Case Nos. 85525 & 85656

In the Supreme Court of Nevada

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC., Appellants, *vs.* FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD., Respondents.	Case No. 85525
UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC., Petitioners, *vs.* THE EIGHTH JUDICIAL DISTRICT COURT of the State of Nevada, in and for the County of Clark; and the Honorable NANCY L. ALLF, District Judge, Respondents, *vs.* FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD., Real Parties in Interest.	Case No. 85656

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441	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 3 of 18 (Filed Under Seal)	12/24/21	115 116	28,485–28,643 28,644–28,742
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443	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 5 of 18 (Filed Under Seal)	12/24/21	117	28,939–29,084
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453	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 15 of 18 (Filed Under Seal)	12/24/21	124	30,678–30,835
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455	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 17 of 18 (Filed Under Seal)	12/24/21	125	30,953–31,122
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460	Transcript of Proceedings Re: Motions (Filed Under Seal)	01/20/22	127 128	31,597–31,643 31,644–31,650
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39	Transcript of Proceedings, All Pending Motions	06/09/20	6	1385–1471
46	Transcript of Proceedings, Plaintiff's Motion to Compel Defendants' Production of Unredacted MultiPlan, Inc. Agreement	07/29/20	7	1644–1663
482	Transcript of Status Check (Filed Under Seal)	10/10/22	142	35,248–35,258
492	Transcript Re: Proposed Jury Instructions	11/21/21	146	36,086–36,250
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CERTIFICATE OF SERVICE

I certify that on April 18, 2023, I submitted the foregoing appendix for filing *via* the Court's eFlex electronic filing system.

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Enrolling in optional associate life insurance

Your coverage choices for optional associate life insurance depend on your job classification, as follows:

If you are an hourly associate or part-time truck driver, your coverage choices for optional associate life insurance are:

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

If you are a management associate, your coverage choices for optional associate life insurance are:

- $25,000
- $50,000
- $75,000
- $100,000
- $150,000
- $200,000
- $300,000
- $500,000
- $750,000
- $1,000,000

NOTE: To be eligible for this benefit as a management associate, you must be classified in the company's payroll system as a management associate, management trainee, California pharmacist, full-time Vision Center manager, Metro professional non-exempt associate or full-time truck driver.

For all associates enrolling in optional associate life insurance, Proof of Good Health may be required when you enroll, depending on the coverage amount you choose and when you enroll.

This policy has no cash value, and premiums from optional associate life coverage do not subsidize coverage under company-paid life insurance.

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

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

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

Hourly associates, part-time truck drivers and management associates (including the job classifications listed in the **NOTE** to the left) can enroll in optional associate life insurance at any time once they are eligible. Proof of Good Health is required if you enroll after your initial enrollment period. You can change or drop coverage at any time. However, if you want to increase your coverage or re-enroll after dropping coverage, you will be required to provide Proof of Good Health.

PROVIDING PROOF OF GOOD HEALTH

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

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

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

Naming a beneficiary

In order to ensure that your life insurance benefit is paid according to your wishes, you must name a beneficiary(ies) to receive your optional associate life insurance benefit if you die. You may do this by going to the WIRE, WalmartOne.com or Workday. Any change in beneficiary must be completed and submitted to Walmart before the covered person's death.

You can name anyone you wish. If the beneficiary(ies) you have listed with Walmart differs from those named in your will, the list that Walmart has prevails. If you have not designated a beneficiary(ies) under the optional associate life insurance benefit, payment will be made to your surviving family member(s) as described under If you do not name a beneficiary later in this chapter.

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, and
- The percentage you wish to designate per beneficiary, up to 100%.

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

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

If you name a minor as a beneficiary, funeral expenses cannot be paid from the minor's beneficiary proceeds.

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

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IF YOU DO NOT NAME A BENEFICIARY

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

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

When your optional associate life insurance coverage begins

When Proof of Good Health is required (as described on the previous page), your coverage will become effective the day that the company receives approval from Prudential or at the end of your eligibility waiting period, whichever is later.

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

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

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

Early payout due to terminal illness

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

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

You are terminally ill if:

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

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

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

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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, Pennsylvania 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 designated beneficiary or a beneficiary in the default list, as specified under If you do not name a beneficiary earlier in this chapter.

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 actual facts will be used to determine what amount of coverage should have been in effect, if any, and:

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

If you go on a leave of absence

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums either before the leave begins or during the leave. For information about making payments while on a leave of absence, see the Eligibility and enrollment chapter.

BREAK IN COVERAGE

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-work status within one year from cancellation, you will be enrolled for the same coverage (or, if this coverage is not available, the coverage that is most similar to your prior coverage). Your coverage will be effective the first day of the pay period that you meet the actively-at-work requirement. For more information, contact People Services at 800-421-1362.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-work status after one year from cancellation, you will be considered newly eligible; you may enroll for coverage within the applicable time period and under the conditions described in the Eligibility and enrollment chapter.

When coverage ends

Your optional associate life insurance coverage ends:

- At termination of your employment
- Upon failure to pay your premiums
- On the date of your death
- On the last day of an approved leave of absence (unless you return to work)
- When the benefit is no longer offered by the company, or
- On the day after you drop coverage.

This policy has no cash value.

Continuing your optional associate life insurance after you leave Walmart

In most circumstances, you will have two options to continue your optional associate life insurance if your group life coverage ends. The first option, called **portability**, allows you to continue all or a portion of your current coverage through a group term policy with Prudential. The second option, called **conversion**, allows you to convert all or a portion of your coverage to a Prudential individual policy.

You must apply for portability or conversion within 31 days of the date your coverage ends. If you die within 31 days of a qualifying loss of coverage and before electing portability or conversion of your life insurance coverage, Prudential will pay a death benefit to your beneficiary. The benefit will be paid based on the amount of coverage in effect prior to the qualifying loss of coverage, even if you did not apply for portability or conversion of your coverage.

Portability enables you to maintain similar term life insurance with Prudential after your employment ends if certain conditions are met. Proof of Good Health is not required to port your coverage. You can, however, receive preferred rates similar to the rates you paid while an active

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associate if you submit and pass Proof of Good Health. If you do not pass or submit Proof of Good Health, your rates will be based on Prudential's standard portability rates.

You will be able to apply for term life coverage under the portability feature if you meet all of these conditions:

1. Your optional associate life coverage ends for any reason other than:
   a. your failure to pay premiums while you were an active associate
   b. you leave the company due to a disability, or
   c. Walmart changes group life insurance carriers and you are or become eligible within the next 31 days.
2. You meet the actively-at-work requirement on the day your insurance ends.
3. You are less than age 80.
4. Your amount of insurance is at least $20,000 on the day your insurance ends.

If you meet these conditions, you will have 31 days from your termination date to contact Prudential and enroll.

Conversion is a required Plan provision that allows you to convert your life insurance coverage to an individual policy. Rates are based on an individual's age and amount converted. You have 31 days from the termination date of coverage to request to convert your coverage to an individual policy. If your death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted.

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

To request information on portability or conversion, call Prudential at 877-740-2116.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be re-enrolled for the same coverage in effect prior to leaving the company (or the most similar coverage offered under the Plan). You can drop or otherwise change your coverage at any time.

If you return to work after 13 weeks, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period. Proof of Good Health is required for coverage plans above $25,000. See the Eligibility and enrollment chapter for details.

If you drop or decrease your coverage and re-enroll

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

If you re-enroll more than 30 days after dropping or decreasing your coverage, Proof of Good Health will be required.

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Optional dependent life insurance

WHERE CAN I FIND?

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

Optional dependent life insurance

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

OPTIONAL DEPENDENT LIFE INSURANCE RESOURCES

Find What You Need	Online	Other Resources
Get more details about life insurance	Go to the WIRE or WalmartOne.com	Call Prudential at 877-740-2116
File a claim		Call Prudential at 877-740-2116

What you need to know about optional dependent life insurance

- All full-time hourly and management associates can enroll their spouses/partners and/or children in optional dependent life insurance when they are eligible, as described in the Eligibility and enrollment chapter.
- All part-time hourly associates and part-time truck drivers can enroll their children in optional dependent life insurance when they are eligible, but cannot enroll their spouses/partners.
- Proof of Good Health for your spouse/partner is required if you enroll for a coverage amount above $5,000 during your initial enrollment period, or for any coverage amount if you enroll at any other time.

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Enrolling in optional dependent life insurance

All hourly and management associates can enroll in optional dependent life insurance. When you enroll in optional dependent life insurance, if your covered spouse/partner and/or legal dependent dies, you may receive a lump sum payment for the coverage amount you select. Optional dependent life insurance is insured by The Prudential Insurance Company of America (Prudential).

Your coverage choices for optional dependent life insurance are:

- Spouse/partner (except for part-time hourly associates, temporary associates and part-time truck drivers):
  - $5,000
  - $15,000
  - $25,000
  - $50,000
  - $75,000
  - $100,000
- Child:
  - $2,000 per child
  - $5,000 per child
  - $10,000 per child

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

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

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

This policy has no cash value, and premiums from optional dependent life coverage do not subsidize coverage under company-paid life insurance.

You can enroll in optional dependent life insurance at any time. Proof of Good Health is required for your spouse/partner if you enroll after your initial enrollment period.

Also, you can change or drop coverage at any time. However, if you want to increase your spouse/partner's coverage or re-enroll after dropping coverage, you will be required to provide Proof of Good Health for your spouse/partner.

PROOF OF GOOD HEALTH

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

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

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

When your optional dependent life insurance coverage begins

When Proof of Good Health is required (as described above), coverage for your spouse/partner will become effective the day that the company receives approval from Prudential or at the end of your eligibility waiting period, whichever is later. Proof of Good Health is not required for children.

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

When Proof of Good Health is not required, coverage for your spouse/partner or child will be effective on the date you enroll or at the end of your eligibility waiting period, whichever is later.

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

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.

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Additional benefits

Benefits also are payable under the following circumstances:

- If a dependent child is born alive and dies within 60 days of birth and was eligible but not enrolled in optional dependent life insurance prior to the loss — with a live birth certificate and a death certificate — Prudential will pay a $2,000 benefit only.
- If a dependent child is stillborn, Prudential will pay a $2,000 benefit to associates who have met the eligibility waiting period for dependent life insurance. See the Eligibility and enrollment chapter for details. A stillborn child is defined as an eligible associate's natural-born child whose death occurs before expulsion, extraction or delivery and whose fetal weight is 350 grams or more; or, if fetal weight is unknown, whose duration in utero was 20 or more complete weeks of gestation. If both the mother and father of the stillborn child work at Walmart, each associate is eligible to submit a claim for this benefit separately, for a total of $4,000.

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, Pennsylvania 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 results in the death of the insured. Instead, the benefit may go to the insured's estate.

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

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

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

If you go on a leave of absence

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums either before the leave begins or during the leave. For information about making payments while on a leave of absence, see the Eligibility and enrollment chapter.

BREAK IN COVERAGE

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-work status within one year from cancellation, you will be enrolled for the same coverage (or, if this coverage is not available, the coverage that is most similar to your prior coverage). Your coverage will be effective the first day of the pay period that you meet the actively-at-work requirement. For more information, contact People Services at 800-421-1362.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-work status after one year from cancellation, you will be considered newly eligible; you may enroll for coverage within the applicable time period and under the conditions described in the Eligibility and enrollment chapter.

When coverage ends

Your optional dependent life insurance coverage ends:

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

In addition, if you have optional dependent life coverage for your spouse/partner and your job status changes to part-time hourly associate, temporary associate or part-time truck driver, your coverage for your spouse/partner will end on the last day of the pay period when your job status changes.

This policy has no cash value.

Continuing your optional dependent life insurance after you leave Walmart

In most circumstances, you will have two options to continue your optional dependent life insurance if your group life coverage ends. The first option, called **portability**, allows you and your dependents to continue all or a portion of your current coverage through a group term policy with Prudential. The second option, called **conversion**, allows you to convert all or a portion of your coverage to a Prudential individual policy.

Portability enables you to maintain similar term life insurance with Prudential after your employment ends if certain conditions are met.

Proof of Good Health is not required to "port" your coverage. You can, however, receive preferred rates similar to the rates you paid while an active associate if you and your dependents submit and pass Proof of Good Health. If you do not pass or submit Proof of Good Health, your rates will be based on Prudential's standard portability rates.

You will be able to apply for term life coverage under the portability feature if you meet all of these conditions:

1. The optional dependent life coverage on the dependent ends because your optional associate life coverage ends for any reason other than:
   a. your failure to pay, when due, any contribution required for it
   b. the end of your employment on account of your retirement due to disability, or
   c. the end of the optional associate life coverage for all associates when such coverage is replaced by group life insurance from any carrier for which you are or become eligible within the next 31 days.
2. You apply and become covered for term life coverage under the portability plan.
3. With respect to a dependent spouse/partner, that spouse/partner is less than age 80.
4. With respect to a dependent child, that child is less than age 26.
5. The dependent is covered for optional dependent life coverage on the day your optional associate life coverage ends.
6. The dependent is not confined for medical care or treatment, at home or elsewhere, on the day your optional associate life coverage ends.

Conversion is a required Plan provision that allows you to convert your life insurance coverage to an individual policy. Rates are based on an individual's age and amount converted.

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

To request information on portability or conversion, call Prudential at 877-740-2116.

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If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be re-enrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan). You can drop or otherwise change this coverage at any time.

If you return to work after 13 weeks, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period. Proof of Good Health is required for spouse/partner coverage plans above $5,000.

See the Eligibility and enrollment chapter for details.

If you drop or decrease your coverage and re-enroll

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

If you re-enroll more than 30 days after dropping or decreasing coverage, Proof of Good Health will be required for spouse/partner coverage plans.

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Accidental death and dismemberment (AD&D) insurance

WHERE CAN I FIND?

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential regarding the calculation of benefits and limitations under the policy, 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	Go to the WIRE, WalmartOne.com or Workday	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 hourly and management associates can enroll in AD&D when they are eligible, as described in the Eligibility and enrollment chapter.
- 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 hourly 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 + dependent(s)

NOTE: If you are a part-time hourly associate, temporary associate or part-time truck driver and you choose associate + dependent(s) coverage, you can cover your dependent children but not your spouse/partner.

The coverage amount for your dependent(s) 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

Management associates may also choose the following coverage amounts:

- $300,000
- $500,000
- $750,000
- $1,000,000

The amount of your benefit depends on the type of loss you experience. 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 + dependent(s) coverage.

Naming a beneficiary

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

You can name anyone you wish. If the beneficiary(ies) you have listed with Walmart differs from those named in your will, the list that Walmart has prevails. If you have not designated a beneficiary(ies) under the AD&D benefit, payment will be made to your surviving family surviving family member(s) as described under If you do not name a beneficiary later in this chapter.

