-4015**.

Because the Company Funded Profit Sharing Account is an Employee Stock Ownership Plan, profit sharing assets, as a whole, are significantly invested in Walmart stock. For Plan years ending prior to January 31, 2006, all or a significant portion of Walmart's profit sharing contribution was invested in Walmart stock. If you were a participant in the Plan prior to that date, you may have Walmart stock in your Company Funded Profit Sharing Account. For Plan years ending January 31, 2007, or later, Walmart's profit sharing contribution was not invested in Walmart stock.

A description of all investment options, including the *myRetirement Funds*, is included in the enrollment packet you receive when you are eligible to enroll. You also may obtain additional information for each investment option, free of charge, by accessing your account online at **benefits.ml.com** or by calling the Customer Service Center at **(888) 968-4015**.

Please note that this Plan is intended to be an "ERISA Section 404(c) plan." This means that you assume all investment risks connected with the investment options you choose in the Plan, or in which your funds are invested if you fail to make investment selections, including the increase or decrease in market value. Walmart, the Retirement Plans Committee and the trustee are not responsible for losses to your accounts as a result of investment decisions you make or, if you fail to make an affirmative investment decision, as a result of your accounts being invested in a default fund.

If you have a Company Funded Profit Sharing Account (see **Your Walmart 401(k) Plan accounts** earlier in this summary) and you choose to invest some or all of your Company Funded Profit Sharing Account in Walmart stock or retain Walmart stock in your other accounts, be aware that since this option is a single stock investment, it generally carries more risk than the funds offered through the Plan.

The importance of diversification

How to obtain more investment information

It is also important to periodically review your investment portfolio, your investment objectives, and the investment options under the Plan to help ensure that your investments are in line with your objectives and your risk tolerance. If you would like more sources of information on individual investing and diversification, you may go to the website of the Department of Labor, <http://www.dol.gov/ebsa/investing.html>.

You may obtain more specific information regarding your investment rights and investment options under the Plan at **benefits.ml.com** or by calling the Customer Service Center at **(888) 968-4015**.

Changing your investment choices

You can change your investment choices at any time online at **benefits.ml.com** or by calling the Customer Service Center at **(888) 968-4015**. If you make an investment change, a confirmation notice will be sent to your home address or you will receive an email notification when the confirmation is available if you have chosen electronic delivery of Plan documents. If you don't receive a confirmation notice or you do not see that your change is applied, it is your responsibility to contact the Customer Service Center at **(888) 968-4015** to make sure your change has been implemented.

If you call the Customer Service Center at **(888) 968-4015** prior to 3:00 p.m. Eastern time, your investment change generally will be applied on the day you call. If your call is after 3:00 p.m. Eastern time, your investment change generally will be applied on the following business day. If, however, your account is invested in Walmart stock and you wish to transfer your money to another investment, there is a three-day settlement time required by the Securities and Exchange Commission before your funds can be transferred to the new investment fund. There is a two-day settlement time required for transfers from other Plan investment options to Walmart stock. A transfer from a fund or trust to another fund or trust occurs on the same day. Purchases and sales will generally be valued on the date your investment election is given effect under the Plan.

More about owning Walmart stock

If any part of your account is invested in Walmart stock through the Plan, each year you will receive all of the materials generally distributed to the shareholders of Walmart, including an instruction card telling the trustee how to vote your shares in your Plan account.

You can instruct the trustee, through the company's transfer agent, to vote Walmart stock held in your Plan accounts. This usually occurs in May of each year.

Your instructions to the transfer agent and the trustee are kept confidential at all times. You will send your voting instructions directly to the transfer agent, who will compile the votes and notify the Retirement Plans Committee of the total votes cast. The Retirement Plans Committee will then notify the Plan trustee of the total votes that are to be cast. Neither Walmart nor the Retirement Plans Committee will know how any individual participant voted (except as necessary to comply with securities laws).

If you do not instruct the trustee how to vote your shares, the Retirement Plans Committee will vote these shares at its discretion. If neither you nor the Retirement Plans Committee exercise voting rights, the trustee or an independent fiduciary appointed by the trustee may vote the unvoted shares.

Dividends on your Walmart Stock

If you have Walmart stock in your accounts, your accounts will be credited with any dividends paid by Walmart with respect to its stock. Dividends allocated to Your 401(k) Account, your Company Funded 401(k) Account, or your 401(k) Rollover Account will be automatically reinvested in Walmart stock. Dividends allocated to your Company Funded Profit Sharing Account will also be reinvested in Walmart stock, except as noted below.

If you are an active participant with six or more years of service, you have an option to take a cash payout of any dividends paid on Walmart stock held in your Company Funded Profit Sharing Account. Also, if you are a terminated participant who had more than six years of service when you terminated and you continue to maintain your balance in the Plan after you leave, you will have the option to elect a cash payout of dividends paid on Walmart stock held in your Company Funded Profit Sharing Account. If you do not receive cash, your dividend will be reinvested in Walmart stock.

You may make an election anytime by contacting the Customer Service Center online at **benefits.ml.com** or by calling **(888) 968-4015**. Your most recently filed election will apply to all subsequent dividends until you change your election. (You may change your election only once each business day.) Keep in mind that your election must be made no later than the close of business on the day prior to the record date for the dividend in order to be effective for that dividend. You will not be able to make any elections or election changes during the period from the record date of the dividend through the dividend pay date (which is usually three to four weeks after the record date).

Each year, Walmart releases the quarterly record dates for dividend payouts. You can find this information on **walmart.com**. You may also contact Customer Service at **(888) 968-4015** if you need information about upcoming record dates for dividends. You should keep in mind that a dividend payout will be taxable to you.

Please note that if you request a hardship payout from Your 401(k) Account within five business days of the record date for a dividend and you have the right to elect a cash distribution of the dividend, tax laws require that the dividend be automatically paid to you in cash.

Account balances and statements

At least once a year, you'll receive a statement on your accounts showing contributions made by you and by Walmart, if any, the performance of your investment funds, and the values of your accounts. You can easily get information about your accounts, including a quarterly statement, at any time online at **benefits.ml.com** or by calling the Customer Service Center at **(888) 968-4015**. You can also request a paper copy of any quarterly statement at any time free of charge by calling the Customer Service Center at **(888) 968-4015**.

Fees charged to your account

In general, the administrative costs of the Plan are being paid as follows:

- Plan administrative expenses for active associates will be paid out of the Plan's forfeiture account. The forfeiture account contains unvested profit sharing contributions of associates who have separated from service. Any amounts remaining in the forfeiture account at the end of the year (if not held for Plan expenses) may be used to reduce Walmart's matching contribution. If there is a shortfall, an administrative fee may be assessed against the Plan accounts of active associates to cover the remaining costs of the Plan;
- Accounts of former associates with a balance in the Plan will be assessed an annual recordkeeping fee;
- Participants receiving a distribution will be assessed a check fee per distribution from the Plan; and
- Participants accounts subject to a Qualified Domestic Relations Order will be assessed an administrative fee.
- Participants buying or selling Walmart stock will be assessed a brokerage fee to cover the costs of the transaction.

The Plan also makes available a Plan Fees Document, which contains a list of fees associated with the Plan, including both administrative fees and expenses that apply to each investment option. You may obtain a copy of this list, as well as additional information about each investment option, by accessing your account at **benefits.ml.com** or by calling the Customer Service at **(888) 968-4015**.

Receiving a payout while working for Walmart

Generally, you are not entitled to a payout from the Walmart 401(k) Plan until you stop working for Walmart. However, in the following limited situations you may be entitled to receive a payout of some or all of your accounts while you're still working:

- In the case of a financial hardship (as defined by the IRS); and
- After you attain age 59 ½.

It's important to understand how any type of payout from the Walmart 401(k) Plan affects your tax situation. For more information, see **The income tax consequences of a payout** later in this summary.

Financial hardship withdrawals

You may withdraw some or all of Your 401(k) Account (other than earnings on those contributions) and your 401(k) Rollover Account necessary to meet a "financial hardship."

Under IRS guidelines, a financial hardship may exist if the request is for:

- Payment of medical care expenses not covered by insurance for you, your spouse or your dependents;
- Costs directly related to the purchase of your primary residence (home);
- Payment of tuition, fees and room and board expenses for up to the next 12 months of post-high school education for you, your spouse or your dependents;
- Payments necessary to prevent eviction from, or foreclosure on, your primary residence;
- Payment for burial or funeral expenses for your deceased parent, spouse, children or dependent; or
- Expenses for the repair of damage to your principal residence which would qualify for a casualty deduction under federal income tax rules.

Federal tax law requires that you must have already obtained all available age 59 ½ in-service payouts before you can request a financial hardship payout.

Also, federal tax laws will not allow you to contribute to this Plan and certain other retirement or stock purchase plans (including the Associate Stock Purchase Plan) for six months after the date of your financial hardship payout. If you are a management associate with stock options, you may not exercise options during this six-month period. Also, please note that if you request a financial hardship payout within five business days of the record date of a dividend and you are entitled to elect a cash payout of that dividend, the dividend will automatically be distributed to you in cash.

A financial hardship payout is immediately taxable to you, including a 10 percent penalty tax if you are under age 59 ½ or if the payout is not for certain medical purposes. For more information, see **The income tax consequences of a payout** later in this chapter.

You can make a request for a financial hardship payout online at benefits.ml.com or by calling the Customer Service Center at **(888) 968-4015**.

Withdrawals after you reach age 59 ½

Any time after you reach age 59 ½, you may elect to withdraw all or any portion of your Plan accounts, to the extent vested, even though you are still working for Walmart. You can make a request for a withdrawal online at **benefits.ml.com** or by calling the Customer Service Center at **(888) 968-4015**.

Special provisions for former participants in the Wal-Mart.com USA, LLC 401(k) Plan

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

If you die: your designated beneficiary

In the event of your death, your entire Plan balance will be paid out to your beneficiary. It is very important for you to keep your beneficiary information up to date. Beneficiary choices should be made at mywalmart.com or on the **WIRE**. Since your spouse has certain rights in the death benefit, you should immediately update your beneficiary election if there is a change in your marital status.

If you are married and wish to name someone other than your spouse as your designated beneficiary, your spouse must consent to that designation. You must complete the Alternate Beneficiary Form for Married Participants Form B and your spouse must complete the Spousal Consent form. The Spousal Consent form must be notarized and must accompany the Form B in order to be valid.

Form B and the Spousal Consent form can be found on the **WIRE**, or you may talk to the Personnel Representative at your facility. Any beneficiary designation you make will be effective with respect to all of your accounts in the Plan – your 401(k) accounts and your Profit Sharing accounts.

If you do not designate a beneficiary, your death benefit will be distributed in accordance with the Plan's default provisions in the following order, as stated below:

- Living spouse
- Living children (stepchildren are not included)
- Living parents
- Living siblings
- The estate

Please note that if you designate your spouse as your beneficiary and you later divorce, your designation will not be effective after the divorce unless you complete a new designation form. Similarly, if you are unmarried and later marry, your prior beneficiary designation will not be effective after the marriage unless you complete a new designation form with your spouse's consent.

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

Beneficiary designations made before October 31, 2003

If you made a beneficiary designation under the 401(k) Plan before October 31, 2003, that designation will continue to apply to Your 401(k) Account, your Company Funded 401(k) Account and your 401(k) Rollover Account. Similarly, if you made a beneficiary designation under the Profit Sharing Plan before October 31, 2003, that designation will continue to apply to your Company Funded Profit Sharing Account.

Any beneficiary designation you make after October 31, 2003, however, will be effective with respect to all of your accounts in the Plan—both those in the 401(k) part of the Plan and those in the Profit Sharing part of the Plan.

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

If you get divorced

If you go through a divorce, all or part of your Plan balance may be awarded to an "alternate payee" in the court order, called a "Qualified Domestic Relations Order" or (QDRO). An alternate payee may be your spouse or former spouse, child, or other dependent. Because there are very strict requirements for these cases, you should contact Benefits Customer Service and get a free copy of the procedures your attorney should use in drafting the court order. After the court order is sent to Benefits Customer Service, it must be reviewed to determine if it meets legal requirements for this type of order and will take a period of time to be processed. The administrative fee for processing your QDRO will be charged to your 401(k) account.

If you leave Walmart

When you stop working for Walmart, you are entitled to receive a payout of all of your vested accounts in the Plan. It is important to understand how any type of payout from the Walmart 401(k) Plan affects your tax situation. For more information, see **The income tax consequences of a payout** later in this summary.