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

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

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

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

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

CHANGING YOUR BENEFICIARY

Your beneficiary(ies) can be changed at any time on the WIRE, WalmartOne.com or Workday. Any change in beneficiary must be completed and submitted to Walmart before the covered person's death.

IF YOU DO NOT NAME A BENEFICIARY

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

1. Widow or widower or partner of the deceased; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares, if not surviving, then
5. Your estate.

When your AD&D coverage begins

If you enroll during annual enrollment, your coverage will become effective on January 1 of the next Plan year.

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

When you enroll in AD&D insurance, the coverage amount you select is the amount that applies to you, the associate. If you enroll in associate + dependent(s) coverage, the coverage amount for your dependent(s) is a percentage of your associate coverage amount. The coverage amount for your dependent(s) depends on the type of dependents you are covering. See the **Full benefit amount** chart below for information on the coverage amount for your family members.

When AD&D benefits are paid

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

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

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

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

COVERED LOSSES PAID AT FULL BENEFIT

The following covered losses resulting from an accident are payable at the full benefit:

- Loss of life: It will be presumed that you have suffered a loss of life if your body is not found within one year of disappearance, stranding, sinking or wrecking of any vehicle in which you were an occupant.
- Loss of both hands above the wrists; both feet above the ankles; total and permanent loss of sight in both eyes; loss of speech and hearing in both ears that lasts for six consecutive months following the accident.
- Loss of one hand and one foot: Severance at or above the wrist or ankle joint.
- Loss of one arm or one leg: Severance at or above the elbow or above the knee.
- Loss of one hand or foot and sight in one eye: Severance at or above the wrist or ankle joint, with total and permanent loss of sight in one eye.
- 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.

FULL BENEFIT AMOUNT

Associate coverage amount	If a spouse/partner is the only dependent covered	If both a spouse/partner and children are covered dependents		If children are the only dependents
Associate — 100%	Spouse/partner — 50%	Spouse/partner — 40%	Children — 10%	Children — 25%
$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
Management associates only:				
$300,000	$150,000	$120,000	$30,000	$75,000
$500,000	$250,000	$200,000	$50,000	$125,000
$750,000	$375,000	$300,000	$75,000	$187,500
$1,000,000	$500,000	$400,000	$100,000	$250,000

50% OF FULL BENEFIT

The following covered losses resulting from an accident are payable at 50% of full benefit:

- Brain damage: Brain damage means permanent and irreversible physical damage to the brain, causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of more than five consecutive days within 30 days of the accident and continue for 12 consecutive months.
- Loss of hand or foot: Severance at or above the wrist or ankle.
- Loss of sight in one eye: Permanent loss of sight in one eye.
- Loss of speech or hearing in both ears: Total and permanent loss of speech or hearing (i.e., continuing for at least six consecutive months following the accident).

25% OF FULL BENEFIT

The following covered losses resulting from an accident are payable at 25% of full benefit:

- Loss of hearing in one ear: Total and permanent loss of hearing (i.e., continuing for at least six consecutive months following the accident).
- Loss of thumb and index finger of the same hand: Severance at or above the point at which they are attached to the hand.
- Uniplegia: Total paralysis of one limb.

COMA BENEFIT

If you or your covered dependent(s) is comatose or becomes comatose within 365 days as the result of an accident, a coma benefit equal to 1% of the insured's coverage amount will be paid for 11 consecutive months to you, your spouse/partner, your children or a legal guardian. The benefit is payable after 31 consecutive days of being comatose. If you or your covered dependent(s) remains comatose beyond 11 months, the full sum of the coverage, less any AD&D benefit already paid, will be made to you or your designated beneficiary.

"Coma" means a profound state of unconsciousness from which the comatose person cannot be aroused, even by powerful stimulation, as determined by the person's doctor. Such state must begin within 365 days of the accidental injury and continue for 31 consecutive days.

Additional AD&D benefits

Additional benefits may be payable by the Plan:

- Seat belt benefit: If you and/or your covered dependents suffer a loss of life as a result of a covered accident that occurs while wearing a seat belt, an additional benefit may be payable.
- Safe motorcycle rider benefit: If you and/or your covered dependents suffer a loss of life as a result of a covered accident that occurs while wearing a helmet, an additional benefit may be payable.
- Education and childcare benefit: If you (the associate) suffer a loss of life, a childcare benefit, child education benefit and/or spouse/partner education benefit may be payable.
- Home alteration and vehicle modification benefit: If you and/or your covered dependents suffer a covered loss that requires home alteration or vehicle modification, an additional benefit may be payable.
- COBRA monthly medical premium benefit: If you (the associate) suffer a covered accidental bodily injury, which results in a termination after a leave of absence, an additional benefit may be payable to assist with the continuation of your medical benefits under the Associates' 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 that occurs prior to your enrollment in the Plan nor 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 (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

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- While operating a land, water or air vehicle, being legally intoxicated, or
- Being under the influence of or taking any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, and all amendments, unless prescribed by and administered in accordance with the advice of the insured's 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, Pennsylvania 19176

Benefits are paid in a lump sum. If you or a covered dependent sustains more than one covered loss due to an accidental injury, the amount paid, on behalf of any such injured person, will not exceed the full amount of the benefit.

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

If you go on a leave of absence

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums either before the leave begins or during the leave. For information about making payments while on a leave of absence, see the Eligibility and enrollment chapter.

BREAK IN SERVICE

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-work status within one year of cancellation, you will be enrolled for the same coverage you had prior to your leave of absence. Your coverage will be effective the first day of the pay period that you meet the actively-at-work requirement. For more information, contact People Services at 800-421-1362.

If your coverage has been canceled (by your choice or due to nonpayment of premiums while you are on leave) and you return to actively-at-work status after one year of cancellation, you will be considered newly eligible; you may enroll for coverage within the applicable time period and under the conditions described in the Eligibility and enrollment chapter.

When coverage ends

Your AD&D coverage ends:

- At termination of your employment
- Upon failure to pay your premiums
- On the date of your death
- On the date you or a dependent spouse/partner or child loses eligibility
- On the last day of an approved leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company. AD&D coverage cannot be converted to individual coverage after coverage ends.

In addition, if you have chosen associate + dependent(s) coverage and your job status changes to part-time hourly associate, temporary associate or part-time truck driver, your coverage for your spouse/partner will end on the last day of the pay period when your job status changes.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be re-enrolled for the same coverage in effect prior to leaving the company (or the most similar coverage offered under the Plan). If your break is greater than 30 days but less than 13 weeks, you will have 60 days after resuming employment to drop or otherwise change the coverage in which you were automatically re-enrolled.

If you return to work after 13 weeks, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period.

See the Eligibility and enrollment chapter for details.

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 coverage, you may enroll for coverage under the time periods and conditions described in the Eligibility and enrollment chapter.

Business travel accident insurance

WHERE CAN I FIND?

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policies issued by the applicable insurers under this chapter regarding the calculation of benefits and limitations under the policies, the terms of the policies will govern. You may obtain a copy of these policies 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 death or certain types of injury. 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	Go to the WIRE, WalmartOne.com or Workday	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
Get more details about international business travel medical insurance through GeoBlue	Go to geo-blue.com	Call GeoBlue at 888-412-6403

What you need to know about business travel accident insurance

- Wal-Mart Stores, Inc. provides all associates with business travel accident insurance — at no cost to you. The company pays for this coverage in full.
- No enrollment is necessary. Coverage will become effective on your first day of active work. See the Eligibility and enrollment chapter for details.
- Business travel accident insurance pays a lump-sum benefit for loss of life, limb, sight, speech or hearing or paralysis, due to an accident you are involved in while traveling on authorized company business.
- Your coverage amount is three times your Base Annual Earnings — maximum of $1 million and minimum of $200,000 (unless otherwise specified). This company-paid insurance is provided through The Prudential Insurance Company of America (Prudential).
- International business travel medical insurance is available for eligible business travelers through GeoBlue.

Your business travel accident insurance

If you experience a covered injury resulting in loss or death while traveling on authorized company business, a lump-sum benefit is payable to you or your beneficiary(ies) of up to three times your Base Annual Earnings, with a maximum of $1 million and minimum of $200,000 (unless otherwise specified).

Base Annual Earnings* is defined as follows:

- **For hourly associates:** Annualized hourly rate as shown in the Walmart payroll system as of date of loss or death.
- **For management associates and officers:** Base salary as shown in the Walmart payroll system as of date of loss or death.
- **For truck drivers:** Annualized average day's pay as of date of loss or death, as determined by Logistics Finance.

** Base Annual Earnings shall exclude any bonus you may receive.*

Naming a beneficiary

In order to ensure that your business travel accident insurance benefit is paid according to your wishes, you must name a beneficiary(ies). You (the associate) will receive any benefits payable for the injuries listed in When business travel accident insurance benefits are paid later in this chapter.

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

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

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

It's important to update your beneficiary information annually. Keep in mind, proceeds will go to whomever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person. You can change your beneficiary(ies) at any time on the WIRE, WalmartOne.com or Workday. Any change in beneficiary must be completed and submitted to Walmart before the covered person's death.

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

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

IF YOU DO NOT NAME A BENEFICIARY

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

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

Filing a claim for business travel accident benefits

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, Pennsylvania 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 AND MINIMUM OF $200,000 (UNLESS OTHERWISE SPECIFIED)

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

50% OF FULL BENEFIT

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

25% OF FULL BENEFIT

- Thumb and index finger of the same hand: Severance of each through or above the joint closest to the wrist, or
- Uniplegia: Total paralysis of one limb.

Additional business travel accident insurance benefits

Business travel accident insurance provides these additional benefits:

- Seat belt benefit
- Airbag benefit
- Coma benefit
- Funeral expenses benefit
- Medical evacuation benefit
- Family relocation and accompaniment, and
- Specific activity hazard: traveling to, from or while attending Walmart's Annual Shareholders Meeting.

Felonious assault benefit: If you (the associate) suffer a covered loss from a felonious assault because of your employment with Walmart while you are working or on an authorized business trip, a benefit of up to $10,000 may be payable. A covered loss is either death, dismemberment or paralysis, as described under When business travel accident insurance benefits are paid.

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When business travel accident insurance benefits are not paid

Business travel accident insurance benefits will not be paid for the following:

- Intentionally self-inflicted injuries while sane or insane
- Suicide or attempted suicide
- Sickness, whether the loss results directly or indirectly from the sickness
- Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the sickness
- Any bacterial or viral infection, except a pyogenic infection resulting from an accidental cut or wound or a bacterial infection resulting from accidental ingestion of a contaminated substance
- Losses resulting from war or act of war (declared or undeclared), including resistance to armed aggression or an accident while on full duty with the armed services for more than 30 days (this does not include Reserve or National Guard active duty for training)
- Losses resulting from riding in an unlicensed aircraft
- Losses resulting from flying as a crew member of an airplane, except one owned and operated by the company
- Injuries that arise during an attempt to commit an assault or the commission of a felony
- Losses resulting from being legally intoxicated while operating a land, water or air vehicle, or
- Losses resulting from being under the influence of or taking any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, and all amendments, unless prescribed by and administered in accordance with the advice of the insured's doctor.

When coverage ends

Your business travel accident insurance coverage ends on your last day of employment.

If you leave the company and are rehired

Your business travel accident insurance coverage (or the most similar coverage offered under the Plan) will be reinstated.

International business travel medical insurance

International business travel medical insurance is available through a policy with GeoBlue for associates who travel internationally for business.

GeoBlue provides travel assistance services to you and your eligible dependents if you require emergency medical treatment while traveling on company-authorized business. For eligible associates, Walmart pays for this coverage in full — there is no cost to you and no enrollment is necessary. Coverage is valid for a trip lasting up to 180 days. Coverage is not available for personal travel even when you add personal travel to a business trip.

You are not eligible to make Health Savings Account contributions for any month in which you are traveling on Walmart business outside the U.S. and are covered under the GeoBlue policy. You are encouraged to consult with your tax advisor if you have questions about the amount to reduce your contributions based on your individual circumstances.

GEOBLUE SERVICES

Business travel medical insurance through GeoBlue provides coverage for emergency medical treatment including hospitalization, doctor visits and prescription drug coverage (not including over-the-counter medication).

GeoBlue has a network of doctors, physicians and medical facilities in over 180 countries and can also make appointments on your behalf and arrange for direct billing. Associates are advised to contact GeoBlue Customer Service at 888-412-6403 before obtaining medical treatment to ensure that the treatment is covered.

GeoBlue provides the following services:

- Reimbursement for eligible medical expenses
- Assistance in location of physician, medical facilities and making medical appointments
- Direct billing and payment guarantees
- Coordination for emergency medical evacuation to the nearest appropriate medical facility for the associate and an accompanying family member(s), and
- Repatriation of remains.

If you incur eligible medical expenses, submit them to GeoBlue for reimbursement. They should not be charged to the corporate credit card or submitted for reimbursement through the travel and expense system.

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Associates are advised to register on geo-blue.com before their business travel, using group access code QHG9999WALM. By registering, you gain access to services and benefits including the following:

- Ability to print out your insurance ID card in case yours is lost
- Locate a doctor or facility
- Check your symptoms
- Translate medical terms and medications, and
- Understand health and security risks.

Downloading the GeoBlue App: Once you've registered, download the GeoBlue app and log in with the email address and password you created when you registered on the website. The GeoBlue app provides you with the most convenient access to your ID card and GeoBlue's self-service tools including mapping to your nearest approved medical facility/provider, making appointments, etc.

GeoBlue Member ID cards: Cards will carry the Blue Cross Blue Shield logo and will be available in your travel department. Additional or replacement cards can be downloaded via geo-blue.com.

Claims: Claim forms are generally not required for GeoBlue services. However, if you have a question about your benefits or disagree with the benefits provided, you may contact GeoBlue or file a claim by writing the following address:

GeoBlue
One Radnor Corporate Center, Suite 100
Radnor, Pennsylvania 19087

Any claims and appeals will be determined under the time frames and requirements set out in the procedures for filing a claim for medical benefits outlined in the Claims and appeals chapter. Contact GeoBlue at any time by calling 888-412-6403. Outside the U.S. call collect: 610-254-5830.

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Short-term disability for hourly associates

WHERE CAN I FIND?

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Short-term disability for hourly associates

Pregnancy, a scheduled surgery or an unexpected illness or injury could keep you off the job and off the payroll for an extended period of time. The Walmart short-term disability plan for hourly associates can protect part of your paycheck if you become disabled for more than seven calendar days. When you can't work, the Walmart short-term disability plan works for you.