You may elect to receive your payout 30 calendar days after your termination is actually entered into Walmart's payroll system. For example, if your termination is entered into and processed by the payroll system on July 20, 2012, you may elect your payout on or after August 19, 2012.

A notice will normally be mailed to your home address after you leave Walmart and its subsidiaries to inform you that you are entitled to payment. Please make sure that your address is correct on your payroll check when you leave Walmart or a participating subsidiary or that you give a forwarding address during your exit interview. If you have not received any information regarding your payout within 60 days of your termination date, you should contact the Customer Service Center at **(888) 968-4015**. To obtain your payout, you will need to access your account on [benefits.ml.com](#) or by calling the Customer Service Center at **(888) 968-4015**.

Your consent to the payout is not required and your payout will automatically be made to you:

- If your total vested Plan balance (both profit sharing and 401(k) accounts) is or becomes \$1,000 or less. This automatic payout will be made as soon as possible after the last business day of the third calendar month following the calendar month in which your termination date is actually entered into Walmart's payroll system, unless you consent to an earlier payout as described above. In the example above, if your account is eligible for automatic payout and you do not consent to payout on August 19, 2012, your payout will automatically be made to you as soon as possible after October 31, 2012; or
- If you are over age 65 regardless of the amount of your total vested Plan balance. This automatic payout will be made as soon as possible after the last business day of the second calendar month following the calendar month in which you turn age 65, unless you consent to an earlier payout as described above. If you turn age 65 in July 2012 and your account is eligible for automatic payout, and you do not consent to payout, your payout would automatically be made on the first scheduled force-out date after September 30, 2012.

If your total vested Plan balance is more than \$1,000 and you are under age 65, you must consent to your payout. Payout will be made as soon as possible after your consent is received by the Customer Service Center at **(888) 968-4015** but no earlier than 30 calendar days after your termination is actually entered into Walmart's payroll system.

If you wish, you can delay your payout until any date up to age 65, but your Plan balance will be subject to an annual maintenance fee. If you choose to delay your payout, you will be able to continue to make changes in your investment choices just as you did while you were an active participant in the Plan.

If you return to work with Walmart before your payout is completed, the payout will be canceled and no payout will be made from your account.

The amount of your payout

The entire value of Your 401(k) Account, your Company Funded 401(k) Account, your 401(k) Rollover Account, and the Company Match Account will be paid out to you. In addition, if you have a Company Funded Profit Sharing Account (see **Your Walmart 401(k) Plan accounts** earlier in this summary) you will also be paid the value of the vested portion of your Company Funded Profit Sharing Account. You will forfeit (give up) the remainder of your Company Funded Profit Sharing Account, as explained in the **Vesting in your Company Funded Profit Sharing Account** earlier in this summary.

The amount you will receive will be based on the value of your accounts as of the date the payout is processed. If a cash payout is made directly to you rather than being rolled over to an IRA or other employer plan, applicable taxes will be withheld from your check.

A check processing fee will be applied to your Plan balance when it is paid out to you.

How you receive your payout

You have several options for receiving your payout.

Your accounts will be distributed in a single lump sum payment directly to you, unless you elect to roll them over to an IRA or to another employer's retirement plan.

Your accounts will normally be paid to you in cash. However, you may elect to have your Company Funded Profit Sharing Account distributed to you in the form of Walmart stock (even if it is not invested in Walmart stock at the time your payout is processed) or partly in cash and partly in Walmart stock. You may also elect to have Your 401(k) Account, your Company Funded 401(k) Account and your 401(k) Rollover Account paid to you in Walmart stock to the extent those accounts are invested in Walmart stock at the time your distribution is processed. Any part of those accounts that is not invested in Walmart stock at the time of your payout will be distributed in cash.

If the total of your vested accounts is \$1,000 or less, or if you are over age 65 regardless of the amount of your vested accounts, your payout will be made directly to you in a single cash payout. If you wish to take any of your payout in the form of Walmart stock or if you wish to roll over your payout to an IRA or other employer plan, you must contact the Customer Service Center at **(888) 968-4015** with your payout instructions within the time period shown in your payout notice. If you fail to contact the Customer Service Center at **(888) 968-4015** in a timely manner, your payout will be made in a single cash payment to you.

If the total of your vested accounts in the Plan is more than \$1,000, your payout will not be made until you make an election as to the form of payout and consent to the distribution or until you reach age 65. To obtain your payout, you should contact the Customer Service Center at **(888) 968-4015**.

If you leave and are then rehired by Walmart

If you leave Walmart and its subsidiaries after your participation in the Plan began and are later rehired by Walmart or a participating subsidiary, you will automatically be eligible to participate on your rehire date. Similarly, if you leave Walmart and its subsidiaries after you have met the 1,000-hour requirement but before your actual participation date, you will become a participant on the later of the date you would have initially become a participant or your rehire date. If you were not a participant when you left, or had not satisfied the 1,000-hour requirement, you will be treated as a new associate on rehire and will be required to complete the eligibility requirements (see **When participation begins** earlier in this summary) in order to become a participant in the Plan.

The nonvested portion of your Company Funded Profit Sharing Account

When you terminate employment, the portion of your Company Funded Profit Sharing Account that is not vested (if any) will not be paid to you. This nonvested amount is called a "forfeiture."

- If you receive a total payout of your vested Plan balance after your termination of employment and while your Company Funded Profit Sharing Account is partially vested, the nonvested portion of your Company Funded Profit Sharing Account will be forfeited on the date of your payout.
- If you do not receive a total payout of your vested Plan balance after your termination of employment, the nonvested portion of your Company Funded Profit Sharing Account will not be forfeited until you have five consecutive "breaks in service." A break in service is a Plan year (February 1-January 31) in which you are credited with less than 500 hours of service. If you are absent from work due to an FMLA leave and have worked less than 500 hours in the Plan year, you will be credited with enough hours to get you up to 500 hours so that you will not incur a break in service.

The nonvested portion of your Company Funded Profit Sharing Account that was forfeited will be reinstated (at its former value) if you are rehired by Walmart or a participating subsidiary before you have five consecutive breaks in service and you pay back to the Plan the total amount of your payout within five years after your rehire. If you return to work with Walmart or a participating subsidiary after five or more consecutive breaks in service, or if you chose not to repay your payout as discussed above, the nonvested portion of your Company Funded Profit Sharing Account that was forfeited will not be reinstated.

If you were zero percent vested in your Company Funded Profit Sharing Account when you terminated employment, your non-vested Company Funded Profit Sharing Account will automatically be reinstated if you are rehired prior to five consecutive breaks in service.

Forfeitures of your nonvested Company Funded Profit Sharing Account generally are used to pay Plan expenses and for certain other purposes, such as to restore account balances as discussed above. Any remaining forfeitures will be used to reduce Walmart's matching contribution.

Your years of service with Walmart before you left will be counted for purposes of determining your vesting in Walmart's contributions to your Company Funded Profit Sharing Account after you are rehired.

The income tax consequences of a payout

The tax consequences of your participation in the Plan are your responsibility. This explanation is only a brief description of the U.S. federal tax consequences related to your participation in the Plan. This description is based on current law and current interpretations of the law by the Internal Revenue Service. Because the law is subject to change and because the application of the law may vary depending on your particular circumstances, this description is general in nature and you should not rely on it in determining your tax consequences. You are strongly urged to consult a tax advisor with respect to your particular situation.

Walmart is entitled to a deduction on the amount of its contributions, as well as your contributions, to the Plan. Your contributions and Walmart's contributions to the Plan, as well as earnings on those contributions, generally are not subject to federal income taxes until paid to you.

Postpone paying taxes on payouts through a rollover

Although payouts from the Plan are subject to federal income taxes, the Internal Revenue Code provides favorable tax treatment to payouts in certain circumstances. For example, you can postpone paying taxes on your payout if you direct the Plan to issue your check directly to an IRA or to another employer's qualified retirement plan, a 403(b) plan, or a governmental 457 plan. This is called a direct rollover. (The check will be made payable to the IRA or other plan trustee and it will be delivered to you or your IRA or rollover institution. If the check is mailed to you, you will be responsible for delivering it to the IRA or other plan trustee within 60 days.) If you handle your payout in this manner, no taxes will be withheld from the amount you are rolling over and such amount will not be taxed until you later receive a payout from the IRA or other plan.

If you do not direct your payout to be directly rolled over, federal law requires that Walmart withhold 20 percent of the payout for federal taxes, in addition to any required state withholding. In some cases, 20 percent withholding may not be enough, which could mean that you will owe additional taxes when you file your income tax return.

If you do not elect a direct rollover (and instead receive an actual Plan distribution), you may still roll over those funds to an IRA or an employer's qualified retirement plan, 403(b) plan, or governmental 457 plan, as long as you do so within 60 calendar days after you received the distribution. The amount rolled over will not be subject to federal income tax until you take it out of the IRA or other plan. If you want to roll over 100 percent of your payout to an IRA or other plan, however, you will have to use other money to replace the 20 percent that was withheld from your payout. If you roll over only the 80 percent that you received, you will be taxed on the 20 percent that was withheld and that is not rolled over.

Note: You may roll over all or any portion of your account that is eligible for rollover to a Roth IRA. Any amount rolled over that would have been taxable if not rolled over will be taxable at the time of the rollover to the Roth IRA. (Note that you may voluntarily choose to have taxes withheld from amounts you roll over to a Roth IRA.)

Early withdrawal penalty

In addition to the income tax withholding, if you take a payout prior to age 59½ rather than rolling it over, in most cases you will be subject to a 10 percent early withdrawal penalty by the IRS. There are some exceptions to the penalty, such as death, disability, retirement after age 55 and payouts for certain medical expenses. Special rules also apply to distributions made to reservists who are called to active duty in the military.

Taxation of payouts of Walmart stock

There are also special rules for distributions of Walmart common stock. If you receive cash (in excess of \$200) in addition to Walmart stock and the cash is not directly rolled over, some withholding may apply but not greater than the amount of cash you receive.

Generally, if you receive Walmart common stock as part of your payout that is not rolled over, you are taxed only on the value of the stock at the time it was purchased by the Plan. If the stock has increased in value since it was purchased by the Plan, you will not be taxed on this increased value, called "net unrealized appreciation," until you actually sell the stock. You can elect, however, to be taxed on this increase in value at the time of your payout. These special tax rules apply only in certain specific situations and may not be available for in-service distributions. You should consult your tax advisor to see if they apply to your payout.

You should also keep in mind that if you are eligible to elect cash payouts of dividends paid on Walmart stock held in your Company Funded Profit Sharing account, the dividend is taxable to you and is not eligible for rollover. The dividend is also taxable if you request a financial hardship payout from Your 401(k) Account within five business days of the record date for a dividend and the dividend is automatically paid out to you in cash. The dividend payout is not subject to the 10 percent early withdrawal penalty discussed above. In some cases, Walmart will be entitled to deduct dividends paid on shares subject to this election.

The tax treatment discussed above applies only to payouts to participants. Different rules may apply to payouts to beneficiaries of deceased participants and also to payouts to alternate payees (such as former spouses and dependents of participants) under Qualified Domestic Relations Orders (QDRO). Note: In some cases, a payout on behalf of a non-spouse dependent pursuant to a QDRO (e.g. state-ordered child support) may result in taxation to the participant even though the payout is made to or on behalf of the dependent alternate payee.

Filing a Walmart 401(k) Plan claim

If you think you are entitled to a benefit beyond that processed by the Plan's record keeper (Merrill Lynch), you may file a claim with the Retirement Plans Committee or its delegate at:

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

For questions about filing a claim, contact Benefits Customer Service at **(800) 421-1362**.

If your claim is partially or fully denied, you will receive written notice of the decision within a reasonable time, but no later than 90 days after Benefits Customer Service receives your claim. The Retirement Plans Committee or its delegate can extend this period for up to an additional 90 days if it determines that special circumstances require an extension of time. You will receive notice of any extension before the expiration of the original 90-day period. The written notice you receive will state the specific reasons for the denial of your claim, a specific reference to the provisions of the Plan upon which the denial is based, and a description of the review procedures and the time limits applicable to such procedures, including your right to bring a court action following a denial on appeal.