SHORT-TERM DISABILITY FOR HOURLY ASSOCIATES RESOURCES

Find What You Need	Online	Other Resources
Get more details about short-term disability or file a claim (for all states except California and Rhode Island)	Go to WalmartOne.com	Call Sedgwick/Liberty at 800-492-5678
If you work in California	Go to edd.ca.gov	Call the state of California at 800-480-3287
If you work in Rhode Island	Go to www.dlt.ri.gov/tdi	Call the state disability carrier at 401-462-8420

What you need to know about short-term disability for hourly associates

- Walmart offers a short-term disability basic plan and a short-term disability enhanced plan to all full-time hourly associates (including full-time hourly pharmacists, field Logistics associates, field supervisor positions in stores and clubs and full-time hourly Vision Center managers), except for associates who work in California, Hawaii, New Jersey and Rhode Island, who are eligible for state-mandated disability coverage.
- Eligible full-time hourly associates will automatically be enrolled in the short-term disability basic plan after their eligibility waiting period, except for associates who work in California, Hawaii, New Jersey and Rhode Island. No associate contributions are required for the short-term disability basic plan.
- All full-time hourly associates who are eligible for the short-term disability basic plan will also have the option to enroll in the short-term disability enhanced plan, except for associates who work in California, Hawaii, New Jersey, New York and Rhode Island. Associates who work in New York will have the option to enroll in the New York short-term disability enhanced plan, which is separately funded and administered.
- While you are disabled and receiving short-term disability benefits, the short-term disability basic plan replaces 50% of your income up to a maximum of $200 per week. The short-term disability enhanced plan replaces 60% of your income with no weekly maximum. The New York short-term disability enhanced plan replaces 60% of your income up to a maximum of $6,000 per week.
- If you enroll in the short-term disability enhanced plan during your initial enrollment period, your coverage begins on your effective date, as described in this chapter. If you enroll in the short-term disability enhanced plan at any time other than during your initial enrollment period, your short-term disability enhanced plan coverage will not begin until you complete a 12-month waiting period.
- There is a 90-day deadline from the date your disability begins to file a claim for short-term disability benefits, except in the states of California, Hawaii, New Jersey, New York and Rhode Island. Associates who work in these states should refer to the Filing a claim for short-term disability section for more information.

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Enrollment in short-term disability and when coverage is effective

All full-time hourly associates (with the exceptions listed below) will be automatically enrolled for coverage in the short-term disability basic plan after their eligibility waiting period. At that time, all associates automatically enrolled in the short-term disability basic plan will also have the opportunity to enroll in the short-term disability enhanced plan.

Associates who work in the following states are not eligible for, and will not be enrolled in, either the short-term disability basic plan or the short-term disability enhanced plan: California, Hawaii, New Jersey and Rhode Island. These states have state-mandated disability plans.

Associates who work in New York have a state-mandated disability plan; however, they will also be automatically enrolled for coverage in the short-term disability basic plan after their eligibility waiting period, in order to supplement their state-mandated benefit. Associates who work in New York will also have the opportunity to enroll in the New York short-term disability enhanced plan. The short-term disability basic benefit for associates in New York and the New York short-term disability enhanced plans are fully insured and administered by Liberty Life Assurance Company of Boston (Liberty), a Liberty Mutual company.

HOW SHORT-TERM DISABILITY IS FUNDED AND ADMINISTERED

In all states except California, Hawaii, New Jersey, New York and Rhode Island, short-term disability coverage is administered by Sedgwick Claims Management Services, Inc. (Sedgwick). Coverage in California and Rhode Island is provided and administered by the state. Coverage in New York is provided as stated above. Coverage in Hawaii and New Jersey is provided in accordance with the state program and insured by Liberty.

Except as noted above with respect to certain specific states, short-term disability coverage is self-insured. This means there is no insurance company that collects premiums and pays benefits. No associate contributions are required for the short-term disability basic plan. The company may fund benefits under the short-term disability basic plan by using the company's general assets, by using any asset of the Plan or Trust, or through a combination of these sources. For the short-term disability enhanced plan, participating associates make contributions intended to cover the costs of the benefits.

For information on coverage, call the phone number listed in **Short-term disability resources** at the beginning of this chapter.

The short-term disability basic plan provides up to 50% of your average weekly wage for up to 25 weeks of an approved disability, after a waiting period of seven calendar days if you become totally disabled as defined by the Plan. The maximum weekly benefit under the short-term disability basic plan is $200. For more information about your average weekly wage, see **Your short-term disability benefit** later in this chapter.

For all participants other than those working in New York: if you become totally disabled as defined by the Plan, the short-term disability enhanced plan provides up to 60% of your average weekly wage for up to 25 weeks after a waiting period of seven calendar days, with no weekly maximum benefit. The New York short-term disability enhanced plan provides up to 60% of your average weekly wage for up to 25 weeks after a waiting period of seven calendar days if you become totally disabled as defined by the Plan, and has a $6,000 maximum weekly benefit.

Short-term disability benefits are different in the following states: California, Hawaii, New Jersey, New York and Rhode Island. For information about benefits in any of these states, call the applicable number listed in **Short-term disability resources** at the beginning of this chapter.

ENROLLMENT FOR SHORT-TERM DISABILITY BENEFITS

You are automatically enrolled in the short-term disability basic plan after your 12-month eligibility waiting period. You must be actively at work for your coverage to become effective. You will be considered actively at work on a day that is one of your scheduled work days if you are performing in the usual way all of the duties of your job. See the **Eligibility and enrollment** chapter for details.

The date your short-term disability enhanced plan 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 before your coverage is effective. You will not pay short-term disability enhanced plan premiums during your 12-month waiting period.
  - If your late enrollment is due to a status change event, your 12-month waiting period will begin as of the date of the event.
  - If your late enrollment is during an annual enrollment, your 12-month waiting period will begin as of the date you enroll.

You may drop your short-term disability enhanced plan coverage at any time; the change will be effective the day after you drop coverage. If you drop your short-term disability enhanced plan coverage and later decide to re-enroll, you will be treated as a late enrollee with a 12-month waiting period, as described on the previous page.

COST OF COVERAGE

The short-term disability basic plan is provided at no cost to you. Your cost for the short-term disability enhanced plan 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 enhanced plan premiums from any short-term disability benefit payments you receive. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving short-term disability benefits, your premiums will be withheld from those payments.

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

- California
- Hawaii
- New Jersey
- New York, and
- Rhode Island.

For details, refer to the contact information in the Short-term disability resources at the beginning of this chapter.

When you qualify for benefits

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

- You must be actively at work at the time of your total disability (except in certain cases of leave of absence or layoff, as described later in this chapter under Coverage during a leave of absence or temporary layoff).
- You must submit medical evidence provided by a qualified doctor that you are totally disabled as defined by the Plan (qualified doctors are legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors (M.D.), osteopaths (D.O.), nurse practitioners, physician's assistants, psychologists or other medical practitioners whose services are eligible for reimbursement by the Associates' Health and Welfare Plan).
- You must receive approval by Sedgwick or Liberty of your claim.

These conditions apply whether you are covered under the short-term disability basic plan, enhanced plan or New York short-term disability enhanced plan. Sedgwick or Liberty may require written proof of your disability or additional information before making a decision on your claim. A statement by your physician(s) that you are unable to work does not in and of itself qualify you for short-term disability benefits. Also note that approval of a Medical Leave of Absence does not constitute approval for short-term disability benefits.

Qualification requirements in California, Hawaii, New Jersey, New York and Rhode Island may be dfferent. If you are an associate working in one of these states, contact the applicable number listed in Short-term disability resources at the beginning of this chapter for information on qualification requirements.

As defined by the Plan, "totally disabled" or "total disability" means that you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy. Benefits will be payable during a loss of license only while you are disabled and pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. The determination of whether you are disabled will be made by Sedgwick (or Liberty, as applicable) on the basis of objective medical evidence. Objective medical evidence consists of facts and findings, including, but not limited to, X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician. In addition, you must be under the continuous care of a qualified doctor and following the course of treatment prescribed. Loss of license in and of itself is not sufficient for meeting the definition of disability.

If Sedgwick or Liberty requests that you be examined by an independent physician or other medical professional, you must attend the exam in order to be considered for benefits.

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 25 weeks, after the initial seven-day waiting period.

NOTE: If your disability is caused by a mental illness or substance abuse, you are strongly encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, or clinical social worker who holds a Master of Social Work (M.S.W.), specializes in mental health and substance abuse and is licensed pursuant to state law.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that is:

- Not under the care of and being treated by a qualified doctor
- Caused by taking part in an insurrection, rebellion or a riot or civil disorder
- Resulting from your commission of or attempt to commit a crime (e.g., assault, battery, felony or any illegal occupation or activity)
- One for which workers' compensation benefits are paid, or may be paid, if properly claimed, or
- Sustained as a result of doing any work for pay or profit.

Filing a claim for short-term disability

In California and Rhode Island, you must submit your short-term disability claim directly to the state, as described below.

Claims for short-term disability benefits in Hawaii, New Jersey and New York must be submitted to Sedgwick within 30 days of the date your disability begins. Sedgwick will notify Liberty of your disability claim.

For all other states, you must submit your short-term disability claim to Sedgwick within 90 days of the date your disability begins in order to assure consideration for benefits. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

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

STEP 1: Notify Sedgwick to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury or pregnancy. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated. Report your disability online by going to WalmartOne.com/LOA > viaOne express, or call 800-492-5678 (you may also file in advance of your last day worked for scheduled surgery or pregnancy claims). Processing of your claim cannot begin until you have stopped working.

STEP 2: Tell your doctor's office that they will be contacted and asked to complete an attending physician's statement and provide medical information, including the following:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, and
- Doctor visit notes.

You will need to sign a form authorizing your doctor to release this information. (If filing your claim online, an electronic signature is accepted.)

STEP 3: Follow up with your doctor to ensure that information was forwarded to the disability administrator.

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

You may be required to provide written proof of your disability or additional medical information before your benefit payments begin.

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.

Rhode Island associates: You must file a claim with the state of Rhode Island by calling 401-462-8420.

When short-term disability benefits begin

If you are approved for short-term disability benefits, the benefit will begin, after a waiting period of seven calendar days, on the eighth calendar day after your total disability begins.

You may use up to 40 hours of available paid time off (PTO) to substitute for the benefit waiting period. You must repay the company for PTO taken beyond the benefit waiting period of seven calendar days.

If you are receiving short-term disability at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information. You will not accrue additional PTO while you are receiving short-term disability benefits.

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Your short-term disability benefit

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

- Your average weekly wage, and
- Whether or not you have enrolled in the short-term disability enhanced plan.

AVERAGE WEEKLY WAGE

Length of employment	How average weekly wage is determined
Employed 12 months or more	Total gross pay ÷ 52 weeks For example, the average weekly wage for an associate with a total annual gross pay of $36,400 is $700 ($36,400 ÷ 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 $8,400 for 12 weeks of work is $700 ($8,400 ÷ 12)

If a weekly benefit is payable for less than a week, your pay will be 1/7 of the weekly benefit for each day you were disabled.

Total gross pay includes:

- Overtime
- Bonuses
- PTO and other illness protection benefits (not including any previously paid disability benefits), and
- Personal pay for the 26 pay periods prior to your last day worked (or for the number of pay periods worked if less than 26). Note that if you have any pay periods in which you had no earnings, those pay periods will be excluded and the number of pay periods used for the calculation will be decreased.

The maximum weekly benefit under the short-term disability basic plan is $200. There is no maximum weekly benefit under the short-term disability enhanced plan, except in New York, where the maximum is $6,000 per week. A hypothetical benefit calculation is shown to the right, using an average weekly wage of $700.

YOUR SHORT-TERM DISABILITY BENEFIT: AN EXAMPLE

If you have	Your benefit is
Short-term disability basic plan coverage	50% of your average weekly wage to a maximum of $200/week Average weekly wage: $700 50% of $700: $350 Reduced to the maximum weekly benefit: $200
Short-term disability enhanced plan coverage	60% of your average weekly wage Average weekly wage: $700 60% of $700: $420 There is no maximum weekly benefit under the short-term disability enhanced plan, so this figure would not be reduced (in New York, there is a maximum weekly benefit of $6,000 per week).

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

The taxation of benefits payable to you depends on whether you are enrolled in only short-term disability basic or in both short-term disability basic and short-term disability enhanced. If you are enrolled only in short-term disability basic, because you do not make any contributions to the short-term disability basic plan or pay any tax on the coverage that Walmart provides, any short-term disability benefits payable to you are subject to taxes. If you are enrolled in both short-term disability basic and short-term disability enhanced, because both Walmart and you pay for the cost of the coverage through a combination of Walmart pre-tax and associate after-tax contributions, a portion of your short-term disability benefits will be taxed. Walmart will generally withhold federal, state, local and Social Security taxes from the portion of the benefit that is taxable.

In the states of Hawaii, New Jersey and New York, benefits are partially taxed. Please contact Liberty for more information.

NOTE: The Plan has the right to recover from you, and you must repay, any amount that is overpaid to you for short-term disability benefits under this Plan. See The Plan's right to recover overpayment and Right to salary/wage deduction in the Claims and appeals chapter. If you do not repay overpaid amounts in a timely manner, the company may treat the portion of such amounts that were not taxed when paid as taxable wages to you (reportable on your Form W-2) or, alternatively, deduct such amounts from your paycheck(s), to the extent permitted by law.

Continuing benefit coverage while disabled

If you wish to continue medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness insurance and accident insurance coverage while you are receiving short-term disability benefits, you must make premium payments each pay period for each of these benefits. If you are participating in the short-term disability plan and have an approved claim, your premiums for the above benefits will be deducted out of your disability benefit checks, which will be issued through the Walmart payroll system. If you fail to pay your premiums for your other benefit plan(s), your benefits may be canceled. See the **Eligibility and enrollment** chapter for details.

Your disability coverage will not be canceled if you are receiving disability benefits under the Plan. You will not be required to pay short-term disability enhanced plan or long-term disability plan premiums from any short-term disability benefit payments received. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving short-term disability benefits, your premiums will be withheld from those payments.

When short-term disability benefit payments end

If you are receiving short-term disability benefits from the Plan due to an approved disability, your benefit payments from the Plan will end on the earliest of:

- The date you are no longer totally disabled
- The date you fail to furnish the required proof that you are totally disabled when requested to do so by Sedgwick or by Liberty
- The date you are no longer under the continuous care and treatment of a qualified doctor
- The date you refuse to be examined, if Sedgwick or Liberty requires an examination
- The last day of the maximum period for which benefits are payable (end of 25 weeks)
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart, or
- The date of your death.

When your short-term disability benefits end, and for any reason you do not return to work, you must request an extension of your leave. Failure to do so may result in your employment being terminated.

If you return to work within 30 days of the end of your approved disability claim, you will be reinstated to the disability coverage you had prior to your disability. If you do not return to work within 30 days of the end of your disability claim, your coverage will lapse until you return to work and meet the actively-at-work requirement.

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

Returning to work

Sedgwick will contact you prior to your expected return-to-work date and advise you of any steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

Notify Sedgwick when you have physically returned to work. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options, which will include requesting an extension of your leave or voluntarily terminating employment. Failure to request an extension may result in your employment being terminated if you do not voluntarily terminate employment.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less of active full-time work (with or without medical restrictions) and become totally disabled again from the same or a related condition that caused the first period of disability, as determined by Sedgwick or Liberty, known as a "relapse/recurrent claim," 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 for both periods of total disability will not exceed 25 weeks.

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If you have returned to active full-time 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 may be able to receive up to 25 weeks of benefits.

A new benefit waiting period of seven calendar days will apply.

If you have returned to active full-time work for any number of calendar days and then become totally disabled from a new and unrelated cause, it will be considered a new disability, and you may qualify for up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

Coverage during a leave of absence or temporary layoff

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

When coverage ends

Your short-term disability basic plan and enhanced plan coverage ends:

- At termination of your employment
- On the last day of the pay period when your job status changes from an eligible job status
- 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), or
- When the benefit is no longer offered by the company.

In addition, coverage under the short-term disability enhanced plan would end the day after you drop your coverage under that Plan.

If you leave the company and are rehired

If you leave the company and return to full-time work for the company within 13 weeks, you will automatically be re-enrolled for the same coverage plan you had prior to leaving the company (or the most similar coverage offered under the Plan). If you are automatically re-enrolled in short-term disability enhanced plan coverage and choose to drop it after you return, you may do so at any time.

If you return to full-time work after 13 weeks, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the Eligibility and enrollment chapter.

If you lose and then regain eligibility

If you lose eligibility and then regain eligibility 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 lose eligibility and then regain eligibility 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.

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Salaried short-term disability plan

WHERE CAN I FIND?

Salaried short-term disability plan

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

SALARIED DRIVER SHORT-TERM DISABILITY RESOURCES

Find What You Need	Online	Other Resources
Get more details about salaried short-term disability or file a claim within 90 days of the date your disability began (provided to salaried associates in all 50 states)	Go to WalmartOne.com	Call Sedgwick at 800-492-5678
Request review of a denied short-term disability claim	Go to WalmartOne.com/LOA > viaOne® express	Call Sedgwick at 800-492-5678

What you need to know about salaried short-term disability

- Walmart provides the salaried short-term disability plan for all salaried associates, management trainees, associates classified as California pharmacists and Metro professional non-exempt associates. There is no cost to the associate.
- No enrollment in the salaried short-term disability plan is necessary. Coverage is effective as of your date of hire.
- If you become disabled for more than seven consecutive calendar days and are eligible to receive short-term disability benefits, the salaried short-term disability plan replaces 100% of your base pay for up to six weeks and 75% of your base pay for up to 19 additional weeks, after an initial waiting period of seven calendar days. (Note that there is no initial waiting period for work-related disabilities that qualify for workers' compensation through Walmart, but the amount of your benefit will be different. See the chart titled Your salaried short-term disability plan benefit for more information.)
- If your disability is due to pregnancy, the salaried short-term disability plan replaces 100% of your base pay for nine weeks, after an initial waiting period of seven calendar days. Generally no medical evidence is required for this short-term disability maternity benefit.
- The salaried short-term disability plan is not a benefit covered by ERISA and is not part of the Associates' Health and Welfare Plan.
- There is a 90-day deadline from the date your disability begins to file a claim for short-term disability benefits. The claims and appeals procedures described in this chapter apply to the salaried short-term disability benefit rather than the procedures in the Claims and appeals chapter.

Enrollment in short-term disability and when coverage is effective

You are automatically enrolled for coverage in the salaried short-term disability plan if you are:

- A salaried associate (exempt)
- A management trainee (non-exempt)
- An associate classified as a California pharmacist* (non-exempt), or
- A Metro professional non-exempt associate.

Coverage is effective as of your date of hire. Salaried short-term disability coverage is administered by Sedgwick Claims Management Services, Inc. (Sedgwick).

**Pharmacists who work in California and have the designation of "California pharmacist" in payroll systems are eligible for the benefits listed here for salaried associates.*

HOW SALARIED SHORT-TERM DISABILITY IS ADMINISTERED

If you become disabled and eligible to receive short-term disability benefits, the salaried short-term disability plan generally pays 100% of your base pay for up to six weeks of an approved disability, after an initial waiting period of seven calendar days of continuous disability. (Disabilities that qualify for workers' compensation through Walmart are treated differently, as described in the chart titled Your salaried short-term disability plan benefit.) If you remain disabled and eligible for benefits after the first six weeks of disability payments, the salaried short-term disability plan will pay 75% of your base pay for up to 19 additional weeks.

If your disability is due to pregnancy, the salaried short-term disability plan pays a maternity benefit of 100% of your base pay for the first nine weeks, after an initial waiting period of seven calendar days.

In order for your pay to continue during the initial seven-day waiting period, you may use paid time off (PTO). Salaried short-term disability benefits begin on the eighth calendar day after your eligible disability begins.

COST OF COVERAGE

The salaried short-term disability plan is provided by the company at no cost to you.

STATE-SPONSORED SHORT-TERM DISABILITY

Short-term disability benefits provided by individual states will generally have no impact on your eligibility for the salaried short-term disability benefit through Walmart, or the amount of the benefit you receive under Walmart's plan.

An exception to this policy will apply to all Metro professional non-exempt associates who work in California. For these associates, benefits received under Walmart's salaried short-term disability plan will be reduced by the amount of the state-sponsored short-term disability benefit.

When you qualify for benefits

In order to qualify for short-term disability benefits through the salaried short-term disability plan, you must meet the following requirements:

- You must submit medical evidence provided by a qualified doctor that you are totally disabled as defined by the salaried short-term disability plan (qualified doctors are legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors (M.D.), osteopaths (D.O.), nurse practitioners, physician's assistants, psychologists or other medical practitioners recognized by the Associates' Health and Welfare Plan).
- You must receive approval by Sedgwick of your claim.

NOTE: If your disability is caused by a mental illness or substance abuse, you are strongly encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, or clinical social worker who holds a Master of Social Work (M.S.W.), specializes in mental health and substance abuse and is licensed pursuant to state law.

Sedgwick may require written proof of your disability or additional information before making a decision on your claim. A statement by your physician(s) that you are unable to work does not in and of itself qualify you for short-term disability benefits. Also note that approval of a medical leave of absence does not constitute approval for short-term disability benefits.

As defined by the salaried short-term disability plan, "totally disabled" or "total disability" means that you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy. Benefits will be payable during a loss of license only while you are disabled or pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. The determination of whether you are disabled will be made by Sedgwick on the basis of objective medical evidence. Objective medical evidence consists of facts and findings, including but not limited to X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician. In addition, you must be

under the continuous care of a qualified doctor and following the course of treatment prescribed. Loss of license in and of itself is not sufficient for meeting the definition of disability.

If Sedgwick requests that you be examined by an independent physician or other medical professional, you must attend the exam in order to be considered for benefits.

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 25 weeks, after the initial waiting period of seven calendar days.

NOTE: If your disability is due to pregnancy, Sedgwick will not require objective medical evidence (as described on the previous page) as a condition for approving your disability claim for the short-term disability maternity benefit, unless you begin your leave of absence more than two weeks prior to your estimated date of delivery. If you begin your leave of absence more than two weeks prior to your estimated date of delivery, objective medical evidence will be required. The maternity benefit will generally begin on the earlier of two weeks before the estimated date of delivery (as determined by a qualified doctor) or the actual date of delivery.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that is:

- Not under the care of and being treated by a qualified doctor
- Caused by taking part in an insurrection, rebellion or a riot or civil disorder
- Resulting from your commission of or attempt to commit a crime (e.g., assault, battery, felony or any illegal occupation or activity), or
- Sustained as a result of doing any work for pay or profit.

Filing a claim for short-term disability

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

STEP 1: Notify Sedgwick to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury or pregnancy. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated. Report your disability online by going to WalmartOne.com/LOA > viaOne express, or call 800-492-5678 (you may also file in advance of your last day worked for scheduled surgery or pregnancy claims). Processing of your claim cannot begin until you have stopped working. All claims for benefits under Walmart's salaried short-term disability plan must be submitted to Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

STEP 2: Tell your doctor's office that they will be contacted and asked to complete an attending physician's statement and provide medical information, including the following:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, and
- Doctor visit notes.

You will need to sign a form authorizing your doctor to release this information. (If filing your claim online, an electronic signature is accepted.)

STEP 3: Follow up with your doctor to ensure that information was forwarded to the disability administrator.

Provisional pay

If you have notified Sedgwick of your disability, you will have 20 days from the date you initially notified Sedgwick of your disability to provide the required medical documentation. Your pay will continue for up to 20 days from your date of disability, known as "provisional pay." Your pay will be suspended after 20 days from your date of disability if the required medical documentation has not been approved. If you do not meet this 20-day deadline, the suspension of pay will be effective the first day of the pay period in which the 21st day falls. (In cases of pregnancy, verification of your due date is the only medical verification required for the short-term disability maternity benefit, unless you begin your leave of absence more than two weeks prior to your estimated date of delivery.) If your claim is approved, the approval will be effective as of the date of your disability, and the initial 20 days will count toward the duration of your disability benefit and initial waiting period.

If your claim is denied before the 21st day due to your medical circumstances not meeting the salaried short-term disability plan's definition of total disability, your pay will be suspended and Walmart will commence efforts to recover the amount paid to you for the period following your illness or injury.

Provisional pay does not apply to relapse/recurrent claims.

NOTE: If you become disabled, file your claim for benefits promptly. A delay in filing or submitting medical information could result in delayed benefit payment, disruption to your wages or the denial of your claim. If it is determined that any wages have been paid to you in error, the company reserves the right to recover any overpayment.

AFTER YOU HAVE FILED YOUR CLAIM

Once you have filed your claim, Sedgwick will make a decision in no more than 45 days after receipt of your properly filed claim. The time for a decision may be extended for up to two additional 30-day periods, provided that, prior to any extension period, you are notified in writing that an extension

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is necessary due to matters beyond Sedgwick's control, those matters are identified, and you are given the date by which a decision will be rendered. If your claim is extended due to your failure to submit information Sedgwick deems necessary to decide your claim, the time for decision will be suspended as of the date on which the notification of the extension is sent to you until the date your response is received. If your claim is approved, the decision will contain information sufficient to reasonably inform you of that decision.

If your claim is denied, Sedgwick will send you a written notification of the denial, which will include:

- Specific reasons for the decision
- Specific reference to the policy provisions on which the decision is based
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- A description of the review procedures and time limits applicable to such procedures, and
- 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.

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APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for benefits is denied and you would like to appeal, you must submit a written or oral appeal to Sedgwick within 180 days of the denial. Your appeal should include any comments, documents, records or any other information you would like considered.

You will have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. Your appeal will be reviewed, without regard to your initial determination, by someone other than the party who decided your initial claim.

Sedgwick will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if it is determined that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification of the denial that will include:

- The specific reason(s) for the adverse determination
- Reference to the specific plan provisions on which the determination was based
- A statement describing your right to request copies, free of charge, of all documents, records or other information relevant to your claim
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- A statement describing any appeal procedures offered by the Plan.

VOLUNTARY SECOND APPEAL OF A SALARIED SHORT-TERM DISABILITY CLAIM

If your appeal is denied, you may make a voluntary second appeal of your denial orally or in writing to Sedgwick. You must submit your second appeal within 180 days of the receipt of the written notice of denial. 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, as described above, are generally applied to this voluntary second appeal.

All salaried short-term disability appeals should be sent to:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14028
Lexington, Kentucky 40512

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When short-term disability benefits begin

If you are approved for short-term disability benefits, the benefit will begin after a waiting period of seven calendar days, on the eighth calendar day after your total disability begins. (Note that there is no waiting period for work-related disabilities that qualify for workers' compensation through Walmart.)

In order for your pay to continue during the initial seven-day waiting period, you may use paid time off (PTO). Salaried short-term disability benefits begin on the eighth calendar day after your eligible disability begins. PTO may not be used while receiving short-term disability benefits.

If you are receiving short-term disability at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information.

You will not accrue additional PTO 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 base pay as of your last day worked, and
- The duration of your disability.

Base pay, for purposes of the salaried short-term disability benefit, is defined as follows:

ASSOCIATE TYPE	BASE PAY
Exempt associates	Gross biweekly salary
Non-exempt associates	Hourly rate multiplied by hours scheduled that pay period

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If you become disabled and eligible to receive short-term disability benefits, the salaried short-term disability plan pays benefits as described here:

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YOUR SALARIED SHORT-TERM DISABILITY PLAN BENEFIT		
Duration of your disability	Your benefit is:	
	If your disability does not qualify for workers' compensation through Walmart	If you have a work-related disability that qualifies for workers' compensation through Walmart
Up to 7 weeks	*After* an initial waiting period of 7 calendar days, 100% of your base pay. Benefits begin on the 8th calendar day. You may use PTO during your first 7 calendar days of continuous disability.	100% of your base pay, with no initial waiting period. Benefits are payable as of the date of your disability.
More than 7 weeks, up to 26 weeks	75% of your base pay. For example, if your base pay is $1,000, 75% of $1,000 is a $750 benefit.	Workers' compensation benefits are payable at the applicable state rate; short-term disability benefits will make up the difference up to 75% of your base pay. For example, if your base pay is $1,000 and workers' compensation pays 66% for your disability, or $660, short-term disability will pay an additional $90, for a total benefit of $750. (If the state-mandated workers' compensation rate exceeds 75% of your base pay, you will not receive any short-term disability benefit.)

See the Continuing benefit coverage while disabled section for additional details regarding your premiums.

If a weekly benefit is payable for less than a week, your pay will be based on your base pay divided by your regular work schedule for each day you were disabled.

NOTE: Workers' compensation and short-term disability benefits will be made as separate payments.

MATERNITY BENEFIT

Maternity benefits under the salaried short-term disability plan are as described here:

MATERNITY BENEFIT

Duration of benefit	Your benefit is:
Up to 9 weeks*	100% of your base pay after an initial waiting period of 7 calendar days. Maternity benefits under the salaried short-term disability plan begin on the 8th calendar day after your eligible disability begins. You may use PTO during your first 7 calendar days of continuous disability.

* You may also be eligible for additional parental and family care pay equal to 100% of your base pay. For more information, refer to the parental and family care pay policy on the WiRE.

NOTE: If you experience medical complications during pregnancy, benefits may be payable under the salaried short-term disability plan after the end of the nine-week duration of maternity benefits. Benefits would be equal to 75% of your base pay from week 11, up to 25 weeks.

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

Benefits payable to you under Walmart's salaried short-term disability plan are company-provided, at no cost to you. Because you do not make any contributions to the salaried short-term disability plan, any benefits payable to you are subject to taxes. Walmart will generally withhold federal, state, local and Social Security taxes from the amount of your benefits.

NOTE: The salaried short-term disability plan has the right to recover from you, and you must repay, any amount that is overpaid to you for short-term disability benefits under this plan. See The Plan's right to recover overpayment and Right to salary/wage deduction in the Claims and appeals chapter.