If you do not agree with the decision of the Retirement Plans Committee or its delegate, you can request a review of the decision by the Retirement Plans Committee. The Retirement Plans Committee has discretionary authority to resolve all questions concerning administration, interpretation or application of the Plan. Your request must be made in writing and sent to the Retirement Plans Committee at:

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

Your request must be made within 60 calendar days of the denial. Your written request must contain all additional information that you wish the Retirement Plans Committee to consider. If you do not request a review within this time period, you will be deemed to have waived your right to a review.

The Retirement Plans Committee will promptly conduct the review. Written notice of the Retirement Plans Committee's decision on review will be provided to you within 60 calendar days after the receipt of your request, unless special circumstances require an extension of up to 60 additional days. In those circumstances where the review is delayed to allow you to provide additional information necessary for a proper review, the length of the delay will not be included in the calculation of the 60-day deadline and extension periods set forth above. The written notice of the Committee's decision will include specific reasons for the decision and will refer to the specific provisions of the Plan on which the decision is based.

Administrative information

Plan name

The legal name of the Plan is the Walmart 401(k) Plan.

Plan sponsor and Plan administrator

Wal-Mart Stores, Inc. is the Plan sponsor. Its contact information for matters pertaining to the Plan is:

Wal-Mart Stores, Inc.
Attn: Benefits Customer Service
508 SW 8th Street
Bentonville, AR 72716-0295
(800) 421-1362

As the Plan Administrator, Wal-Mart Stores, Inc. is responsible for reporting and disclosure obligations under the Employee Retirement Income Security Act of 1974 (ERISA) and all other obligations required to be performed by plan administrators under the Internal Revenue Code and ERISA, except for those obligations delegated to the Retirement Plans Committee or the trustee of the Trust. ERISA is the federal law that imposes certain responsibilities on Walmart, the Retirement Plans Committee and the trustee with respect to our retirement benefits.

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

Plan sponsor's employer identification number

71-0415188

Named fiduciary

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

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

Plan trustee

Bank of America, N.A.
Attention: Trust Services
Merrill Lynch
1400 Merrill Lynch Drive
3rd Floor South
P.O. Box 1502
Pennington, NJ 08534

One or more trusts hold all Plan assets, such as contributions by participants and Walmart's contributions. As trustee of the Trust, Bank of America, N.A., receives and holds contributions made to the Plan in trust and invests those contributions according to the policies established under the Plan.

Agent for service of legal process

Corporation Trust Company
1209 Orange Street
Corporation Trust Center
Wilmington, DE 19801

Service of legal process may also be made on the Plan Administrator or the trustee.

Plan number

003

Plan year

February 1 through January 31

Type of plan

The Walmart 401(k) Plan is a defined contribution plan (401(k), profit sharing and employee stock ownership plan).

Assignment

Because this is a retirement plan governed by ERISA and other federal laws, your accounts cannot be assigned or used as collateral for a loan, nor can your accounts be garnished or be subject to bankruptcy proceedings. They can, however, be part of a divorce settlement, as explained in the **If you get divorced** section earlier in this summary.

No PBGC coverage

ERISA created a governmental agency called the Pension Benefit Guaranty Corporation (PBGC). One of the purposes of the PBGC is to provide plan benefit insurance. However, this insurance is only available to defined benefit pension plans and our Plan is a defined contribution plan. Therefore, benefits under the Plan are not insured by the PBGC.

Plan amendment or termination

Walmart reserves the right to amend or terminate the Plan at any time. Amendments are made by the Retirement Plans Committee with the prior written consent of the Executive Committee of Walmart's Board of Directors. Neither the Plan nor the benefits described in this summary may be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by a management associate of Walmart or a participating subsidiary, by any member of the Retirement Plans Committee, or by Merrill Lynch.

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

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

You can also contact the Customer Service Center at **(888) 968-4015**.

Statement of ERISA rights

As a participant in this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified facilities, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies. Your request must be mailed to:

Wal-Mart Stores, Inc. - ERISA Section 104(b) Request
Attn: Benefits Customer Service
508 SW 8th Street
Bentonville, AR 72716-0295

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary financial report.
- Obtain a statement telling you the current balance of your account and the portion of your account that is nonforfeitable (vested). This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and in that of other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator or the Retirement Plans Committee to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator or the Retirement Plans Committee. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator or the Retirement Plans Committee. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest regional office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Claims and appeals

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claims and
appeals

Claims and appeals

As a participant in the Associates' Health and Welfare Plan (the Plan), you have the right to appeal a decision of Plan eligibility and benefits. This chapter describes the process and the deadlines for appealing an eligibility, medical, behavioral health, dental, pharmacy, HMO plans, life insurance, disability insurance, AD&D, critical illness and accident insurance claim that has been partially or fully denied. To protect your right to appeal, it's important to follow these processes and meet the deadlines.

Claims and appeals resources	
Find What You Need:	How to contact:
Designate an authorized representative to submit claims or appeals on your behalf	Call Benefits Customer Service at (800) 421-1362
Appeal a decision on eligibility for coverage under the benefit plans	Write to: Walmart Benefits Administration Attn: Internal Appeals Address listed later in this chapter.
Submit a claim for benefits	Submit claims to the Plan's Third Party Administrators as shown later in this chapter.
Appeal the denial of a claim	Submit appeals for: <ul style="list-style-type: none"> • Medical, behavioral health and transplants to Walmart Benefits Administration • Dental to Delta Dental • Pharmacy to Medco • Life insurance, Business Travel Accident insurance and AD&D to Prudential • Disability to The Hartford • Critical Illness and Accident Insurance to Allstate Addresses for each are listed later in this chapter.

What you need to know about claims and appeals

- You have the right to appeal an adverse eligibility decision affecting your or a family member's coverage.
- You submit claims for benefits directly to the Third Party Administrator or provider of the Plan option.
- You have the right to appeal a benefit claim that has been partially or fully denied.
- You can appoint another party to appeal on your behalf. The Plan will provide the appropriate form for you to complete and sign. This is the only authorization form that will be accepted for another party to appeal on your behalf.
- After a final decision of an appeal of a medical, behavioral health or transplant claim is made by the Plan, you may have the right to request an independent external review of the decision.
- After a final decision of an appeal of a pharmacy claim is made by Medco, you may have the right to request an independent external review of the decision.
- Decisions regarding enrollment, eligibility status, and claims for the following plans are not eligible for external review, but will be eligible for voluntary review under the Plan: Dental, Life insurance, AD&D, Disability, Business Travel Accident, Critical Illness and Accident insurance.

Questions? Log on to [mywalmart.com](#) or the WIRE, or call Benefits Customer Service at [\(800\) 421-1362](tel:(800)421-1362)

Deadlines to file a claim or bring legal action

Unless otherwise specified in the chapter describing the applicable benefit, you or your dependent(s) must file an initial claim for benefits under the Plan within 12 months from the date of service (18 months if coordinating with another plan). Since the procedures for filing a claim or an appeal of a decision are different for different benefits plans, be sure to review the relevant section of this chapter for more information. You or your dependent(s) must complete the required claims and appeals process described in this **Claims and appeals** chapter before you may bring legal action or, for certain medical, behavioral health, transplant, pharmacy or dental claims, pursue an external review. You may not file a lawsuit for benefits if the initial claim or appeal is not made within the time periods set forth in the claims procedures of the Plan.

You must file any lawsuit for benefits within 180 days after the final decision on appeal (whether by the Plan or after external review). You may not file suit after that 180-day period expires. You or your dependent(s) are not required to request a voluntary review by the Plan or an external review of the decision on appeal before filing a lawsuit. If you or your dependent(s) do request a voluntary review or an external review of the decision on appeal, where applicable, the time taken by the voluntary review will not be counted against the 180 days you have to file a lawsuit.

Benefits may not be assigned

Except as specifically provided in the Plan document or the 2012 *Associate Benefits Book*, or where required under state Medicaid law or in a Qualified Medical Child Support Order, you may not transfer or assign any benefit or right under the Plan. This anti-assignment provision means that you may not assign benefits to your physician or health care provider. All such assignments will be void.

Appealing an enrollment or eligibility status decision

This section describes the appeal process that applies to enrollment and eligibility only.

If you disagree with the Plan Administrator's determination regarding your enrollment or eligibility status, you

have 365 days from your eligibility enrollment event to appeal in writing to the following address:

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

Your appeal will be handled within 60 days from the date it is received by the Plan, unless an extension is required.

The 60-day period may be extended if it is determined that an extension is necessary due to matters beyond the Plan's control. You will be notified prior to the end of the 60-day period if an extension or additional information is required. Appeals of enrollment or eligibility decisions are not eligible for external review but will be eligible for voluntary review.

If you have submitted a claim for medical, Behavioral Health, transplant or dental benefits and it has been denied due to the Plan's determination regarding your enrollment or eligibility status, see **Appealing a medical, behavioral health, transplant or dental claim that has been fully or partially denied** later in this chapter.

Medical, behavioral health, transplant and dental claim process

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

- Medical, behavioral health and transplant benefits except for HMO; see **HMO plan claims and appeals procedures** later in this chapter
- Dental benefits if you are covered by Delta Dental (PPO or Premier)
- A rescission of coverage, which is a cancellation of coverage that has a retroactive effective date, except where cancellation of coverage is due to failure to timely pay required contributions or premiums

Any review of an inquiry or pretreatment estimate by the Third Party Administrator before you file a claim for benefits or receive treatment is non-binding on the Plan and not subject to appeal.

Your initial claim will be determined by BlueAdvantage Administrators of Arkansas (for medical, behavioral health and transplant claims) or Delta Dental (for dental claims).

Within a reasonable time, but no later than 30 days after a claim is made, you will receive an Explanation of Benefits (EOB). The EOB will detail:

- The amount allowed by the Plan;
- The amount applied to your annual deductible and co-insurance, if any; and
- The amount owed by you to the provider.

If your claim is partially or fully denied, you will receive written notice of the decision no later than 30 days after the initial reviewer receives your claim.

The 30-day period may be extended for 15 days if it is determined that an extension is necessary due to matters beyond the Plan's control. You will be notified prior to the end of the 30-day period if an extension or additional information is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

The denial will include the following information:

- The specific reason(s) for the denial;
- Reference to provisions of the Plan on which the denial was based;
- Information regarding time limits for appeal;
- A description of any additional information necessary to consider your claim and why such information is necessary;
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination;
- If your denial is based on medical necessity or similar limitation, an explanation of this rule (or a statement that it is available upon request); and
- Notice regarding your right to bring legal action following a denial on appeal.

For medical, behavioral health and transplant benefits, the denial also will include:

- Information sufficient to identify the claim involved (including the date of service, health care provider, claim amount (if applicable));

—Upon written request, the Plan will provide you with the diagnosis and treatment codes (and their corresponding meanings) associated with any denied claim or appeal.

- The denial code and its meaning;
- A description of the Plan's standard for denying the claim;
- Information regarding available internal and external appeals, including how to initiate an appeal; and
- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist participants with the internal and external appeals process.

Internal appeal process

Appealing a medical, behavioral health, transplant or dental claim that has been fully or partially denied

You may request an appeal of the decision. In order for your appeal to be considered, it must:

- Be in writing;
- Be sent to the correct address;
- Be submitted within 365 days of the date of the initial denial; and
- Contain any additional information/documentation you would like considered.

Send your written request for review of the initial claim to:

**Medical, Behavioral Health and Transplant Appeals
Walmart Benefits Administration**

Attn: Internal Appeals

**508 SW 8th Street
Bentonville, AR 72716-3500**

Dental Appeals

**Appeals Committee
Delta Dental of Arkansas
P.O. Box 15965
Little Rock, AR 72231-5965**

Note: There is a special claims and appeals process for certain transplant benefits (see details later in this chapter).

Your appeal will be conducted without regard to your initial determination by someone other than the party who decided your initial claim. You have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. The Plan will provide you with any new or additional evidence or rationale considered in connection with your claim sufficiently in advance of the appeals determination date to give you a reasonable opportunity to respond.

You may designate an authorized representative to submit appeals on your behalf by completing a designation form. Call Benefits Customer Service at **(800) 421-1362** to request a form or write to:

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

Your appeal will be handled within 60 days from the date it is received by the Plan.

If your claim is denied on appeal (by the Plan or Delta Dental), you will receive a denial notice that includes:

- The specific reason(s) for the denial;
- Reference to provisions of the Plan on which the denial was based;
- A statement describing your right to request copies, free of charge, of all documents, records or other information relevant to your claim;
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination;
- An explanation of this rule (or a statement that it is available upon request), if your denial is based on a medical necessity or similar limitation;
- A description of any voluntary review procedures available; and
- Notice regarding your right to bring legal action following a denial on appeal.