Continuing benefit coverage while disabled

If you have an approved disability claim and are receiving short-term disability benefits, premiums will be deducted from your disability benefit checks (issued through the Walmart payroll system) for any coverage you have under any of the following Walmart benefits: medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness and accident insurance. See the Eligibility and enrollment chapter for details.

Your salaried short-term disability coverage will not be canceled if you are receiving disability benefits under the plan, unless your employment terminates. You will not be required to pay long-term disability premiums from any short-term disability benefit payments received. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving short-term disability benefits, your long-term disability premiums will be withheld from those payments.

When short-term disability benefit payments end

If you are receiving short-term disability benefit payments from the salaried short-term disability plan due to an approved disability, your benefit payments from the plan will end on the earliest of:

- The date you are no longer totally disabled
- The date you fail to furnish the required proof that you are totally disabled when requested to do so by Sedgwick
- The date you are no longer under the continuous care and treatment of a qualified doctor
- The date you refuse to be examined, if Sedgwick requires an examination
- The last day of the maximum period for which benefits are payable (end of 25 weeks)
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart
- The date your employment terminates, or
- The date of your death.

When your short-term disability benefits end and for any reason you do not return to work, you must request an extension of your leave; failure to do so may result in your employment being terminated.

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Returning to work

Sedgwick will contact you prior to your expected return-to-work date and advise you of any steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

Notify Sedgwick when you have physically returned to work. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options, which will include requesting an extension of your leave or voluntarily terminating employment. Failure to request an extension may result in your employment being terminated if you do not voluntarily terminate employment.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less of active full-time work (with or without medical restrictions) and become totally disabled again from the same or a related condition that caused the first period of disability as determined by Sedgwick, known as a "relapse/recurrent claim," 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 25 weeks.

If you have returned to active full-time 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 may be able to receive up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

If you have returned to active full-time work for any number of calendar days and then become totally disabled from a new and unrelated cause, it will be considered a new disability, and you may qualify for up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

Intermittent leave. If you are able to return to work following a disability claim but the same or a related condition will require you to continue to miss work occasionally, notify Sedgwick and your facility of your situation. Your treatment may be covered under your prior short-term disability claim for up to 12 months from the date you return to work from your short-term disability claim. Salaried short-term disability generally pays 100% of your base pay for the duration of your approved intermittent leave.

Coverage during a leave of absence or temporary layoff

If you are not working due to an approved non-disability leave of absence or temporary layoff, you will continue to be eligible for short-term disability benefits for 90 days from your last day of work. Your eligibility for short-term disability benefits would end on the 91st day after your approved non-disability leave or temporary layoff begins, but would be reinstated if you return to work. See Benefits continuation if you go on a leave of absence in the Eligibility and enrollment chapter for more information, including details on paying for benefits while on leave.

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 from an eligible job status
- On the date of your death
- On the 91st day of an approved non-disability leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company.

If you leave the company and are rehired

If you leave the company and return to work for the company as a salaried associate, you will automatically be re-enrolled in the salaried short-term disability plan.

Truck driver short-term disability plan

WHERE CAN I FIND?

Truck driver short-term disability plan

Pregnancy, a scheduled surgery or an unexpected illness or injury could keep you off the job and off the payroll for an extended period of time. The Walmart truck driver short-term disability plan can protect part of your paycheck if you become disabled for more than seven calendar days. When you can't work, the Walmart truck driver short-term disability plan works for you.

TRUCK DRIVER SHORT-TERM DISABILITY RESOURCES

Find What You Need	Online	Other Resources
Get more details about truck driver shor-term disability or file a claim within 90 days of the date your disability began (provided to all full-time truck drivers in all 50 states)	Go to WalmartOne.com	Call Sedgwick at 800-492-5678
Request review of a denied short-term disability claim	Go to WalmartOne.com/LOA > viaOne' express	Call Sedgwick at 800-492-5678

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

- Walmart provides the truck driver short-term disability plan for all full-time truck drivers. There is no cost to the driver.
- No enrollment in the truck driver short-term disability plan is necessary. Coverage is effective as of your date of hire.
- If you become disabled for more than seven consecutive calendar days and are eligible to receive short-term disability benefits, the truck driver short-term disability plan replaces 75% of your average day's pay for up to 25 weeks, after an initial waiting period of seven calendar days. Note that different rules may apply to work-related disabilities that qualify for workers' compensation through Walmart. See the chart titled Your truck driver short-term disability plan benefit for more information.)
- If your disability is due to pregnancy, the truck driver short-term disability plan replaces 75% of your average day's pay for up to nine weeks, after an initial waiting period of seven calendar days. Generally, no medical evidence is required for this short-term disability maternity benefit.
- The truck driver short-term disability plan is not a benefit covered by ERISA and is not part of the Associates' Health and Welfare Plan.
- There is a 90-day deadline from the date your disability begins to file a claim for short-term disability benefits. The claims and appeals procedures described in this chapter apply to the truck driver short-term disability benefit rather than the procedures in the Claims and appeals chapter.

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Enrollment in short-term disability and when coverage is effective

All full-time truck drivers will be automatically enrolled for coverage in the truck driver short-term disability plan. Coverage is effective as of your date of hire. Truck driver short-term disability coverage is administered by Sedgwick Claims Management Services, Inc. (Sedgwick).

HOW TRUCK DRIVER SHORT-TERM DISABILITY IS ADMINISTERED

If you become disabled and eligible to receive short-term disability benefits, the truck driver short-term disability plan generally pays 75% of your average day's pay for up to 25 weeks of an approved disability, after an initial waiting period of seven calendar days of continuous disability. The waiting period begins on your next scheduled work day after your total disability begins. (Disabilities that qualify for workers' compensation through Walmart are treated differently, as described in the chart titled Your truck driver short-term disability plan benefit.)

If your disability is due to pregnancy, the truck driver short-term disability plan pays a maternity benefit of 75% of your average day's pay for the first nine weeks of an approved disability, after an initial waiting period of seven calendar days.

In order for your pay to continue during the initial seven-day waiting period, you may use paid time off (PTO). Truck driver short-term disability benefits begin the day after the initial waiting period ends.

COST OF COVERAGE

The truck driver short-term disability plan is provided by the company at no cost to you.

STATE-SPONSORED SHORT-TERM DISABILITY

Short-term disability benefits provided by individual states will generally have no impact on your eligibility for the truck driver short-term disability benefit plan through Walmart, or the amount of the benefit you receive under Walmart's plan.

When you qualify for benefits

In order to qualify for short-term disability benefits through the truck driver short-term disability plan, you must meet the following requirements:

- You must submit medical evidence provided by a qualified doctor that you are totally disabled as defined by the truck driver short-term disability plan (qualified doctors are legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors (M.D.), osteopaths (D.O.), nurse practitioners, physician's assistants, psychologists or other medical practitioners recognized by the Associates' Health and Welfare Plan).
- You must receive approval by Sedgwick of your claim.

NOTE: If your disability is caused by a mental illness or substance abuse, you are strongly encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, or clinical social worker who holds a Master of Social Work (M.S.W.), specializes in mental health and substance abuse and is licensed pursuant to state law.

Sedgwick may require written proof of your disability or additional information before making a decision on your claim. A statement by your physician(s) that you are unable to work does not in and of itself qualify you for short-term disability benefits. Also note that approval of a medical leave of absence does not constitute approval for short-term disability benefits.

As defined by the truck driver short-term disability plan, "totally disabled" or "total disability" means that you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy. Benefits will be payable during a loss of license only while you are disabled or pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. The determination of whether you are disabled will be made by Sedgwick on the basis of objective medical evidence. Objective medical evidence consists of facts and findings, including but not limited to X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician. In addition, you must be under the continuous care of a qualified doctor and following the course of treatment prescribed. Loss of license in and of itself is not sufficient for meeting the definition of disability.

If Sedgwick requests that you be examined by an independent physician or other medical professional, you must attend the exam in order to be considered for benefits.

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 25 weeks, after the initial waiting period.

NOTE: If your disability is due to pregnancy, Sedgwick will not require objective medical evidence (as described on this page) as a condition for approving your disability claim

for the short-term disability maternity benefit, unless you begin your leave of absence more than two weeks prior to your estimated date of delivery. If you begin your leave of absence more than two weeks prior to your estimated date of delivery, objective medical evidence will be required. The maternity benefit will generally begin on the earlier of two weeks before the estimated date of delivery (as determined by a qualified doctor) or the actual date of delivery.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that is:

- Not under the care of and being treated by a qualified doctor
- Caused by taking part in an insurrection, rebellion or a riot or civil disorder
- Resulting from your commission of or attempt to commit a crime (e.g., assault, battery, felony or any illegal occupation or activity), or
- Sustained as a result of doing any work for pay or profit.

Filing a claim for short-term disability

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

STEP 1: Notify Sedgwick to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury or pregnancy. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated. Report your disability online by going to WalmartOne.com/LOA > viaOne express, or call 800-492-5678 (you may also file in advance of your last day worked for scheduled surgery or pregnancy claims). Processing of your claim cannot begin until you have stopped working. All claims for benefits under Walmart's truck driver short-term disability plan must be submitted to Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

STEP 2: Tell your doctor's office that they will be contacted and asked to complete an attending physician's statement and provide medical information, including the following:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, and
- Doctor visit notes.

You will need to sign a form authorizing your doctor to release this information. (If filing your claim online, an electronic signature is accepted.)

STEP 3: Follow up with your doctor to ensure that information was forwarded to the disability administrator.

Provisional pay

If you have notified Sedgwick of your disability, you will have 20 days from the date you initially notified Sedgwick of your disability to provide the required medical documentation. Your pay will continue for up to 20 days from your date of disability, known as "provisional pay." Your pay will be suspended after 20 days from your date of disability if the required medical documentation has not been approved. If you do not meet this 20-day deadline, the suspension of pay will be effective the first day of the pay period in which the 21st day falls. (In cases of pregnancy, verification of your due date is the only medical verification required for the short-term disability maternity benefit, unless you begin your leave of absence more than two weeks prior to your estimated date of delivery.) If your claim is approved, the approval will be effective as of the date of your disability, and the initial 20 days will count toward the duration of your disability benefit and initial waiting period.

If your claim is denied before the 21st day due to your medical circumstances not meeting the truck driver short-term disability plan's definition of total disability, your pay will be suspended and Walmart will commence efforts to recover the amount paid to you for the period following your illness or injury.

Provisional pay does not apply to relapse/recurrent claims.

NOTE: If you become disabled, file your claim for benefits promptly. A delay in filing or submitting medical information could result in delayed benefit payments, disruption to your wages or the denial of your claim. If it is determined that any wages have been paid to you in error, the company reserves the right to recover any overpayment.

AFTER YOU HAVE FILED YOUR CLAIM

Once you have filed your claim, Sedgwick will make a decision no more than 45 days after receipt of your properly filed claim. The time for a decision may be extended for up to two additional 30-day periods, provided that, prior to any extension period, you are notified in writing that an extension is necessary due to matters beyond Sedgwick's control, those matters are identified, and you are given the date by which a decision will be rendered. If your claim is extended due to your failure to submit information Sedgwick deems necessary to decide your claim, the time for decision will be suspended as of the date on which the notification of the extension is sent to you until the date your response is received. If your claim is approved, the decision will contain information sufficient to reasonably inform you of that decision.

If your claim is denied, Sedgwick will send you a written notification of the denial, which will include:

- Specific reasons for the decision
- Specific reference to the policy provisions on which the decision is based
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- A description of the review procedures and time limits applicable to such procedures, and
- If an internal rule, guideline, protocol or other similar criteria was relied upon in making the denial, either
  - The specific rule, guideline, protocol or other similar criteria, or
  - A statement that such a rule, guideline, protocol or other similar criteria was relied upon in making the denial and that a copy will be provided free of charge to you upon request.

APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for benefits is denied and you would like to appeal, you must submit a written or oral appeal to Sedgwick within 180 days of the denial. Your appeal should include any comments, documents, records or any other information you would like considered.

You will have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. Your appeal will be reviewed, without regard to your initial determination, by someone other than the party who decided your initial claim.

Sedgwick will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if it is determined that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification of the denial that will include:

- The specific reason(s) for the adverse determination
- Reference to the specific plan provisions on which the determination was based
- A statement describing your right to request copies, free of charge, of all documents, records or other information relevant to your claim
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- A statement describing any appeal procedures offered by the Plan.

VOLUNTARY SECOND APPEAL OF A TRUCK DRIVER SHORT-TERM DISABILITY CLAIM

If your appeal is denied, you may make a voluntary second appeal of your denial orally or in writing to Sedgwick. You must submit your second appeal within 180 days of the receipt of the written notice of denial. 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, as described above, are generally applied to this voluntary second appeal.

All truck driver short-term disability appeals should be sent to:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14028
Lexington, Kentucky 40512

When short-term disability benefits begin

If you are approved for short-term disability benefits, the benefit will begin after a waiting period of seven calendar days. The waiting period begins on your next scheduled work day after your total disability begins. (Note that work-related disabilities that qualify for workers' compensation through Walmart may have different waiting periods under state law.)

In order for your pay to continue during the initial seven-day waiting period, you may use paid time off (PTO). Truck driver short-term disability benefits begin after the initial waiting period. PTO may not be used while receiving short-term disability benefits.

If you are receiving short-term disability at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information.

You will not accrue additional PTO while you are receiving short-term disability benefits.

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Your short-term disability benefit

The amount of your short-term disability benefit is based on your average day's pay as of your last day worked. If you become disabled and eligible to receive short-term disability benefits, the truck driver short-term disability plan replaces 75% of your average day's pay as of your last day prior to your disability for up to 25 weeks, after an initial waiting period of seven calendar days. There is no maximum weekly benefit under the truck driver short-term disability plan.

YOUR TRUCK DRIVER SHORT-TERM DISABILITY PLAN BENEFIT

Duration of your disability	Your benefit is:	
	If your disability does not qualify for workers' compensation through Walmart	If you have a work-related disability that qualifies for workers' compensation through Walmart
Up to 26 weeks	*After* an initial waiting period of 7 calendar days, 75% of your average day's pay. The waiting period begins on your next scheduled workday after your total disability begins. You may use PTO during your first 7 calendar days of continuous disability. For example, if your average day's pay over the week totals $1,000, 75% of $1,000 is a $750 weekly benefit.	75% of your average day's pay. Sedgwick will pay 75% during the state workers' compensation waiting period, then workers' compensation will pay according to the state's compensation rate. Sedgwick will "top off" this pay to 75%. If the state compensation rate is greater than 75%, you will not receive additional benefits from Sedgwick. For example, if your workers' compensation benefit or anticipated benefit is 66%, the short-term disability benefit will provide 9% of your wages. Workers' compensation is not taxed, while short-term disability benefits are taxed. Short-term disability benefits are paid through your payroll check, while workers' compensation is paid through a separate check.