For medical, behavioral health and transplant benefits, the denial also will include:

- Information sufficient to identify the claim involved (including the date of service, health care provider, claim amount (if applicable));

—Upon written request, the Plan will provide you with the diagnosis and treatment codes (and their corresponding meanings) associated with any denied claim or appeal.

- The denial code and its meaning;
- A description of the Plan's standard for denying the claim;
- Information regarding available internal and external appeals, including how to initiate an appeal; and
- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist participants with the internal and external appeals process.

Appealing a transplant denial (for approval of a location other than Mayo Clinic)

As described in the medical chapter, all transplant recipients (except kidney, cornea and intestinal recipients) must undergo a pre-transplant evaluation at Mayo Clinic. For these transplants, the Mayo Clinic will make a recommendation regarding transplant services at Mayo Clinic. If Mayo Clinic does not recommend a transplant because it is not deemed the appropriate medical course of treatment or the patient is not an appropriate candidate, you may file a prior authorization claim with the Plan. The claim will be determined by an Independent Review Panel appointed by the Plan's Administrative Committee which may approve the transplant for a different acceptable facility.

The Independent Review Panel will not include any employee of Walmart, the Mayo Clinic or a Third Party Administrator of the Plan. The Independent Review Panel will review any pertinent medical files that were reviewed or generated by the Mayo Clinic, as well as any additional materials you submit, and will consider 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.

The claim must be received by the Plan within 120 calendar days of the initial denial of the transplant by Mayo Clinic. If the claim is urgent, the Independent Review Panel will make its determination within 72 hours after receipt of the claim (otherwise, the Independent Review Panel will make its determination with 15 days of receipt of the claim). An urgent claim is any claim for medical care or treatment where making a determination under the normal time frame could seriously jeopardize the life, health or ability to regain maximum function, or, in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that could not adequately be managed without the care or treatment is the subject of the claim.

If the urgent claim is determined to be incomplete, you will receive a notice within 24 hours of receipt of the claim, and you will have 48 hours to provide

additional information. For non-urgent claims, the time may be extended 15 days. If the extension is necessary to request additional information, the extension notice will describe the required information and you will be given at least 45 days to submit the information. The Plan will make a determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.

You will have 180 days to request internal review of a denial by the Independent Review Panel. The Independent Review Panel will decide a request for urgent review within 72 hours and non-urgent review within 30 days after receipt. You then may appeal a denial of an internal review appeal under the external appeal process described in this section.

Kidney, cornea and intestinal transplants, and any other transplant service or claim where treatment already has been rendered, will be decided under the regular medical claims and appeals procedures outlined earlier in this chapter.

Requesting a voluntary review of your denied appeal for enrollment or eligibility status determinations or dental benefits, or claims paid but reduced for Maximum Allowable Charge

If you have additional information that was not in your appeal, you may ask for a voluntary review of the decision on your appeal within 180 days of the date on the appeal denial letter. The same criteria and response times that applied to your appeal are generally applied to this voluntary level of review.

The claimant must send a written request for a voluntary appeal to:

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

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

External appeal process for medical, behavioral health or transplant benefits

If your internal appeal for medical, behavioral health or transplant benefits under the Plan is denied, you may have the right to further appeal your claim pursuant to a new independent external review process established under the Patient Protection and Affordable Care Act.

Your external appeal will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan's decision, and the independent review organization's decision will be binding on the Plan. Your internal appeal denial notice will include more information about your right to file a request for an external review and contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Pharmacy claims process

For appeals of all claims other than paper claims

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

- Pharmacy benefits
- A rescission of coverage, which is a cancellation of coverage that has a retroactive effective date, except where cancellation of coverage is due to failure to timely pay required contributions or premiums

In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claim, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician).

To initiate an appeal for coverage, provide in writing:

- Your name;
- Member ID;
- Phone number;

- Prescription drug for which benefit coverage has been denied; and
- Any additional information that may be relevant to your appeal.

This information should be mailed to:

Medco Health Solutions, Inc.
8111 Royal Ridge Parkway
Irving, TX 75063

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing:

- Your name;
- Member ID;
- Phone number;
- Prescription drug for which benefit coverage has been denied; and
- Any additional information that may be relevant to your appeal.

This information should be mailed to:

Medco Health Solutions, Inc.
8111 Royal Ridge Parkway
Irving, TX 75063

You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim.

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for an appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal or your adverse benefit determination notice or final adverse benefit determination notice does not contain all of the information required under ERISA, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility. In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within

24 hours of receipt of the information. If you don't provide the needed information within the 48-hour period, your claim will be deemed denied.

You have the right to request an urgent appeal of an adverse benefit determination (including a deemed denial) if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call (800) 864-1135 or send a written request to:

Medco Health Solutions, Inc.
Attn: Urgent Appeals
8111 Royal Ridge Parkway
Irving, TX 75063

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to bring a civil action under section 502(a) of Employee Retirement Income Security Act of 1974 (ERISA) if your appeal is denied or your adverse benefit determination notice or final adverse benefit determination notice does not contain all of the information required under ERISA. You also have the right to obtain an independent external review. In situations where the timeframe for completion of an internal review would seriously jeopardize your life or health or your ability to regain maximum function you could have the right to immediately request an expedited external review, prior to exhausting the internal appeal process, provided you simultaneously file your request for an internal appeal of the adverse benefit determination. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

For paper claims

Your plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. This claim will be processed based on your plan benefit. To request reimbursement you will send your claim to:

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

If your claim is denied, you will receive a written notice within 30 days of receipt of the claim, as long as all needed information was provided with the claim. You will be notified within this 30 day period if additional information is needed to process the claim, and a one-time extension not longer than 15 days may be requested and your claim pended until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, you will be notified of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be deemed denied.

If you are not satisfied with the decision regarding your benefit coverage or your claim is deemed denied, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing:

- Your name;
- Member ID;
- Phone number;
- Prescription drug for which benefit coverage has been reduced or denied; and
- Any additional information that may be relevant to your appeal.

This information should be mailed to:

Medco Health Solutions, Inc.
8111 Royal Ridge Parkway
Irving, TX 75063

A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provision on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any)

that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of receipt notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician).

To initiate a second level appeal, provide in writing:

- Your name;
- Member ID;
- Phone number;
- Prescription drug for which benefit coverage has been reduced or denied; and
- Any additional information that may be relevant to your appeal.

This information should be mailed to:

Medco Health Solutions, Inc.
8111 Royal Ridge Parkway
Irving, TX 75063

You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request for appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond

prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal or your adverse benefit determination notice or final adverse benefit determination notice does not contain all the information required under ERISA, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.

External appeal process for pharmacy benefits

If your internal appeal for pharmacy benefits under Medco is denied, you may have the right to further appeal your claim pursuant to a new independent external review process established under the Patient Protection and Affordable Care Act. Your external appeal will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn Medco's decision, and the independent review organization's decision will be binding on the Plan. Your internal appeal denial notice will include more information about your right to file a request for an external review and contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Information regarding rights related to medical, behavioral health, transplant and dental benefits

Right to request medical records

The Plan has the right to request medical records for any associate or covered individual.

Plan's right to recover overpayment

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for benefits that are not covered by the Plan, for a participant who is not covered by the Plan, when other insurance is primary or other similar circumstances, the Plan has the right to recover the overpayment. The Plan will try to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from you and/or your dependents. Failure to comply with this request will entitle the Plan to withhold benefits due you and/or your dependents. The Plan has the right to refer the file to an outside collection agency if internal collection efforts are unsuccessful. The Plan may also bring a lawsuit to enforce its rights to recover overpayments. For medical claims, the Plan will not seek overpayments, except in the case of nonpayment of premiums, fraud or intentional misrepresentation.

Your right to recover overpayment

If you overpay your contributions or premiums for any coverage under the Plan (except COBRA) the Plan will refund excess contributions or premiums to you upon request. In this circumstance, any refunds you receive may be offset by any benefits paid during this period by the Plan if you or a dependent were not eligible for such coverage.

Right to audit

The Plan has the right to audit your and your dependents' claims, as well as providers. The Plan may reduce or deny benefits for otherwise covered services for all current and/or future claims with the provider and/or you and your dependents based on the results of an audit.

Right to salary/wage deduction

To the extent that the Plan may recover from you or your dependents all or part of benefits previously paid, you shall be deemed, by virtue of your enrollment in this medical coverage, to have agreed that the company may deduct such amounts from your wage or salary and pay the same to the Plan until recovery is complete. If you enroll for coverage under the Plan, you will be treated by the Plan as if you had consented to the applicable payroll deductions for such coverage. In addition, if you fail to affirmatively enroll or re-enroll during annual enrollment, you will be treated by the Plan as if you

had consented to the automatic re-enrollment described in the **Eligibility and enrollment** chapter, including the applicable payroll deductions.

Right to reduction, reimbursement and subrogation

The Plan has the right to:

- Reduce or deny benefits otherwise payable by the Plan; and
- Recover or subrogate 100 percent of the benefits paid or to be paid by the Plan for covered persons, to the extent of any and all of the following payments:
 - Any judgment, settlement, or payment made or to be made because of an accident or malpractice, including but not limited to other insurance;
 - Any auto or recreational vehicle insurance coverage or benefits, including but not limited to uninsured/underinsured motorist coverage;
 - Business medical and/or liability insurance coverage or payments; and
 - Attorney's fees.

The Plan's lien exists at the time the Plan pays medical benefits. If a covered person files a petition for bankruptcy, the covered person agrees that the Plan's lien existed in time prior to the creation of the bankruptcy estate.

Also note that:

- Covered person means any participant (as defined by ERISA) or dependent of a participant who is entitled to medical coverage under the Plan;
- The Plan has first priority with respect to its right to reduction, reimbursement and subrogation;
- The Plan has the right to recover interest on the amount paid by the Plan because of the accident;
- The Plan has the right to 100 percent reimbursement in a lump sum;
- The Plan is not subject to any state laws, including but not limited to the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of a covered person's attorney's fees and costs;
- The Plan is not responsible for the covered person's attorney's fees, expenses or costs;

- The right of reduction, reimbursement and subrogation is based on the Plan language in effect at the time of judgment, payment or settlement;
- The Plan's right to reduction, reimbursement and subrogation applies to any funds recovered from another party, by or on behalf of the estate of any covered person; and
- The Plan's right to first priority shall not be reduced due to the participant's own negligence.

The Plan will not pursue reduction, reimbursement or subrogation where the injury or illness that is the basis of the covered person's recovery from any party results in:

- Paraplegia or quadriplegia;
- Severe burns;
- Total and permanent physical or mental disability; or
- Death.

In addition to the exceptions listed above, the Plan's Administrative Committee has the authority, in its sole discretion, to determine not to pursue the Plan's rights to reduction, reimbursement or subrogation.

Whether a covered person has a "total and permanent physical or mental disability" will be determined based on criteria developed and applied by the Administrative Committee in its sole discretion. One way of demonstrating total and permanent physical or mental disability is for a covered person to show that the covered person has qualified for Social Security disability income benefits. The Administrative Committee will consider claims for physical and mental disability, even if the covered person does not qualify for Social Security disability income benefits, under criteria developed by the Committee.

Even in circumstances where the Plan is not prohibited from seeking reduction, reimbursement or subrogation based on the exceptions described previously in this chapter, the Plan's right to reduction, reimbursement or subrogation will be limited to no more than 50 percent of the total amount recovered by or on behalf of the covered person from any party (which shall not be reduced for the covered person's attorney's fees or costs). The Plan requires all covered persons and their representatives to cooperate in order to guarantee reimbursement to the Plan from third-party benefits. Failure to comply with this request will entitle the Plan to withhold benefits due to you or your dependents under the Plan. You, your dependents and/or your representatives cannot do anything to hinder reimbursement of over-payment to the Plan after benefits have been accepted by you, your dependents and/or your representatives.

The Plan's rights to reduction, reimbursement and subrogation apply regardless of whether such payments are designated as payment for, but not limited to:

- Pain and suffering; or
- Medical benefits.

The Plan's rights apply regardless of whether a covered person has been made whole or fully compensated for his or her injuries.

Additionally, the Plan has the right to file suit on your behalf for the condition related to the medical expenses in order to recover benefits paid or to be paid by the Plan.

Claims for benefits and right to appeal reduction, reimbursement and subrogation decisions

The Plan's decision to seek reduction, reimbursement or subrogation is a determination of benefits under the Plan and may be appealed in accordance with the procedures below.

Definitions

For purposes of the claims procedures specified below a "claim for benefits" means a request by a participant, beneficiary or dependent ("claimant") to have the benefits provided under the Plan not reduced through the application of the Plan's right to reduction, reimbursement or subrogation.

Initial claim for benefits

If the Plan decides to seek reduction, reimbursement or subrogation, the claimant will be notified of the Plan's decision in a written notice ("notice") from the Plan or an agent of the Plan that administers the Plan's claims for reduction, reimbursement or subrogation.

If a claimant receives a notice that the claimant's benefit is subject to reduction, reimbursement or subrogation and believes that the claimant's case falls within one of the exceptions or limitations to the Plan's right to reduction, reimbursement or subrogation, the claimant may file a claim for benefits with the Plan. The claimant may also designate an authorized representative to submit claims for benefits or appeals on the claimant's behalf.

For an initial claim for benefits to be considered, it must:

- Be in writing;
- Be sent to the correct address;
- Be submitted within 12 months of the date of the notice that a benefit is subject to reduction, reimbursement or subrogation;
- Identify the exception or limitation to the Plan's right to reduction, reimbursement or subrogation that the claimant believes applies to the claimant's case; and
- Include documentation that will assist the Plan in making its decision (e.g., medical and hospital records, physician letters).

The claimant must send a written request for review of the initial claim for benefits to:

**Walmart Benefits Administration
Attn: Subrogation Review Committee
508 SW 8th Street
Bentonville, AR 72716-3500**

Within a reasonable time, but no later than 30 days after a claimant's initial claim for benefits is made, the Plan will provide written notice of its decision to the claimant. If the claim for benefits is partially or fully denied, the notice will include the following information:

- The specific reason(s) for the denial;
- Reference to provisions of the Plan on which the denial was based;
- A description of any additional material or information necessary to perfect the claimant's claim for benefits and an explanation of why such material or information is necessary;

- A statement that the claimant has the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making the Plan's determination;
- A description of the Plan's appeal procedures and the time limits for appeal; and
- Notice regarding the claimant's right to bring a court action following a denial on appeal.

The 30-day period may be extended for 15 days if it is determined that an extension is necessary due to matters beyond the Plan's control. The Plan will notify the claimant prior to the end of the 30-day period if an extension or additional information is required. If asked to provide additional information, the claimant will

have 45 days from the date notified to provide the information. The time to make a determination will be suspended until the claimant provides the requested information (or the deadline to provide the information, if earlier).

If a claim for benefits is fully or partially denied

The claimant may request an appeal of the decision. For a claimant's appeal to be considered, it must:

- Be in writing;
- Be sent to the correct address;
- Be submitted within 180 days of the date of the initial denial; and
- Contain any additional information/documentation the claimant would like considered.

The claimant must send a written request for an appeal to:

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

The appeal will be conducted without regard to the initial determination by someone other than the party who decided the initial claim for benefits. The claimant has the right to request copies, free of charge, of all documents, records or other information relevant to the claimant's claim for benefits. The claimant also has the right to submit written comments, documents, records and other information, which the Plan will take into account in making its decision on appeal. In deciding any claim for benefits that is based in whole or in part on a medical judgment, the Plan's claims fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be an individual who is neither an individual who was consulted in connection with the Plan's decision on the initial claim for benefits, nor the subordinate of the health care professional. If the advice of a health care professional is obtained in deciding an appeal, the name of the health care professional will be provided to the claimant upon request, regardless of whether the Plan relied on the advice. The

Plan must provide the claimant written notice of the Plan's decision on review within 60 days following the Plan's receipt of the claimant's appeal.

If the claim for benefits is denied on appeal, the Plan will provide a denial notice to the claimant that includes:

- The specific reason(s) for the denial;
- Specific reference to provisions of the Plan upon which the denial was based;
- A statement describing the claimant's right to request copies, free of charge, of all documents, records or other information relevant to the claimant's claim for benefits;
- A statement that the claimant has the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination;
- A description of available voluntary review procedures, if any; and
- Notice regarding the claimant's right to bring a court action following a denial on appeal.

The only method the claimant can request the Plan not to reduce benefits is to file a claim for benefits. An initial claim for benefits must be filed within 12 months from the date of the notice. The claimant must complete the required claims and appeals process described in these claims procedures before bringing legal action. A claimant may not file a lawsuit for benefits if the claimant's initial claim for benefits or appeal is not made within the time periods set forth in these claims procedures. A claimant must file any lawsuit for benefits within 180 days after the decision on appeal. A claimant may not file suit after that 180-day period expires.

Covered person's responsibility regarding right of reduction and/or recovery

To aid the Plan in its enforcement of its right of reduction, recovery, reimbursement and subrogation, you and/or your designated representative must, at the Plan's request and at its discretion:

- Take any action;
- Give information; or
- Sign documents so required by the Plan.

Failure to aid the Plan and to comply with such requests may result in the Plan's withholding or recovering benefits, services, payments or credits due or paid under the Plan.

The Plan can seek reimbursement of 100 percent of medical benefits paid from any judgment, payment or settlement that is made on behalf of the covered person for whom the medical benefits were paid. Reimbursement to the Plan of 100 percent of these charges shall be made at the time the payment is received by you, your dependent(s) or your representative.

HMO plan claims and appeals procedures

In some facilities, Walmart offers health insurance coverage through HMOs as part of the Plan. If you participate in an HMO, the HMO will provide a benefit booklet that, together with this document, will serve as the Summary Plan Description for the HMO coverage and will describe their claims and appeals procedures. Contact your HMO for additional information.

Accident and critical illness insurance claim process

Accident and critical illness insurance claims should be submitted within 60 days of the occurrence or commencement of any covered accident or critical illness to:

Allstate Workplace Division
Walmart Claims Unit
P.O. Box 41448
Jacksonville, FL 32203-1488

Critical illness

When you submit a claim to Allstate and your claim is denied, a notice will be sent within a reasonable time period but no later than 30 days after Allstate receives the claim (filed in accordance with the Critical Illness Certificate of Insurance). In special circumstances, an extension of time may be needed to make a decision. In that case, Allstate may take a 15-day extension. You will receive written notice of the extension before the end of the 30-day period.

If your claim is denied, your denial will consist of a written explanation which will include:

- The specific reason(s) for the denial;
- Reference to provisions of the Plan on which the denial was based;
- Information regarding time limits for appeal;
- A description of additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary;
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination;
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that it is available upon request); and
- Notice regarding your right to bring a court action following a denial on appeal.

Appealing a critical illness claim that has been fully or partially denied

You may appeal any denial of a claim for benefits by filing a written request with Allstate. In connection with an appeal, you may request, free of charge, all documents that are relevant (as defined by ERISA) to your claim. You may also submit with your appeal any comments, documents, records and issues that you believe support your claim, even if you have not previously submitted such documentation. You may have representation throughout the review procedure.

An appeal must be filed with Allstate in accordance with the claim filing procedures described in your denial letter within 180 days of receipt of the written notice of denial of a claim. Allstate will render a decision no later than 60 days after receipt of your written appeal. The decision after your review will be in writing and will include:

- The specific reason(s) for the denial;
- Reference to provisions of the Plan on which the denial was based;
- A statement that you have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits;
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination;
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that is available upon request);
- A description of any voluntary review procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement regarding your right to bring court action following a denial on appeal.

You also will receive a notice if the claim on appeal is approved.

Accident insurance

When you submit a claim to Allstate and your claim is denied, a notice will be sent within a reasonable time period but no later than 30 days after Allstate receives the claim (filed in accordance with the Accident Certificate of Insurance). In special circumstances, an extension of time may be needed to make a decision. In that case, Allstate may take a 15-day extension. You will receive written notice of the extension before the end of the 30-day period.

If your claim is denied, your denial will consist of a written explanation which will include:

- The specific reason(s) for the denial;
- Reference to provisions of the Plan on which the denial was based;
- Information regarding time limits for appeal;
- A description of additional material or information, if any needed to perfect the claim and the reasons such material or information is necessary;
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination;
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that it is available upon request); and
- Notice regarding your right to bring a court action following a denial on appeal.

You also will receive a notice if the claim on appeal is approved.

Appealing a accident claim that has been fully or partially denied

You may appeal any denial of a claim for benefits by filing a written request with Allstate. In connection with an appeal, you may request, free of charge, all documents that are relevant (as defined by ERISA) to your claim. You may also submit with your appeal any comments, documents, records and issues that you believe support your claim, even if you have not previously submitted such documentation. You may have representation throughout the review procedure.

An appeal must be filed with Allstate in accordance with the claim filing procedures described in your denial letter within 180 days of receipt of the written notice of denial of a claim. Allstate will render a decision no later than 60 days after receipt of your written appeal. The decision after your review will be in writing and will include:

- The specific reason(s) for the denial;
- Reference to provisions of the Plan on which the denial was based;
- A statement that you have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits;
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination;
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that is available upon request);
- A description of any voluntary review procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement regarding your right to bring court action following a denial on appeal.

You also will receive a notice if the claim on appeal is approved.

If your claim is denied, you have the right to bring action in Federal court in accordance with ERISA 502(a). You can not take any legal action until you have exhausted the Plan's claims review procedure described above.

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadlines to bring legal action.

Company-paid, optional and dependent life insurance, Business Travel Accident insurance and AD&D claim process

Company-paid, optional and dependent life insurance, Business Travel Accident insurance and AD&D claims should be submitted to:

**Prudential Insurance Companies of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, PA 19176**

When you submit a claim to Prudential and your claim is denied, a notice will be sent within a reasonable time period, but not longer than 90 days from receipt of the claim. If Prudential determines that an extension is necessary due to matters beyond Prudential's control, this time may be extended for an additional 90-day period. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which Prudential expects to render a determination.

If your claim is in part or wholly denied, you will receive notice of an adverse benefit determination that will:

- State the specific reason(s) for the adverse benefit determination;
- Reference the specific plan provisions on which the determination is based;
- Describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary; and
- Describe Prudential's claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

Appealing a Prudential claim that has been fully or partially denied

If your claim for benefits is denied and you would like to appeal, you must send a written appeal to Prudential at the address above within 180 days of the denial. Your appeal should include any comments, documents, records or any other information you would like considered.

You will have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. Your appeal will be reviewed without regard to your initial determination by someone other than the party who decided your initial claim. Prudential will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial that will include:

- The specific reason(s) for the adverse determination;
- References to the specific plan provisions on which the determination was based;
- A statement describing your right to request copies, free of charge, of all documents, records or other information relevant to your claim;
- A description of Prudential's review procedures and applicable time limits;
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination; and
- A statement describing any appeals procedures offered by the Plan and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Voluntary second appeal

If your appeal is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a voluntary second appeal of your denial in writing to Prudential. You must submit your second appeal within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit any written comments, documents, records and any other information relating to your claim. The same criteria and response times that applied to your first appeal are generally applied to this voluntary second appeal.

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

Claim process for all types of disability coverage claims

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

Short-term disability, short-term disability plus, long-term disability and truck driver long-term disability claims should be submitted to:

[Atlanta Disability Claim Office](#)
[The Hartford](#)
P.O. Box 14301
Louisville, KY 40512-4301

Once a claim has been filed, The Hartford will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for up to two additional 30-day periods provided that, prior to any extension period, The Hartford notifies you in writing that an extension is necessary due to matters beyond its control, identifies those matters, and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date The Hartford receives your response. If The Hartford approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include:

- Specific reasons for the decision;
- Specific references to the policy provisions on which the decision is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- A description of the review procedures and time limits applicable to such procedures;
- A statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal The Hartford's decision if you receive a written denial on appeal;
- If an internal rule, guideline, protocol or other similar criteria was relied upon in making the denial; either

- The specific rule, guideline, protocol or other similar criteria, or
- A statement that such a rule, guideline, protocol or other similar criteria was relied upon in making the denial and that a copy will be provided free of charge to you upon request.

Appealing a Hartford claim that has been fully or partially denied

If your claim for benefits is denied and you would like to appeal, you must send a written appeal to The Hartford at the address shown earlier in this chapter within 180 days of the denial. Your appeal should include any comments, documents, records or any other information you would like considered.

You will have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. Your appeal will be reviewed without regard to your initial determination by someone other than the party who decided your initial claim.