See the Continuing benefit coverage while disabled section for additional details regarding your premiums.

If a weekly benefit is payable for less than a week, your pay will be based on 75% of your average day's pay multiplied by your program for each day you were disabled.

NOTE: Workers' compensation and short-term disability benefits will be made as separate payments except in the states of Texas and Wyoming, where the entire benefit will be included in the payment you receive from Walmart.

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MATERNITY BENEFIT

Maternity benefits under the truck driver short-term disability plan are as described here:

MATERNITY BENEFIT	
Duration of benefit	Your benefit is:
Up to 9 weeks*	75% of your average day's pay after an initial waiting period of 7 calendar days. You may use PTO during your first 7 calendar days of continuous disability.

* You may also be eligible for additional parental and family care pay equal to 75% of your average day's pay. For more information, refer to the parental and family care pay policy on the WIRE.

NOTE: If you experience medical complications during pregnancy, benefits may be payable under the truck driver short-term disability plan after the end of the nine-week duration of maternity benefits. Benefits would be equal to 75% of your average day's pay from week 11, up to 25 weeks.

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

Benefits payable to you under the truck driver short-term disability plan are company-provided, at no cost to you. Because you do not make any contributions to the truck driver short-term disability plan, any benefits payable to you are subject to taxes. Walmart will generally withhold federal, state, local and Social Security taxes from the amount of your benefit payments.

NOTE: The truck driver short-term disability plan has the right to recover from you, and you must repay, any amount that is overpaid to you for short-term disability benefits under this plan. See **The Plan's right to recover overpayment** and **Right to salary/wage deduction** in the **Claims and appeals** chapter.

Continuing benefit coverage while disabled

If you have an approved disability claim and are receiving short-term disability benefits, premiums will be deducted from your disability benefit checks (issued through the Walmart payroll system) for coverage you may have under any of the following Walmart benefits: medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness and accident insurance. See the **Eligibility and enrollment** chapter for details.

Your truck driver short-term disability coverage will not be canceled if you are receiving disability benefits under the truck driver short-term disability plan unless your employment terminates. You will not be required to pay long-term disability premiums from any short-term disability benefit payments received. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving short-term disability benefits, your long-term disability premiums will be withheld from those payments.

When short-term disability benefit payments end

If you are receiving short-term disability benefit payments from the truck driver short-term disability plan due to an approved disability, your benefit payments from the plan will end on the earliest of:

- The date you are no longer totally disabled
- The date you fail to furnish the required proof that you are totally disabled when requested to do so by Sedgwick
- The date you are no longer under the continuous care and treatment of a qualified doctor
- The date you refuse to be examined, if Sedgwick requires an examination
- The last day of the maximum period for which benefits are payable (end of 25 weeks)
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart
- The date your employment terminates, or
- The date of your death.

When your short-term disability benefits end and for any reason you do not return to work, you must request an extension of your leave; failure to do so may result in your employment being terminated.

Returning to work

Sedgwick will contact you prior to your expected return-to-work date and advise you of any steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

Notify Sedgwick when you have physically returned to work. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options,

which will include requesting an extension of your leave or voluntarily terminating employment. Failure to request an extension may result in your employment being terminated if you do not voluntarily terminate employment.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less of active full-time work (with or without medical restrictions) and become totally disabled again from the same or a related condition that caused the first period of disability, as determined by Sedgwick, known as a "relapse/recurrent claim," 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 25 weeks.

If you have returned to active full-time 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 may be able to receive up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

If you have returned to active full-time work for any number of calendar days and then become totally disabled from a new and unrelated cause, it will be considered a new disability, and you may qualify for up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

Intermittent leave. If you are able to return to work following a disability claim but the same or a related condition will require you to continue to miss work occasionally, notify Sedgwick and your facility of your situation. Your treatment may be covered under your prior short-term disability claim up to 12 months from the date you return to work from your short-term disability claim. Truck driver short-term disability generally pays 100% of your average day's pay for the duration of your approved intermittent leave.

Coverage during a leave of absence or temporary layoff

If you are not working due to an approved non-disability leave of absence or temporary layoff, you will continue to be eligible for short-term disability benefits for 90 days from your last day of work. Your eligibility for short-term disability benefits would end on the 91st day after your approved non-disability leave or temporary layoff begins, but would be reinstated if you return to work. See **Benefits continuation if you go on a leave of absence** in the **Eligibility and enrollment** chapter for more information, including details on paying for benefits while on leave.

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 from an eligible job status
- On the date of your death
- On the 91st day of an approved non-disability leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company.

If you leave the company and are rehired

If you leave the company and return to work for the company as a full-time truck driver, you will automatically be re-enrolled in the truck driver short-term disability plan.

Long-term disability

WHERE CAN I FIND?

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Liberty Life Assurance Company of Boston (Liberty), a Liberty Mutual company, regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

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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 or file a claim	Go to WalmartOne.com	Call Liberty at 800-492-5678

What you need to know about long-term disability

- Walmart offers a long-term disability (LTD) plan and also an LTD enhanced plan. 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 Metro professional non-exempt associates) and management associates (including management trainees and California pharmacists) are eligible to enroll in either plan (but may not enroll in both the LTD and LTD enhanced plans).
- If you enroll in either plan after your initial eligibility period, your long-term disability coverage will not begin until you complete a 12-month waiting period.
- The long-term disability plans work with any other benefits you receive while disabled to replace 50% of your average monthly wage under the LTD plan or 60% of your average monthly wage under the LTD enhanced plan.
- Long-term disability benefits are paid at the end of each 30-day period of disability, as long as you continue to be disabled as defined by the LTD plan or the LTD enhanced plan.

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Enrollment 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, or
- A management associate.

There are two long-term disability plans offered:

- **The LTD plan.** Provides up to 50% of your average monthly wage after your waiting period if you become disabled as defined by the plan.
- **The LTD enhanced plan.** Provides up to 60% of your average monthly wage after your waiting period if you become disabled as defined by the plan.

Both plans are insured by Liberty and both have a maximum monthly benefit of $15,000. For more information about your waiting period, see When LTD benefits begin later in this chapter. For more information about your average monthly wage, see Your LTD benefit later in this chapter.

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, you will be considered a late enrollee and will be required to finish a 12-month waiting period before your coverage is effective, as described below. You will not pay LTD plan or LTD enhanced plan premiums during your 12-month waiting period.
  - If your late enrollment is due to a status change event, your 12-month waiting period will begin as of the date of the event.
  - If your late enrollment is during an annual enrollment, your 12-month waiting period will begin as of the date you enroll.

You may drop your LTD plan or LTD enhanced plan coverage at any time; the change will be effective the day after you drop coverage. If 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, as described above.

In order to receive benefits under the LTD plan or the LTD enhanced plan, you must be actively at work at the time of your disability.

THE COST OF LTD COVERAGE

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

When you qualify for LTD benefits

Under the terms of the LTD plan and LTD enhanced plan, "disability" means that, due to a covered injury or sickness during the benefit waiting period and for the next 24 months of disability, you are unable to perform the material and substantial duties of your own occupation, and after 24 months of benefit payments, you are unable to perform the material and substantial duties of any occupation.

In determining whether you are disabled, Liberty will not consider employment factors, including but not limited to: interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing or loss of professional or occupational license or certification.

To qualify for LTD benefits:

- You must be unable to return to work after the initial benefit waiting period of disability.
- You must continue to be under the appropriate care of a qualified doctor (qualified doctors include legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses).
- Liberty must receive and approve certification with accompanying medical documentation of a disability from your qualified doctor before benefits are considered for payment.

With respect to covered persons employed as pilots and copilots of an aircraft: "disability" or "disabled" means that, as a result of an injury or sickness, the covered person is unable to perform the material and substantial duties of his or her own occupation under the applicable Federal Aviation Administration fitness standards.

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When benefits are not paid

Benefits will not be paid for any LTD claim due to:

- War, declared or undeclared, or any act of war
- Active participation in a riot
- The committing of or attempting to commit a felony or misdemeanor, or
- Cosmetic surgery, unless such surgery is in connection with an injury or sickness sustained while the individual is a covered person.

No benefit will be payable during any period of incarceration.

PRE-EXISTING CONDITION EXCLUSION

You will not receive LTD benefits for any condition, diagnosed or undiagnosed, for which you had received treatment during the 90-day period prior to your effective date unless you have not been treated for the same or related pre-existing condition for more than 365 days while insured. Under the terms of the pre-existing condition exclusion, you are receiving "treatment" when you are consulting, receiving care or services provided by or under the direction of a physician, including diagnostic measures; being prescribed drugs and/or medicines, whether you choose to take them or not; and taking drugs and/or medicines.

If you change from the LTD plan (50% benefit) to the LTD enhanced plan (60% benefit), the pre-existing condition exclusion will apply to the additional coverage amount. If you had satisfied the pre-existing condition requirement of the LTD plan (50% benefit) and then suffer a disability before you had satisfied the pre-existing condition exclusion of the LTD enhanced plan (60% benefit), you will only receive benefits under the LTD plan (50% benefit).

When LTD benefits begin

If you are approved by Liberty for LTD benefits, they will begin after your waiting period: 26 weeks or the end of your short-term disability benefits — whichever is longer.

Paid time off (PTO) may not be used while receiving LTD benefits. If you are receiving LTD benefits at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information. You will not accrue additional PTO while you are receiving LTD benefits.

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

If you cease to be disabled and return to work full-time for a total of 60 calendar days or less during a waiting period, the waiting period will not be interrupted (although the days you work will not be counted toward your benefit waiting period). If you return to work for a total of more than 60 calendar days while satisfying your benefit waiting period, you must satisfy an entirely new benefit waiting period if you again become disabled before you are eligible to receive LTD benefits.

Filing an LTD claim

If you are on an approved short-term disability claim and are eligible for LTD benefits, your claim will be automatically transitioned from Sedgwick to Liberty around the 17th week of disability. You may also call Liberty at 800-492-5678 if you have questions regarding your eligibility or if you have not been contacted within the time frame noted above. Liberty will provide you with additional information on how to complete your claim.

Associates receiving workers' compensation benefits and enrolled in the LTD plan or LTD enhanced plan may be eligible for disability benefits after their waiting period has expired. Call Liberty at 800-492-5678 to report your LTD 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.

Your LTD benefit

The amount of your LTD benefit is based on:

- Your average monthly wage, and
- If you are enrolled in the LTD plan or the LTD enhanced plan.

AVERAGE MONTHLY WAGE

Length of employment	How average monthly wage is determined
Employed 12 months or more	Prior annual pre-disability earnings ÷ 12 months For example, the average monthly wage for an associate with prior annual pre-disability earnings of $36,000 is $3,000 ($36,000 ÷ 12).
Employed less than 12 months	Prior annual pre-disability earnings ÷ number of months worked For example, the average monthly wage for an associate with prior annual pre-disability earnings of $21,000 for seven months of work is $3,000 ($21,000 ÷ 7).

Annual pre-disability earnings include:

- Overtime
- Bonuses
- Paid time off (not including any previous disability benefits), and
- Personal pay for the 26 pay periods (52 if paid weekly) prior to your last day worked.

If you have been employed less than 12 months, an annualized average of earnings will be used, excluding reimbursed expenses.

Your LTD benefit is shown below:

YOUR LTD BENEFIT

If you enrolled	Your coverage is
In the LTD plan	50% of your average monthly wage minus the amount of other benefits or income you or your family are eligible to receive (for example, Social Security disability benefits*)
In the LTD enhanced plan	60% 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 reduces LTD benefits for more information.

The maximum monthly benefit under both the LTD plan and the LTD enhanced plan is $15,000. Your benefit will be no less than $100 or 10% of your gross benefit, whichever is greater, for any month that you are eligible to receive LTD benefits. The total of your monthly disability payment, plus all earnings, cannot exceed 100% of your average monthly wage prior to your disability.

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

Liberty has the right to recover, and you must repay, any amount that is overpaid to you for LTD benefits under the LTD plan or LTD enhanced plan.

TAXES AND YOUR LTD BENEFIT

You pay the costs of your LTD coverage with after-tax contributions. As such, benefits payable to you under the LTD plan or LTD enhanced plan are not subject to income taxes.

OTHER BENEFITS OR INCOME THAT REDUCES LTD BENEFITS

Your LTD benefit amount will be reduced, or offset, by other benefits or income you or your family receives or are eligible to receive. Examples include, but are not limited to, income from the following:

- Social Security disability insurance
- Social Security retirement benefits that are granted after the date of total disability
- Workers' compensation
- Employer-related individual policies
- No-fault automobile insurance
- An employer retirement plan that begins after the date of the total disability, or
- Settlement or judgment, less associated costs of a lawsuit that represents or compensates for your loss of earnings.

If any of the benefits that reduce your LTD benefits are subsequently adjusted by cost-of-living increases, your LTD benefit will not be further reduced. Please refer to the policy for a complete list of offsets. You may obtain a copy of the LTD policy by calling Liberty at 800-492-5678.

REDUCTION OF LTD BENEFIT EXAMPLE

Annual salary: $36,000	LTD Plan (50%)	LTD Enhanced Plan (60%)
Average monthly wage	$3,000	$3,000
Benefit amount (percentage of average monthly wage, subject to the $15,000 maximum)	$1,500	$1,800
Less estimated Social Security disability benefit	-$750	-$750
Less dependent's estimated Social Security benefits	-$375	-$375
LTD payment (monthly)	$375	$675

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 LTD policy terms may require you to apply for Social Security disability benefits. If the Social Security Administration denies you benefits, you will be required to follow the Social Security Administration's appeal process.

Failure to file for Social Security disability benefits could result in your Social Security retirement benefits being reduced when you reach the age of retirement. If you qualify for Social Security disability or retirement benefits while you are receiving benefits under the LTD plan and your Social Security disability claim is approved retroactively, you must reimburse Liberty for any LTD benefits overpaid during the period covered by the retroactive Social Security approval.

If you are disabled and working

You may be eligible to receive disability benefits if you are partially disabled. Under the Plan, "partial disability" and "partially disabled" mean that, as a result of sickness or injury, you are able to:

- Perform one or more, but not all, of the material and substantial duties of your own or any occupation on a full-time or part-time basis, or
- Perform all of the material and substantial duties of your own occupation on a part-time basis, and
- Earn between 20% and 80% of your indexed pre-disability earnings.

Your "pre-disability monthly earnings" means your regular monthly rate of pay in effect for the 26 regular pay periods (52 if paid weekly) immediately prior to your last day worked, divided by 12. Pre-disability earnings include overtime, bonuses, paid time off, vacation, illness protection and personal pay, but not commissions or any other fringe benefits or extra compensation. If you have worked for less than 12 months with the company, your regular monthly rate of pay will be based upon the total earnings you actually received while working for the company immediately prior to the date you became totally disabled, annualized and divided by 12.