The Hartford will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if The Hartford determines that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to

provide the information and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification from The Hartford of the denial that will include:

- The specific reason(s) for the adverse determination;
- References to the specific plan provisions on which the determination was based;
- A statement describing your right to request copies free of charge, of all documents, records or other information relevant to your claim;
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination; and

- A statement describing any appeals procedures offered by the Plan and your right to bring a civil suit under ERISA.

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

Short-term disability appeals should be sent to:

[Disability Claim Appeal Unit](#)
The Hartford
P.O. Box 14301
Louisville, KY 40512-4301

Long-term disability and truck driver long-term disability appeals should be sent to:

[Group Benefits Claim Appeal Unit](#)
The Hartford
P.O. Box 2999
Hartford, CT 06104-2999

Resources For Living benefits

You do not have to file a claim or appeal for Resources For Living benefits. You may access the Resources For Living Web site or contact Resources For Living at any time.

However, if you have a question about your benefits, or disagree with the benefits provided, you may contact Benefits Customer Service or file a claim or appeal by writing to the following address:

[Walmart Benefits Administration](#)
Attn: Internal Appeals
508 SW 8th Street
Bentonville, AR 72716-3500

Any claims or appeals will be determined under the time frames and requirements in the medical, Behavioral Health, transplant and dental claims sections, respectively, in this chapter.

Legal information

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legal info

Legal information

This chapter describes your legal rights as a participant in the Associates' Health and Welfare Plan, including information about the confidentiality of your personal medical information under the Notice of Privacy Practices HIPAA Information. You will also find information on your rights to enrollment or premium assistance under Medicaid or the Children's Health Insurance Program (CHIP), the prescription drug coverage available through Medicare Part D and the decisions you need to make about your prescription drug coverage if you're eligible for Medicare.

Legal information resources		
Find What You Need:	Online:	Other Resources:
Contact the Plan Administrator of the Plan		Write to: Walmart The Administrative Committee Associates' Health and Welfare Plan 508 SW 8th Street Bentonville, AR 72716-3500 Call (479) 621-2058
Answers to questions about the HIPAA Privacy Notice	Send an e-mail to privacy@wal-mart.com	Call (800) 421-1362
Answers to questions about Medicare Part D	Visit medicare.gov for personalized help	(800) MEDICARE [633-4227] TTY users should call (877) 486-2048
Answers to your questions about Medicaid/CHIP	insurekidsnow.gov	(877) KIDSNOW [543-7669]

What you need to know about the legal information for the Associates' Health and Welfare Plan

- As a participant in the Associates' Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.
- The HIPAA Privacy Notice in this chapter describes how medical information about you may be used and disclosed and how you can get access to this information.
- The **Medicare** and your **prescription** drug coverage section in this chapter explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.
- The Medicaid/Children's Health Insurance Program (CHIP) notice explains special enrollment and premium assistance rights for individuals eligible for these programs.

Associates' Health and Welfare Plan

The Plan is an employer-sponsored health and welfare employee benefit plan governed under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The terms and conditions of the Associates' Health and Welfare Plan are set forth in this book, the Associates' Health and Welfare Plan Wrap Document (Wrap Document), and the insurance policies and other welfare program documents incorporated into the Wrap Document. The Wrap Document, together with this book and the other incorporated documents, constitutes the written instrument under which the Associates' Health and Welfare Plan is established and maintained. This book also serves as a Summary Plan Description for the Associates' Health and Welfare Plan.

Plan Year: January 1 through December 31

Plan Number: 501

Type of Plan: Welfare, including medical, dental, short-term disability, short-term disability plus, long-term disability, truck driver long-term disability, Business Travel Accident insurance, accidental death and dismemberment (AD&D), company-paid life, optional life, dependent life, accident insurance, critical illness insurance and Resources For Living.

Type of Administration: The Committees (or their delegates) shall have complete discretion to interpret and construe the provisions of the Plan, make findings of fact, correct errors and supply omissions. All decisions and interpretations of any of the Committees (or their delegates) made pursuant to the Plan shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious. Benefits will be paid only if the Appeals Committee, or its delegate, determines in its discretion that the claimant is entitled to them.

Plan Sponsor:

Wal-Mart Stores, Inc.
702 SW 8th Street
Bentonville, AR 72716-0295

Plan Administrator/Named Fiduciary:

The Administrative Committee
Associates' Health and Welfare Plan
508 SW 8th Street
Bentonville, AR 72716-3500
(479) 621-2058

Agent for Service of Legal Process:

Corporation Trust Company
1209 Orange Street
Corporation Trust Center
Wilmington, DE 19801

Legal process may also be served on the Plan Administrator or Trustee.

Plan Sponsor's EIN: 71-0415188

Funding for the Plan

Contributions to the Plan may be made by Wal-Mart Stores, Inc. out of its general assets or through the Wal-Mart Stores, Inc. Associates' Health and Welfare Trust. Contributions also may be required by employees, in an amount determined by Wal-Mart Stores, Inc. in its discretion. All assets of the Plan, including associate contributions and any dividends or earnings of the Plan, shall be available to pay any benefits provided under the Plan or expenses of the Plan, including insurance premiums.

Plan Trustees:

JP Morgan
4 New York Plaza, 15th Floor
New York, NY 10004-2413

Plan amendment or termination

Walmart reserves the right to amend or terminate at any time and to any extent the Associates' Health and Welfare Plan and any of the benefits (whether self-insured or insured under a policy paid by the company) described in this book.

Neither the Plan nor the benefits described in this book can be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by the Plan Administrator, by a management associate of the company, or by any member of the applicable committees of the Plan. Only written statements by the applicable committee of the Plan shall bind the Plan.

Your rights under ERISA

As a participant in the Associates' Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

Receive information about your Plan and benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified facilities, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this annual report.

Continue group health plan coverage

You have the right to continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights. (See the **COBRA** chapter for more information.)

You are entitled to a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months after your enrollment date in your coverage.

Prudent actions by Plan fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, can fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request materials from the Plan and do not receive them within 30 days, you can file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you can file suit in a state or federal court. Generally, you must complete the appeals process before filing a lawsuit against the Plan. However, you should consult with your own legal counsel in determining when it is proper to file a lawsuit against the Plan.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you can file suit in a federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you can seek assistance from the U.S. Department of Labor, or you can file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the:

**Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210**

You can also obtain certain publications about your rights under ERISA by calling the Employee Benefits Security Administration publications hotline at **(866) 444-3272** or by logging on to the Internet at dol.gov/ebsa.

Notice of privacy practices — HIPAA information

Associates' Medical Plan, dental plan and Resources For Living (RFL) notice of privacy practices

Effective date of this notice: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

YOU SHOULD ALSO SHARE A COPY OF THIS NOTICE WITH YOUR FAMILY MEMBERS WHO ARE COVERED UNDER THE ASSOCIATES' MEDICAL PLAN, DENTAL PLAN AND RFL.

Walmart's commitment to your privacy

This notice applies to the self-insured medical and dental plans and to RFL coverage (Plans) maintained by Wal-Mart Stores, Inc. (Walmart). References to "we" and "us" throughout this notice mean the Plans. Walmart also provides benefits through a Health Maintenance Organization (HMO). The HMO in that case possesses your health information and maintains its own notice of privacy practices.

The Plans are dedicated to maintaining the privacy of your health information. In operating the Plans, we create records regarding you and the benefits we provide to you. This notice will tell you about the ways in which we may use and disclose medical information about you. We will also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- Maintain the privacy of your health information, also known as Protected Health Information (PHI);
- Provide you with this notice; and
- Comply with this notice.

The Plans reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If there is a material revision to this notice, the new notice will be distributed to you. You may obtain a paper copy of the current notice by contacting the Plans using the contact information listed at the end of this notice. The current notice is also available on the benefits Web site on the WIRE.

How the Associates' Medical Plan, dental plan and RFL may use and disclose your PHI

The law permits us to use and disclose your personal health information (PHI) for certain purposes without your permission or authorization. The following gives examples of each of these circumstances.

1. For Treatment. We may use or disclose your PHI for purposes of treatment. For example, we may disclose your PHI to physicians, nurses and other professionals who are involved in your care.
2. For Payment. We may use or disclose your PHI to provide payment for the treatment you receive under the Plans. For example, we may contact your health care provider to certify that you have received treatment (and for what range of benefits), and we may request details regarding your treatment to determine if your benefits will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members or other insurance companies.
3. For Health Care Operations. We may use or disclose your PHI for our health care operations. For example, our claims administrators in some states or the Plans may use your PHI to conduct cost-management and planning activities.
4. To the Plan Sponsor. The Plans may use or disclose your PHI to Walmart, the Plan Sponsor. The Plan Sponsor will only use your PHI as necessary to administer the Plan. The law only permits the Plans to disclose your PHI to Walmart, in its role as the Plan Sponsor, if Walmart certifies, among other things, that it will only use or disclose your PHI as permitted by the Plan, will restrict access to your PHI to those Walmart employees whose job it is to administer the Plan and will not use PHI for any employment-related actions.
5. For Health-Related Programs and Services. The Plans may contact you about information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.

6. To Individuals Involved in Your Care or Payment for Your Care. The Plans may disclose your PHI to a family member or friend who is involved in your medical care or payment for your care, provided that you agree to this disclosure, or we give you an opportunity to object to this disclosure. However, if you are not available or are unable to agree or object, we will use our best judgment to decide whether this disclosure is in your best interest.

Other uses or disclosures of your PHI without an authorization

The law allows us to disclose your PHI in the following circumstances without your permission or authorization:

1. When Required by Law. The Plans will use and disclose your PHI when we are required to do so by federal, state or local law.
2. For Public Health Risks. The Plans may disclose your PHI for public health activities, such as those aimed at preventing or controlling disease, preventing injury, reporting reactions to medications or problems with products, and reporting the abuse or neglect of children, elders and dependent adults.
3. For Health Oversight Activities. The Plans may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include investigations, inspections, audits and licensure.
4. For Lawsuits and Disputes. The Plans may use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or obtain an order protecting the information the party has requested.
5. To Law Enforcement. The Plans may release your PHI if asked to do so by a law enforcement official in the following circumstances:
 - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
 - Concerning a death we believe might have resulted from criminal conduct;

- Regarding criminal conduct at our offices;
 - In response to a warrant, summons, court order, subpoena or similar legal process;
 - To identify/locate a suspect, material witness, fugitive or missing person; and
 - In an emergency, to report a crime (including the location or victim(s) of the crime or the description, identity or location of the person who committed the crime).
6. To Avert a Serious Threat to Health or Safety. The Plans may use or disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
 7. For Military Functions. The Plans may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans), and if required by the appropriate military command authorities.
 8. For National Security. The Plans may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state or to conduct investigations.
 9. Inmates. The Plans may disclose your health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution and/or (c) to protect your health and safety or the health and safety of other individuals.
 10. To Workers' Compensation Programs. The Plans may release your health information for Workers' Compensation and similar programs.
 11. For Services Related to Death. Upon your death, to a coroner, funeral director or to tissue or organ donation services, as necessary to permit them to perform their functions.
 12. Research. For government-approved research purposes.

Uses and disclosures requiring your authorization

Other uses and disclosures of your PHI that are not covered by this notice or the laws that apply to us will be made only with written authorization. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization at any time in writing. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization, except for the two situations noted below:

- We have taken action in reliance on your authorization before we received your written revocation; and
- You were required to give us your authorization as a condition of obtaining coverage.

Stricter state privacy laws

Under the HIPAA Privacy Regulations, the Plan is required to comply with state laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws. Additional information regarding state privacy laws may be located on the WIRE.

Your rights related to your PHI

You have the following rights regarding your PHI that we maintain:

1. Right to Request Confidential Communications. You have the right to request that the Plans communicate with you about your health and related issues in a particular manner or at a certain location if you feel like your life may be endangered if communications are sent to your home. For example, you may ask that we contact you at work rather than home. In order to request a type of confidential communication, you must make a written request to the address at the bottom of this section specifying the requested method of contact or the location where you wish to be contacted. For us to consider granting your request for a confidential communication, your written request must clearly state that your life could be endangered by the disclosure of all or part of this information.

2. Right to Request Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we limit our disclosure of your PHI to individuals involved in your care or the payment for your care, such as family members and friends. We generally are not required to agree to your request except in limited circumstances; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. To request a restriction in our use or disclosure of your PHI, you must make your request in writing to the address at the bottom of this section. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit the Associates' Medical Plan's, dental plan's or RFL's use, disclosure or both; and (c) to whom you want the limits to apply.
 3. Right to Inspect and Copy. Except for limited circumstances, you have the right to inspect and copy the PHI that may be used to make decisions about you. Usually, this includes medical and billing records. To inspect or copy your PHI, you must submit your request in writing to the address listed at the end of this section. The Plans may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances, in which case you may request that the denial be reviewed.
 4. Right to Request Amendment. You have the right to request that we amend your PHI if you believe it is incorrect or incomplete. To request an amendment, you must submit a written request to the address listed at the end of this section. You must provide a reason that supports your request for amendment. We may deny your request if you ask us to amend PHI that is: (a) accurate and complete; (b) not part of the PHI kept by or for the Plan; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by the Plan, unless the individual or entity that created the PHI is not available to amend it. Even if we deny your request for amendment, you have the right to submit a statement of disagreement regarding any item in your record you believe is incomplete or incorrect. If you request, it will become part of your medical record and we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.
 5. Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures. An accounting of disclosures is a list of certain disclosures we have made of your PHI after April 14, 2003, for most purposes other than treatment, payment, health care operations and other exceptions pursuant to law. To request an accounting of disclosures, you must submit a written request to the address at the end of this section. You must specify the time period, which may not be longer than six years and may not include dates before April 14, 2003. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.
 6. Paper Notice. You have a right to request a paper copy of this notice, even if you have agreed to receive this notice electronically.
- If you believe your privacy rights have been violated, you may file a complaint with the Associates' Medical Plan, dental plan or RFL, or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, you must submit it in writing to the address listed at the end of this section. Neither Walmart nor the Plans will retaliate against you for filing a complaint.
- If you have questions about this notice or would like to exercise one or more of the rights listed in this notice, please contact:
- Benefits Customer Service
Attn: HIPAA Compliance Team
508 SW 8th Street
Mail stop #3500
Bentonville, AR 72716-3500**
- E-mail Address: privacy@wal-mart.com
- Telephone: (800) 421-1362

Medicare and your prescription drug coverage

Please read this notice, Medicare and your prescription drug coverage, carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Plan and your prescription drug coverage option under Medicare. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

There are important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Some of the Walmart prescription drug plans (as described later in this notice under the heading **Which Walmart plans are considered creditable coverage?**) are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and are therefore considered creditable coverage. If you are a participant in one of these plans, you may keep your current coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
- Other Walmart plan options (as described later in the notice under the heading **Which Walmart plans have creditable coverage?**) are, on average for all plan participants, not expected to pay out as much as the standard Medicare prescription drug coverage will pay. If you are a participant in one of these plans, your coverage is non-creditable coverage. This is important

because for most people enrolled in these plan options, enrolling in Medicare prescription drug coverage means you will get more assistance with drug costs than if you had prescription drug coverage exclusively through the plan. This is also important because it may mean that you pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

Creditable and non-creditable coverage

What is the meaning of the term "creditable coverage"? Creditable coverage means that your current prescription drug coverage is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Prescription drug coverage that does not satisfy this requirement is not creditable coverage.

Which Walmart plans are considered creditable coverage?

Walmart has determined that the following prescription drug plans are considered creditable coverage according to Medicare guidelines:

- HRA Elite 3000
- HRA Elite 5000
- HRA Enhanced
- HRA Basic
- HMO

If your coverage is creditable, you can keep your existing coverage and not pay extra if you later decide to enroll in Medicare coverage.

If you are enrolled in an HRA plan or an HMO, you can choose to join a Medicare prescription drug plan later without paying extra because you have existing prescription drug coverage that, on average, is as good as Medicare's coverage.

If you are enrolled in Medicare Part D, you are not eligible to enroll in an HRA plan or the HDP Standard plan. 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 coverage.

If you drop your medical coverage with Walmart and enroll in a Medicare prescription drug plan, you and your eligible dependents will have the option of re-enrolling in the Walmart plan during annual enrollment or with a valid status change event. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Which Walmart plans are considered non-creditable coverage?

The following prescription drug plan is considered non-creditable coverage according to Medicare guidelines:

- HDP Standard plan

If your coverage is non-creditable, you might want to consider enrolling in Medicare prescription drug coverage.

If you are enrolled in the HDP Standard plan, you may want to consider switching to a Medicare prescription drug coverage because the coverage you have is, on average for all participants, not expected to pay out as much as the standard Medicare prescription drug coverage will pay.

When can I enroll for Medicare prescription drug coverage?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

If you have creditable prescription drug coverage and you lose it, through no fault of your own, you will be eligible for a two month special enrollment period (SEP) to join a Medicare drug plan.

If you have non-creditable prescription drug coverage and you drop coverage, because your coverage is employer-sponsored group coverage, you will be eligible for a two month SEP to join a Medicare drug plan. However, you may pay a higher premium (a penalty) because you did not have creditable coverage under the Plan.

When will I pay a higher premium (a penalty) to join a Medicare drug plan?

If you have creditable coverage and drop or lose your coverage under the Plan and do not join a Medicare drug plan within 63 consecutive days after your current coverage ends, you may pay a higher premium (a penalty) to join the Medicare drug plan later.

If you have non-creditable coverage, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may always be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following Medicare annual enrollment period to join.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current coverage under the AMP plan will be affected. Plan guidelines restrict you from enrolling in the HRA or HDP Standard plan if you are enrolled in Medicare Part D. If your dependent is enrolled in Medicare Part D and you are not, you are able to enroll in a Walmart medical plan, but your dependent would not be eligible for coverage.

If you decide to join a Medicare drug plan and drop your coverage under the Walmart AMP, be aware that you and your dependents will be able to get your AMP coverage back.

If you enroll in a Medicare Part D plan and decide within 60 days to switch back to a Walmart plan, you will automatically be reenrolled for the same coverage you had prior to the status change event. See the **Eligibility and enrollment** chapter for further details.

**For more information about Medicare and
your prescription drug coverage**

- You will get this notice each year before your Medicare enrollment period.
- If we make a plan change that affects your credible coverage, you will receive another notice.
- If you need a copy of this notice, you can request one from Benefits Customer Service at **(800) 421-1362**.

Additional information available

More detailed information about Medicare plans that offer prescription drug coverage is available through the "Medicare & You" handbook from Medicare. You may also be contacted directly by Medicare-approved prescription drug plans. You will get a copy of the handbook in the mail. You can also get more information about Medicare prescription drug plans from these sources:

- Visit medicare.gov for personalized help.
- Call your state health insurance assistance program (see your copy of the "Medicare & You" handbook for its telephone number).
- Call **(800) MEDICARE [633-4227]**. TTY users should call **(877) 486-2048**.

For people with limited income and resources, extra help paying for the Medicare prescription drug plan is available. For more information about this resource, visit SSA online at socialsecurity.gov, or call **(800) 772-1213** [TTY **(800) 325-0778**].

Keep this notice. If you enroll in one of the Medicare prescription drug plans, you may need to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Name of Sender: [Associates' Health and Welfare Plan](#)

Contact: [Associates' Health and Welfare Plan](#)
508 SW 8th Street
Bentonville, AR 72716-3500
[\(800\) 421-1362](#)

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

If you are eligible for health coverage from Wal-Mart Stores, Inc., but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office, call **1-877-KIDSNOW**, or visit www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for the Plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, the Plan is required to permit you and your dependents to enroll in the Plan – as long as you and your dependents are eligible, but not already enrolled in the employer's Plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following states, you may be eligible for assistance paying your health plan premiums. The following list of states is current as of July 31, 2011. For current contact information, go to your state's Web site. You should contact your state for further information on eligibility :

ALABAMA – Medicaid

Web site: medicaid.alabama.gov
Phone: (800) 362-1504

ALASKA – Medicaid

Web site: health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): (888) 318-8890
Phone (Anchorage): (907) 269-6529

ARIZONA – CHIP

Web site: azahccs.gov/applicants/default.aspx
Phone (outside of Maricopa County): (877) 764-5437
Phone (Maricopa County): (602) 417-5437

ARKANSAS – CHIP

Web site: arkidsfirst.com/
Phone: (888) 474-8275

CALIFORNIA – Medicaid

Web site: dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: (866) 298-8443

COLORADO – Medicaid and CHIP

Medicaid Web site: colorado.gov/
Medicaid Phone: (800) 866-3513
Medicaid Phone (out of state): (800) 221-3943
CHIP Web site: CHPplus.org
CHIP Phone: (303) 866-3243

FLORIDA – Medicaid

Web site: flmedicaidtplrecovery.com
Phone: (877) 357-3268

GEORGIA – Medicaid

Web site: dch.georgia.gov/
Click on Programs, then Medicaid
Phone: (800) 869-1150

IDAHO – Medicaid and CHIP

Medicaid Web site: accesstohealthinsurance.idaho.gov
Medicaid Phone: (800) 926-2588
CHIP Web site: medicaid.idaho.gov
CHIP Phone: (800) 926-2588

INDIANA – Medicaid

Web site: in.gov/fssa
Phone: (800) 889-9948

IOWA – Medicaid

Web site: dhs.state.ia.us/hipp/
Phone: (888) 346-9562

KANSAS – Medicaid

Web site: kdheks.gov/hef
Phone: (800) 792-4884

KENTUCKY – Medicaid

Web site: chfs.ky.gov/dms/default.htm
Phone: (800) 635-2570

LOUISIANA – Medicaid

Web site: la.hipp.dhh.louisiana.gov
Phone: (888) 695-2447

MAINE – Medicaid

Web site: maine.gov/dhhs/OIAS/public-assistance/index.html
Phone: (800) 572-3839

MASSACHUSETTS – Medicaid and CHIP

Medicaid & CHIP Web site: mass.gov/MassHealth
Medicaid & CHIP Phone: (800) 462-1120

MINNESOTA – Medicaid

Web site: dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: (800) 657-3739
Phone (Twin City area): (651) 431-2670

MISSOURI – Medicaid

Web site: dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: (573) 751-2005

MONTANA – Medicaid

Web site: medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: (800) 694-3084

NEBRASKA – Medicaid

Web site: dhhs.ne.gov/med/medindex.htm
Phone: (877) 255-3092

NEVADA – Medicaid and CHIP

Medicaid Web site: dwss.nv.gov/
Medicaid Phone: (800) 992-0900

NEW HAMPSHIRE – Medicaid

Web site: dhhs.nh.gov/ombp/index.htm
Phone: (603) 271-8183

NEW JERSEY – Medicaid and CHIP

Medicaid Web site: state.nj.us/humanservices/dmabs/clients/medicaid/
Medicaid Phone: (800) 356-1561
CHIP Web site: njfamilycare.org/index.html
CHIP Phone: (800) 701-0710

NEW MEXICO – Medicaid and CHIP

Medicaid Web site: hsd.state.nm.us/mad/index.html
Medicaid Phone: (888) 997-2583
CHIP Web site: hsd.state.nm.us/mad/index.html
Click on Insure New Mexico
CHIP Phone: (888) 997-2583

NEW YORK – Medicaid

Web site: nyhealth.gov/health_care/medicaid/
Phone: (800) 541-2831

NORTH CAROLINA – Medicaid

Web site: nc.gov
Phone: (919) 855-4100

NORTH DAKOTA – Medicaid

Web site: nd.gov/dhs/services/medicalserv/medicaid/
Phone: (800) 755-2604

OKLAHOMA – Medicaid

Web site: insureoklahoma.org
Phone: (888) 365-3742

OREGON – Medicaid and CHIP

Medicaid & CHIP Web site: oregon.gov/OHA/ODHP/FHIAP/
index.shtml
Medicaid & CHIP Phone: (888) 564-9669

PENNSYLVANIA – Medicaid

Web site: dpw.state.pa.us/hipp
Phone: (800) 692-7462

RHODE ISLAND – Medicaid

Web site: dhs.ri.gov
Phone: (401) 462-5300

SOUTH CAROLINA – Medicaid

Web site: scdhhs.gov
Phone: (888) 549-0820

TEXAS – Medicaid

Web site: gethipptexas.com/
Phone: (800) 440-0493

To see if any more states have added a premium assistance program since January 31, 2011 or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/ebsa

1-866-444-EBSA (3272)

UTAH – Medicaid

Web site: health.utah.gov/upp
Phone: (866) 435-7414

VERMONT – Medicaid

Web site: greenmountaincare.org
Phone: (800) 250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Web site: dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: (800) 432-5924
CHIP Web site: famis.org/
CHIP Phone: (866) 873-2647

WASHINGTON – Medicaid

Web site: hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: (800) 562-3022, x15473

WEST VIRGINIA – Medicaid

Web site: dhhr.wv.gov/bins/
Phone: (304) 558-1700

WISCONSIN – Medicaid

Web site: badgercareplus.org/pubs/p-10095.htm
Phone: (800) 362-3002

WYOMING – Medicaid

Web site: health.wyo.gov/healthcarefin/index.html
Phone: (307) 777-7531

Glossary of terms

Actively-At-Work or Active Work: For medical, dental, Resources For Living, critical illness, accidental death and dismemberment, and accident insurance coverage, actively-at-work or active-work means you have reported to work for Walmart.