Your "indexed pre-disability monthly earnings" means your pre-disability earnings increased annually by 7% or the percentage change in the Consumer Price Index, whichever is less.

Liberty offers a work incentive benefit for the first three months that you are partially disabled and working. You will continue to receive the full amount of your monthly benefit for the first three months if you are partially disabled, unless your benefit and current monthly earnings exceed your pre-disability monthly earnings. Your monthly benefit will be reduced by the excess amount so that the monthly benefit plus your earnings do not exceed 100% of your pre-disability monthly earnings.

After the first three months that you are partially disabled and working, the following calculation is used to determine your monthly benefit for a partial disability.

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 qualified as totally disabled
D	The disabled and working benefit payable

Continuing benefit coverage while disabled

If you wish to continue medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness insurance and accident insurance coverage while you are receiving LTD benefits, you must make premium payments each pay period. These amounts will not be deducted from your LTD benefit payments. If you fail to pay your premiums for these benefit plans, your benefits may be canceled. See the Eligibility and enrollment chapter for details.

Your disability coverage will not be canceled while you are receiving disability benefits under this policy. You will not be required to pay short-term disability enhanced plan or LTD plan premiums from any LTD benefit payments you receive. If, however, you receive any other earnings through the Walmart payroll systems while you are receiving LTD benefits, your premiums will be withheld from those payments.

IF YOU PASS AWAY WHILE RECEIVING LTD BENEFITS

Coverage under the LTD plan and LTD enhanced plan ends upon your death. However, if you pass away while you are receiving LTD benefits, a lump-sum payment of $5,000 or three times your gross monthly LTD benefit, whichever is greater, will be paid to your surviving spouse/partner. If you are not survived by a spouse/partner, the payment will be made to your surviving children, including stepchildren and legally adopted children, in equal shares. However, if any of these children are minors or incapacitated, payment will be made on their behalf to the court-appointed guardian of the children's property. If you are not survived by a spouse/partner or children, the payment will be made to your estate.

When LTD benefit payments end

LTD benefit payments will end on the earliest of:

- The date you fail to furnish proof of continued disability and regular attendance of a doctor
- The date you fail to cooperate in the administration of your claim. For example: providing information or documents needed to determine whether benefits are payable and/or determining the benefit amount
- The date you refuse to be examined or evaluated at reasonable intervals
- The date you refuse to receive appropriate available treatment
- The date you refuse a similar job with Walmart, paying comparable wages, where workplace modifications or accommodations are made to allow you to perform the material and substantial duties of your job
- The date you are able to work in your own occupation on a part-time basis but choose not to
- The date your partial disability monthly earnings exceed 80% of your indexed pre-disability earnings
- The date you are no longer totally disabled
- The last day of the maximum period for which benefits are payable (see chart below), or
- The date of your death.

IF THE DISABILITY IS DUE TO MENTAL ILLNESS, ALCOHOLISM OR DRUG ADDICTION

To receive LTD 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.

MAXIMUM DURATION OF LTD BENEFITS

Age when you become totally disabled	Benefits duration (months of LTD benefits)
Prior to age 62	Until normal retirement age (as listed to the right)
62	48 months
63	42 months
64	36 months
65	30 months
66	27 months
67	24 months
68	21 months
69 or older	18 months

SOCIAL SECURITY NORMAL RETIREMENT AGE

Year of birth	Normal retirement age
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 through 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

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When you are not confined to a hospital or other licensed facility, there will be a 24-month lifetime benefit for these disabilities unless you are fully participating in an extended treatment plan for the condition that caused the disability, in which case the benefit will be payable for up to 36 months.

If you return to work and become disabled again

If you return to work for less than six months of active full-time work and become totally disabled again from the same or a related condition that caused the first period of disability, as determined by Liberty, known as a "relapse/ recurrent claim," the recurrent disability will be part of the same disability.

If you return to work as an active full-time associate for six months or more, any recurrence of a disability will be treated as a new disability. A new waiting period must be completed.

Coverage during a leave of absence or temporary layoff

Once your LTD coverage is effective and you are eligible to file a claim for benefits, if you are not actively-at-work due to an approved non-disability leave of absence or temporary layoff, you will continue to be eligible for LTD benefits for 90 days from your last day of work. Your eligibility for LTD benefits will end on the 91st day after your approved non-disability leave or temporary layoff begins, but will be reinstated if you return to actively-at-work status within one year. See **Benefits continuation if you go on a leave of absence** in the **Eligibility and enrollment** chapter for more information, including details on paying for benefits while on leave.

When coverage ends

Your LTD coverage ends:

- At termination of your employment, except that coverage will be continued if you are absent due to disability during the benefit waiting period and any period during which premium payments are waived
- On the last day of the pay period when your job status changes from an eligible job status
- Upon failure to pay your premiums
- On the date you lose eligibility
- If you do not return to work after the last day of an approved leave of absence
- When the benefit is no longer offered by the company
- The day after you drop coverage, or
- On the date of your death.

If you leave the company and are rehired

If you leave the company and return to full-time work for the company within 13 weeks, you will automatically be re-enrolled for the same coverage plan you had prior to leaving the company (or the most similar coverage offered under the Plan). If you are automatically re-enrolled in LTD plan or LTD enhanced plan coverage and choose to drop it after you return, you may do so at any time.

If you return to full-time work after 13 weeks, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you lose and then regain eligibility

If you lose eligibility and then regain eligibility within 30 days, you will automatically be re-enrolled for the same coverage you had prior to losing eligibility (or the most similar coverage offered under the Plan).

If you lose eligibility and then regain eligibility 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.

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Truck driver long-term disability

WHERE CAN I FIND?

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Liberty Life Assurance Company of Boston (Liberty), a Liberty Mutual company, regarding the calculation of benefits and limitations under the policy, 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, truck driver long-term disability benefits works with other benefits you receive to replace part of your paycheck. The Plan offers two truck driver long-term disability plans that pay benefits for different lengths of time.

TRUCK DRIVER LONG-TERM DISABILITY RESOURCES

Find What You Need	Online	Other Resources
Get more details about truck driver long-term disability or file a claim	Go to WalmartOne.com	Call Liberty at 800-492-5678

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

- Full-time truck drivers may choose from two truck driver long-term disability (LTD) plans: the truck driver LTD plan or the truck driver LTD enhanced plan. Each plan offers a choice of full-duration coverage or five-year coverage.
- The truck driver long-term disability plan works with any other benefits you receive while disabled to replace 50% of your average monthly wage if you select the truck driver LTD plan or 60% of your average monthly wage if you select the truck driver LTD enhanced plan.
- If you enroll in either plan after your initial eligibility period, you will have to submit Evidence of Insurability, and you may be required to undergo a medical exam at your own expense before you can be approved for coverage.
- Truck driver long-term disability benefits are paid at the end of each 30-day period of disability, as long as you continue to be disabled as defined by the truck driver LTD plan or the truck driver LTD enhanced plan.

Enrollment in truck driver LTD and when coverage is effective

You are eligible to enroll in truck driver LTD coverage if you are a full-time truck driver. Truck driver LTD offers two coverage plans, each of which can be chosen in either of two options:

- **LTD plan**
  - Five-year coverage
  - Full-duration coverage
- **LTD enhanced plan**
  - Five-year coverage
  - Full-duration coverage

The truck driver LTD plan options pay benefits as described in the following chart.

TRUCK DRIVER LTD

	LTD PLAN	LTD ENHANCED PLAN
Five-year coverage	Pays 50% of average monthly wage	Pays 60% of average monthly wage
	Both plans pay benefits for 60 months, unless the longer of the following time periods is less than 60 months, in which case the monthly benefit will be payable for the longer period: • The amount of time shown in the Maximum duration of truck driver LTD chart (later in this chapter), or • The amount of time between the date you become disabled and your normal retirement age under the Social Security Act, as shown in the Social Security normal retirement age chart (later in this chapter).	
	LTD PLAN	LTD ENHANCED PLAN
Full-duration coverage	Pays 50% of average monthly wage	Pays 60% of average monthly wage
	Both plan options pay benefits for the longer of: • The amount of time shown in the Maximum duration of truck driver LTD chart (later in this chapter), or • The amount of time between the date you become disabled and your normal retirement age under the Social Security Act, as shown in the Social Security normal retirement age chart (later in this chapter).	

The truck driver LTD plans are insured by Liberty and have a maximum monthly benefit of $15,000. Your benefit will be no less than $100 or 10% of your gross benefit, whichever is greater, for any month that you are eligible to receive LTD benefits.

The date your coverage is effective depends on when you enroll for coverage:

- If you enroll during your initial enrollment period, 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 coverage will be effective the first day of the pay period after People Services receives approval from Liberty. You will be required to provide Evidence of Insurability (you must complete a medical history questionnaire and may be required to undergo a medical exam at your own expense) and may be denied coverage.
- If you enroll in the five-year coverage plan and subsequently decide to enroll in the full-duration coverage plan, you will be treated as a late enrollee and required to provide Evidence of Insurability before you can be approved for coverage. Your coverage will be effective the first day of the pay period after People Services receives approval from Liberty.

You may drop your truck driver LTD plan or truck driver LTD enhanced plan coverage at any time; the change will be effective the day after you drop coverage. If you drop long-term disability and later decide to re-enroll in either plan, you will be treated as a late enrollee, as described above.

THE COST OF TRUCK DRIVER LTD COVERAGE

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

When you qualify for truck driver LTD benefits

Under the terms of the truck driver LTD plans, "disability" means that, due to an injury or sickness during the benefit waiting period and for the next 24 months of disability, you are unable to perform the material and substantial duties of your own occupation, or you lose medical certification in accordance with the Federal Motor Carrier Safety Regulations. After 24 months of benefit payments, "disability" means that you are unable to perform the material and substantial duties of any occupation.

In determining whether you are disabled, Liberty will not consider employment factors, including but not limited to: interpersonal conflict in the workplace, recession, job

obsolescence, pay cuts, job sharing or loss of professional or occupational license or certification for reasons other than a covered injury or sickness.

To qualify for truck driver LTD benefits:

- You must be unable to return to work after the initial benefit waiting period of disability.
- You must continue to be under the appropriate care of a qualified doctor (qualified doctors include legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses).
- Liberty must receive and approve certification with accompanying medical documentation of a disability from your qualified doctor before benefits are considered for payment.

If you file a claim within the first two years of your approval date, Liberty has the right to re-examine your Evidence of Insurability questionnaire. If material facts about you were stated inaccurately, the true circumstances will be used to determine if and for what amount your coverage should have been in effect, and your premium may be adjusted.

When benefits are not paid

Benefits will not be paid for any truck driver LTD claim due to:

- War, declared or undeclared, or any act of war
- Active participation in a riot
- The committing of or attempting to commit a felony or misdemeanor, or
- Cosmetic surgery, unless such surgery is in connection with an injury or sickness sustained while the individual is a covered person.

No benefit will be payable during any period of incarceration.

PRE-EXISTING CONDITION EXCLUSION

You will not receive truck driver LTD benefits for any condition, diagnosed or undiagnosed, for which you had received treatment during the 90-day period prior to your effective date unless you have not been treated for the same or related pre-existing condition for more than 365 continuous days while insured. Under the terms of the pre-existing condition exclusion, you are receiving "treatment" when you are consulting, receiving care or services provided by or under the direction of a physician, including diagnostic measures; being prescribed drugs and/or medicines, whether you choose to take them or not; and taking drugs and/or medicines.

If you change from the five-year duration coverage to the full-duration coverage under either of the truck driver LTD plans, the pre-existing condition exclusion will apply to the additional duration. If you had satisfied the pre-existing condition requirement of the five-year duration coverage plan and then suffer a disability before you had satisfied the pre-existing condition exclusion of the full-duration coverage plan, you will only receive benefits under the five-year duration coverage plan.

When truck driver LTD benefits begin

If you are approved by Liberty for truck driver LTD benefits, they will begin after your waiting period: 26 weeks or the end of your short-term disability benefits — whichever is longer.

Paid time off (PTO) may not be used while receiving LTD benefits. If you are receiving LTD benefits at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information. You will not accrue additional PTO while you are receiving LTD benefits.

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

If you cease to be disabled and return to work for a total of 60 calendar days or less during a waiting period, the waiting period will not be interrupted (although any days that you work will not be counted toward meeting your waiting period). If you return to work for a total of more than 60 calendar days while satisfying your benefit waiting period, you must satisfy an entirely new benefit waiting period if you again become disabled before you are eligible to receive LTD benefits.

Filing a truck driver LTD claim

If you are on an approved short-term disability claim and are eligible for LTD benefits, your claim will be automatically transitioned from Sedgwick to Liberty around the 17th week of disability. You may also call Liberty at 800-492-5678 as soon as you know you will need to use your truck driver LTD benefit. Liberty will provide you with additional information on how to complete your claim.

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

The amount of your truck driver LTD is based on:

- Your average monthly wage, and
- Which truck driver LTD plan you're enrolled in.

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 your last day worked ÷ 12 months
Employed less than 12 months	Your activity pay, mileage rate and bonuses ÷ the number of months worked

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

YOUR TRUCK DRIVER LONG-TERM DISABILITY BENEFIT

If you enrolled	Your coverage is
In the truck driver five-year coverage LTD plan or the truck driver full-duration coverage LTD plan	50% of your average monthly wage minus the amount of other benefits or income you or your family are eligible to receive (for example, Social Security disability benefits*)
In the truck driver five-year coverage LTD enhanced plan or the truck driver full-duration coverage LTD enhanced plan	60% 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 reduces truck driver long-term disability benefits for more information.

The maximum monthly benefit under any of the four truck driver long-term disability plan options is $15,000. Your benefit will be no less than $100 or 10% of your gross benefit, whichever is greater, for any month that you are eligible to receive truck driver long-term disability benefits. The total of your monthly disability payment, plus all earnings, cannot exceed your average monthly wage prior to your disability.

Truck driver long-term disability benefits are paid at the end of each 30-day period of disability, as long as you continue to be disabled as defined by the truck driver LTD plans.

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

TAXES AND YOUR LTD BENEFIT

You pay the costs of your LTD coverage with after-tax contributions. As such, benefits payable to you under the truck driver LTD plans are not subject to income taxes.

OTHER BENEFITS OR INCOME THAT REDUCES TRUCK DRIVER LTD BENEFITS

Your truck driver LTD benefit amount will be reduced, or offset, by other benefits or income you or your family receive or are eligible to receive. Examples include, but are not limited to, income from the following:

- Social Security disability insurance
- Social Security retirement benefits that are granted after the date of total disability
- Workers' compensation
- Employer-related individual policies
- No-fault automobile insurance
- An employer retirement plan that begins after the date of the total disability, or
- Settlement or judgment, less associated costs of a lawsuit, that represents or compensates for your loss of earnings.