For company-paid life, optional life, dependent life, Business Travel Accident, short-term disability, short-term disability plus, long-term disability and truck driver long-term disability, actively-at-work or active-work means you are actively-at-work with the company on a day that is one of your scheduled work days if you are performing, in the usual way, all of the regular duties of your job on a full-time basis on that day. You will be deemed to be actively-at-work on a day that is not one of your scheduled work days only if you were actively-at-work on the preceding scheduled work day.

Annual Deductible: The amount you pay each year for eligible medical expenses before the Plan will begin to pay. (If you choose one of the HRA plans, your 2012 Walmart-provided HRA deposit and any rollover dollars you have from your 2011 HRA help you meet your annual deductible.)

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

Associates' Health and Welfare Plan (the Plan): The employer-sponsored health and welfare employee benefit plan sponsored by Wal-Mart Stores, Inc., and governed under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Associates' Medical Plan (AMP): Reference to the medical plans offered by Walmart (HRA Elite 3000, HRA Elite 5000, HRA Enhanced, HRA Basic and HDP Standard plans). See **The medical plan** chapter for more information.

Authorized company business travel: A trip the company authorizes you to take for the purpose of furthering the business. An authorized trip:

- Begins when you leave your residence or regular place of employment, and

- Ends when you return to your residence or regular place of employment.

Behavioral Health: The benefits for mental health and substance abuse including alcohol and drug abuse.

Behavioral Health Facility: A medical facility that provides:

- Inpatient care of 24-hour-a-day service;
- Partial hospitalization or outpatient facility that requires six to eight hours a day service, five to seven days per week; or
- Intensive outpatient care that requires two to four hours a day, three to five days per week.

Catch-up Contributions: Additional contributions allowed by the IRS to an associate's HSA if age 55 or older. Catch-up contributions are allowed by the IRS to an associate's 401(k) plan if age 50 or older.

Certificate of Creditable Coverage: Evidence of prior medical coverage an individual had before joining the Associates' Medical Plan showing whether the individual had a break in coverage of 63 days or more.

COBRA: Consolidated Omnibus Budget Reconciliation Act which allows associates and their eligible dependents who experience a loss in coverage due to a qualifying event to continue medical and dental coverage.

Co-insurance: The amount you pay (20 percent for eligible network expenses) after you've met your annual deductible. The Plan pays 80 percent for eligible network expenses.

Company: Wal-Mart Stores, Inc. and its participating subsidiaries.

Coordination of Benefits (COB): When two benefits plans insure the same participant and coordinate primary versus secondary coverage.

Copay: A fixed dollar amount required for each prescription, or if enrolled in an HMO, each doctor or hospital visit.

Covered Brand Name Drug: A drug manufactured by a single manufacturer that has been evaluated for safety and effectiveness when compared with similar drugs treating the same condition and identified for inclusion on the covered brand name drug list.

Covered Expenses: Charges for procedures, supplies, equipment or services that are covered under the Associates' Medical Plan are:

- Medically necessary;
- Not in excess of the maximum allowable charge;
- Not excluded under the Plan; and
- Not otherwise in excess of Plan limits.

Custodial Care: Services that are given merely as "care" in a facility or home to maintain a person's present state of health, which cannot reasonably be expected to significantly improve.

Deductible: The amount you pay for eligible medical expenses before the Plan begins to pay.

Eligible Dependents: Limited to:

- Your legal spouse of the opposite gender, as long as you are not legally separated (part-time associates and part-time truck drivers may cover their eligible children and may not cover their spouses for medical benefits);
- Your legal dependents up to age 26.

To be eligible, your children must be one of the following:

- Natural children;
- Adopted children or children placed with you for adoption;
- Stepchildren;
- Foster child; or
- Any child for whom you have legal custody or guardianship.

If a court order requires you to provide medical and/or dental coverage for children, the children must meet the Plan's eligibility requirements for dependent coverage.

Eligibility Waiting Period: The time between an associate's hire date and the date the associate is eligible to enroll for benefits.

Explanation of Benefits (EOB): A document sent to Plan participants explaining how a claim was paid or applied.

Experimental and/or Investigational: Medical procedures, supplies, equipment or services that are defined as experimental and/or investigational according to protocols established by the Third Party Administrator.

Health Reimbursement Account (HRA): An amount of money the company sets aside to help pay your eligible medical expenses before you have to pay anything (except prescriptions). If you choose one of the HRA plans, Walmart will contribute \$250 if you select Associate Only coverage, or \$500 if you cover your dependents. If you have money left in your HRA at the end of the year, it rolls over year-to-year up to your annual deductible amount plus your HRA annual contribution amount.

Health Savings Account (HSA): An account you can open with U.S. Bank or BNY Mellon, which can be used to pay for qualified (as defined by the IRS) medical expenses tax-free and Walmart will match your contributions dollar-for-dollar up to \$300 if you select Associate Only coverage, or \$600 if you cover your dependents.

HIPAA: Health Insurance Portability and Accountability Act of 1996, which protects the privacy of personal health information.

Hospital: An institution where sick or injured individuals are given medical or surgical care. The hospital must be a licensed and legally operated acute care general facility that provides:

- Room and board and nursing services for all patients on a 24-hour basis, with a staff of one or more doctors available at all times; and
- On-premise facilities for diagnosis, therapy and major surgery.

A hospital is an institution that is not primarily a nursing home, rest home, convalescent home, institution for treating substance abuse or custodial care institution.

Initial Enrollment Period: The first time you are eligible to enroll for benefits under the Plan. Initial enrollment periods may vary by job classification. See the chart in the **Enrollment and eligibility** chapter.

Leave of Absence: Provides associates with needed time away from work while maintaining eligibility for benefits and continuity of employment. To accommodate situations that necessitate absence from work, the company provides three types of leave:

- Family Medical Leave Act (FMLA);
- Personal; and
- Military.

The decision to grant a request for leave shall be based on applicable laws, the nature of the request, the effect on work requirements, and consistency with the policy guidelines and procedures.

Maximum Allowable Charge (MAC): The amount of a provider's charge (whether in network or out-of-network) paid to providers in a given geographic area, as determined by the Third Party Administrator.

Medically Necessary: Procedures, supplies, equipment or services that are determined by the Plan to be:

- Appropriate for the symptoms, diagnosis or treatment of a medical condition;
- Provided for the diagnosis or direct care and treatment of the medical condition;
- Within the standards of good medical practice within the organized medical community;
- Not primarily for the convenience of the patient or the patient's doctor or other provider; and
- The most appropriate procedure, supply, equipment or service which can be safely provided, and
 - There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications for the patient with the particular medical condition being treated, than other possible alternatives;
 - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
 - For hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

Network: Health care providers that have a written agreement with Third Party Administrators to provide services at discounted rates.

Non-network: Health care providers that do not have a written agreement with Third Party Administrators to provide services at discounted rates.

Out-of-Network: Payment for covered expenses that do not meet the criteria in the section **When network benefits are paid for out-of-network expenses**, or are provided by a non-network provider. Charges do not apply to your out-of-pocket maximum.

Out-of-Pocket Maximum: The most you will pay each year for eligible network services including prescriptions.

Pre-Existing Condition: A physical or behavioral health condition for which an individual received medical care, advice, diagnosis or treatment, including prescription drugs, during the six-month period before his or her "determination date."

Premium: The amount you pay out of each paycheck for the benefits you choose.

Pre-Notification: A notification made by enrollees/providers to advise of any upcoming hospital admissions or outpatient services.

Proof of Good Health: Evidence of your health condition and includes completing a questionnaire regarding your medical history and possibly having a medical exam. The Proof of Good Health questionnaire is made available when you enroll.

Qualified Medical Expense: As defined by IRS Publication 502 - Medical and Dental Expenses.

Qualified Medical Child Support Order (QMCSO): A final court or administrative order requiring an associate to carry health care coverage for eligible dependents, usually following a divorce or child custody proceeding.

Specialty Drug: Specialty drugs are those pharmaceuticals that target and treat specific chronic or genetic conditions. Specialty drugs include biopharmaceuticals (bioengineered proteins), blood-derived products and complex molecules. They are available in oral, injectable or infused forms. The list of covered specialty drugs is available at mywalmart.com.

Status Change Event: A status change event is an event that allows you to make changes to your coverage outside of the initial enrollment period or annual enrollment period and is in accordance with federal law. These events are listed in the **Eligibility and enrollment** chapter.

Third Party Administrator (TPA): A third party that makes claims determinations under the Plan, pursuant to a contractual arrangement with the Plan. Third Party Administrators process your claims with respect to the Plan's self-funded medical benefits. Third Party Administrators do not insure any benefits under the Plan.

Total Disability or Totally Disabled for Short-Term Disability or Short-Term Disability Plus:

- You are unable to perform the essential duties of your occupation according to the medical evidence provided by a qualified doctor other than you or a family member (failure to meet requirements necessary to maintain a license to perform the duties of your occupation does not mean you are totally disabled);
- You are under the continuous care of a qualified doctor; and
- The disability is due to injury, sickness or pregnancy.

Total Disability or Totally Disabled for Full-Time, Management and Truck Driver Long-Term Disability:

- You are unable to perform the essential duties of your occupation (or any occupation after 12 months of benefit payments) according to the medical evidence provided by a qualified doctor other than you or a family member (failure to meet requirements necessary to maintain a license to perform the duties of your occupation does not mean you are totally disabled);
- You are under the continuous care of a qualified doctor; and
- The disability is due to accidental bodily injury, sickness, substance abuse or pregnancy.

Your Occupation (for total disability): Includes similar job positions with the company with a rate of pay 50 percent or greater of your indexed pre-disability earnings.

Walmart: Wal-Mart Stores, Inc. and its participating subsidiaries.

If you have questions about...

	Call or go here:
<ul style="list-style-type: none">• When you're eligible for benefits• How and when to enroll	Walmart Benefits Customer Service <ul style="list-style-type: none">• (800) 421-1362• TDD (800) 335-4225 for the hearing impaired• Visit mywalmart.com
Medical claims	<ul style="list-style-type: none">• Call the phone number on your insurance ID card• mywalmart.com• The WIRE at work
Medical pre-notification Behavioral Health pre-notification	(866) 823-3790 (877) 709-6822
Find a network provider	<ul style="list-style-type: none">• mywalmart.com• The WIRE at work
Pharmacy benefits	Medco (800) 887-6194
Health Savings Account	<ul style="list-style-type: none">• BNY Mellon (800) 358-3494• U.S. Bank (800) 358-3494
Dental claims	Delta Dental (800) 462-5410
<ul style="list-style-type: none">• Short-term disability• Short-term disability plus• Long-term disability• Truck driver long-term disability	The Hartford (800) 492-5678
<ul style="list-style-type: none">• Accident insurance• Critical illness insurance	Allstate Benefits (800) 514-9525
<ul style="list-style-type: none">• Company-paid life• Optional life• Dependent life• Accidental death and dismemberment (AD&D) insurance• Business Travel Accident	Prudential (877) 740-2116
Life with Baby Maternity Program	<ul style="list-style-type: none">• (888) 659-8936
Ask Mayo Clinic nurse line	<ul style="list-style-type: none">• (800) 418-0758• Call 24 hours a day, 7 days a week
Resources For Living®	<ul style="list-style-type: none">• (800) 825-3555• Call 24 hours a day, 7 days a week
Walmart 401(k) Plan	Merrill Lynch (888) 968-4015
Associate Stock Purchase Plan	<ul style="list-style-type: none">• Computershare (800) 438-6278• mywalmart.com• TDD (800) 952-9245 for the hearing impaired