If any of the benefits that reduce your LTD benefits are subsequently adjusted by cost-of-living increases, your LTD benefit will not be further reduced. Please refer to the policy for a complete list of offsets. You may obtain a copy of the truck driver LTD policy by calling Liberty at 800-492-5678.

REDUCTION OF TRUCK DRIVER LTD BENEFIT EXAMPLE

	LTD Plan (50%)	LTD Enhanced Plan (60%)
Average monthly wage	$3,000	$3,000
Benefit amount (percentage of average monthly wage, subject to the $15,000 maximum)	$1,500	$1,800
Less estimated Social Security disability benefit	- $750	- $750
Less dependent's estimated Social Security benefits	- $375	- $375
LTD payment (monthly)	$375	$675

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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 LTD policy terms may require you to apply for Social Security disability benefits. If the Social Security Administration denies you benefits, you will be required to follow the Social Security Administration's appeal process.

Failure to file for Social Security disability benefits could result in your Social Security retirement benefits being reduced when you reach the age of retirement. If you qualify for Social Security disability or retirement benefits while you are receiving benefits under any of the truck driver LTD plan options and your Social Security disability claim is approved retroactively, you must reimburse Liberty for any LTD benefits overpaid during the period covered by the retroactive Social Security approval.

If you are disabled and working

You may be eligible to receive disability benefits if you are partially disabled. Under the truck driver LTD plans, "partial disability" and "partially disabled" mean that, as a result of sickness or injury, you are able to:

- Perform one or more, but not all, of the material and substantial duties of your own or any occupation on a full-time or part-time basis, or
- Perform all of the material and substantial duties of your own occupation on a part-time basis, and
- Earn between 20% and 80% of your indexed pre-disability earnings.

Your "pre-disability monthly earnings" means your activity pay, mileage rate and bonus in effect for the 52 weeks immediately prior to your last day worked, divided by 12.

Your "indexed pre-disability monthly earnings" means your pre-disability monthly earnings increased annually by 7% or the percentage change in the Consumer Price Index, whichever is less.

Liberty offers a work incentive benefit for the first three months that you are partially disabled and working. You will continue to receive the full amount of your monthly benefit for the first three months if you are partially disabled, unless your benefit and current monthly earnings exceed your pre-disability monthly earnings. Your monthly benefit will be reduced by the excess amount so that the monthly benefit plus your earnings do not exceed 100% of your pre-disability monthly earnings.

After the first three months that you are partially disabled and working, the following calculation is used to determine your monthly benefit for a partial disability.

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 qualified as totally disabled
D	The disabled and working benefit payable

Continuing benefit coverage while disabled

If you wish to continue medical, dental, AD&D, optional associate and dependent life insurance, critical illness insurance and accident insurance coverage while you are receiving truck driver LTD benefits, you must make benefits premium payments each pay period. These amounts will not be deducted from your truck driver LTD benefit payments. If you fail to pay your premiums for these benefit plans, your benefits may be canceled. See the Eligibility and enrollment chapter for details.

Your disability coverage will not be canceled while you are receiving disability benefits under this policy. You will not be required to pay truck driver LTD premiums from any truck driver LTD benefit payments you receive. If, however, you receive any other earnings through the Walmart payroll systems while you are receiving truck driver LTD benefits, your premiums will be withheld from those payments.

IF YOU PASS AWAY WHILE RECEIVING TRUCK DRIVER LTD BENEFITS

Coverage under the truck driver LTD plans ends upon your death. However, if you pass away while you are receiving truck driver LTD benefits, a lump sum payment of $5,000 or three times your gross monthly LTD benefit, whichever is greater, will be paid to your surviving spouse/partner. If you are not survived by a spouse/partner, the payment will be made to your surviving children, including stepchildren and legally adopted children, in equal shares. However, if any of these children are minors or incapacitated, payment will be made on their behalf to the court-appointed guardian of the children's property. If you are not survived by a spouse/partner or children, the payment will be made to your estate.

When truck driver LTD benefit payments end

Truck driver LTD benefit payments will end on the earliest of:

- The date you fail to furnish proof of continued disability and regular attendance of a doctor
- The date you fail to cooperate in the administration of your claim. For example: providing information or documents needed to determine whether benefits are payable and/or determining the benefit amount
- The date you refuse to be examined or evaluated at reasonable intervals
- The date you refuse to receive appropriate available treatment
- The date you refuse a similar job with Walmart, paying comparable wages, where workplace modifications or accommodations are made to allow you to perform the material and substantial duties of your job
- The date you are able to work in your own occupation on a part-time basis but choose not to
- The date your partial disability monthly earnings exceed 80% of your indexed pre-disability earnings
- The date you are no longer totally disabled
- The last day of the maximum period for which benefits are payable (see charts below), or
- The date of your death.

FIVE-YEAR COVERAGE	FULL-DURATION COVERAGE
Five-year coverage pays benefits for 60 months unless the longer of the following time periods is less than 60 months, in which case the monthly benefit will be payable for the longer period: • The amount of time shown in the Maximum duration of truck driver LTD chart below; or • The amount of time between the date you become disabled and your normal retirement age under the Social Security Act, as shown in the Social Security normal retirement age chart below.	Full-duration coverage pays benefits for the longer of: • The amount of time shown in the Maximum duration of truck driver LTD chart below; or • The amount of time between the date you become disabled and your normal retirement age under the Social Security Act, as shown in the Social Security normal retirement age chart below.

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MAXIMUM DURATION OF TRUCK DRIVER LTD BENEFITS

Age when you become totally disabled	Benefits duration (months of LTD benefits)
Prior to age 62	Until normal retirement age (as listed to the right)
62	48 months
63	42 months
64	36 months
65	30 months
66	27 months
67	24 months
68	21 months
69 or older	18 months

SOCIAL SECURITY NORMAL RETIREMENT AGE

Year of birth	Normal retirement age
1937 or before	65 + 2 months
1938	65 + 4 months
1939	65 + 6 months
1940	65 + 8 months
1941	65 + 10 months
1942	66
1943 through 1954	66 + 2 months
1955	66 + 4 months
1956	66 + 6 months
1957	66 + 8 months
1958	66 + 10 months
1959	67
1960 or after	67

IF THE DISABILITY IS DUE TO MENTAL ILLNESS, ALCOHOLISM OR DRUG ADDICTION

To receive truck driver LTD benefits for more than 24 months for the following disabilities, you must be confined in a hospital or other place licensed to provide medical care:

- Mental illness (excluding demonstrable, structural brain damage)
- Any condition that results from mental illness
- Alcoholism, and
- Non-medical use of narcotics, sedatives, stimulants, hallucinogens or similar substances.

When you are not confined to a hospital or other licensed facility, there will be a 24-month lifetime benefit for these disabilities unless you are fully participating in an extended treatment plan for the condition that caused the disability, in which case the benefit will be payable for up to 36 months.

If you return to work and become disabled again

If you return to work for less than six months of active full-time work and become disabled again from the same or a related condition that caused the first period of disability, as determined by Liberty, known as a "relapse/recurrent claim," the recurrent disability will be part of the same disability. No additional waiting period will be required.

If you return to work as an active full-time associate for six months or more, any recurrence of a disability will be treated as a new disability. A new benefit waiting period must be completed.

Coverage during a leave of absence or temporary layoff

Once your truck driver LTD coverage is effective and you are eligible to file a claim for benefits, if you are not actively-at-work due to an approved non-disability leave of absence or temporary layoff, you will continue to be eligible for truck driver LTD benefits for 90 days from your last day of work. Your eligibility for truck driver LTD benefits will end on the 91st day after your approved non-disability leave or temporary layoff begins, but will be reinstated if you return to actively-at-work status within one year. See **Benefits continuation if you go on a leave of absence** in the **Eligibility and enrollment** chapter for more information, including details on paying for benefits while on leave.

When coverage ends

Your truck driver LTD coverage ends:

- At termination of your employment
- On the last day of the pay period when your job status changes from an eligible job status
- Upon failure to pay your premiums
- On the date you lose eligibility
- If you do not return to work after the last day of an approved leave of absence
- When the benefit is no longer offered by the company
- On the day after you drop coverage, or
- On the date of your death.

If you leave the company and are rehired

If you leave the company and return to full-time work for the company within 13 weeks, you will automatically be re-enrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan). If you are automatically re-enrolled in truck driver LTD plan or LTD enhanced plan coverage and choose to drop it after you return, you may do so at any time.

If you return to full-time work after 13 weeks, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you lose and then regain eligibility

If you lose eligibility and then regain eligibility within 30 days, you will automatically be re-enrolled for the same coverage you had prior to losing eligibility (or the most similar plans offered under the Plan).

If you lose eligibility and then regain eligibility 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.

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The Associate Stock Purchase Plan (ASPP)

WHERE CAN I FIND?

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The Associate Stock Purchase Plan (ASPP)

The Associate Stock Purchase Plan (ASPP or Plan) allows you to buy Walmart stock conveniently through payroll deductions and through direct payments to the Plan Administrator. You can have any amount from $2 to $1,000 withheld from your biweekly paycheck ($1 to $500 if you are paid weekly) to buy stock. Walmart matches $0.15 for every dollar that you contribute through payroll deduction to purchase stock, up to the first $1,800 you contribute to the Plan in each Plan year (April through March).

THE ASSOCIATE STOCK PURCHASE PLAN RESOURCES

Find What You Need	Online	Other Resources
Enroll in the Plan or change your deduction amount		Associates must complete an online enrollment session on the WIRE, WalmartOne.com/ASPP or Workday
• Access your account information • Get your account statement • Get a Form 1099	Go to the Computershare website 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, Rhode Island 02940-3080 (Company matching contributions will not be made on money sent directly to Computershare)

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What you need to know about the Associate Stock Purchase Plan

- All eligible associates can purchase Walmart stock through convenient payroll deductions and direct payments to Computershare.
- Walmart matches $0.15 for every $1 you put into the Plan through payroll deductions, up to the first $1,800 that you contribute in each plan year.
- There are no fees to purchase shares of Walmart stock through the Plan. You only pay a fee when you sell shares of stock.
- Your shares will be credited to an account that is maintained in your name at Computershare. You can access your account online or by telephone to get your balance or sell stock held in your account.

Associate Stock Purchase Plan eligibility

You are eligible to enroll in the Associate Stock Purchase Plan if you are:

- Not a member of a collective bargaining unit whose benefits were the subject of good faith collective bargaining.
- At least 18 years of age or the legal age of majority in your payroll state to participate (19 is the legal age of majority in Alabama and Nebraska). If you live in Puerto Rico, you must be 21 years of age to participate. If you have questions about the age requirement, review your state laws on legal age of majority.

Enrolling in the Associate Stock Purchase Plan

You can enroll in the Plan by completing an online benefits enrollment session on the WIRE, WalmartOne.com/ASPP or Workday. Before you enroll in this plan, you should carefully review this Associate Stock Purchase Plan brochure and the Plan Prospectus (a copy of which appears on the following pages), as well as the reports and other documents that the company has incorporated by reference into the Plan Prospectus.

The decision to participate in the Plan and to purchase company stock is an individual decision to be made solely by you. The company is not recommending, endorsing or soliciting your participation in the Plan or purchase of company stock. In making your decision, you should be aware that the past performance of the company stock is not an indication or prediction of future performance. The value of company stock may be affected by many factors, including those outside the company itself, such as economic conditions. The company urges you to consult with your financial and tax advisors regarding your participation in the Plan and investment in company stock.

Walmart's contribution to your company stock ownership

The Associate Stock Purchase Plan allows all eligible associates to buy Walmart stock conveniently through payroll deductions. You can have any whole dollar amount from $2 to $1,000 withheld from your paycheck to buy stock ($1 to $500 for associates with a weekly paycheck).

Walmart contributes to your stock purchase account by matching $0.15 for every $1 you contribute to the Plan through payroll deductions, up to your first $1,800 you contribute in each Plan year. The Plan year runs from April through March. The company match is reflected as income on your check stub and on your Form W-2.

In addition to your payroll deductions, you can also contribute to the Associate Stock Purchase Plan by sending money directly to Computershare, the Plan's administrator, at:

Computershare
Attn: Walmart ASPP
P.O. Box 43080
Providence, Rhode Island 02940-3080

Money sent directly to Computershare will not receive the Walmart matching contribution. The total of your payroll deductions and money sent directly to Computershare cannot exceed $125,000 per Plan year. Dividends paid on the stock you hold as of each dividend record date are automatically reinvested to buy additional shares of stock for you, but do not count against the $125,000 maximum.

The value of the stock you purchase can fluctuate and may decline. There is no way to guarantee that your stock will have the same value in the future that it had when you made the purchase or that the value of the stock will increase. When making a decision about purchasing Walmart stock, consider all your investments, including other Walmart stock you may own. For investment questions, consult a financial advisor. Investment in the stock is subject to certain risks as described in the Plan Prospectus and Walmart's most recent Annual Report on Form 10-K that is incorporated by reference in the Plan Prospectus.

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 $0.15 for every $1 up to $1,800)	$2,090

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

Selling stock through the Plan

No fees are charged to you for buying stock; however, when you sell stock you will be charged a fee. The fees charged by Computershare described in this brochure are subject to change from time to time.

If you choose to sell your stock, your stock will be sold pursuant to a market order. Your stock will be sold as soon as your request can reasonably be processed. Generally, market orders are executed immediately after they are placed. The price at which your order will be executed is not guaranteed, and the Walmart stock price prior to the execution of your order is not necessarily the price at which your order will be executed.

Generally, any sales of your stock will be executed over the New York Stock Exchange (NYSE). If the NYSE is closed when your order is ready to be processed, your order will be processed as early as possible on the next NYSE trading day. The fee is $25.50 per sale plus $0.05 (five cents) per share sold for each sell you execute.

To sell stock, call Computershare at 800-438-6278 or go to computershare.com/walmart. A check will be mailed to the address on file at Computershare. You should receive your check within seven to 10 business days after you place an order to sell stock in your Plan account.

The sell fee is automatically deducted from your check for the net proceeds of the sale. Each time you sell stock, you will receive a transaction summary form along with your check. For tax reporting purposes, you'll receive appropriate tax documents (1099B and/or 1099DIV) enclosed with your annual statement in the first quarter of the following year (January through March). These documents will be mailed to your address on file with Computershare and should be used when filing your taxes.

It's important to understand the tax consequences of a stock sale. If you have tax-related questions, please consult a financial advisor or tax consultant.

Keeping track of your Computershare account

You will receive a statement from Computershare at least annually (first quarter) that shows the activity in your account. However, if you opted to receive your statements electronically, you will receive an email informing you that your statement is ready and can be found on computershare.com/walmart.

The annual statement you receive will contain important tax information. It is very important that you keep your statement so that you will know the difference between your purchase price and sale price of any shares of stock you sell. You will need this information for your income taxes.

You can access your account information by phone by calling Computershare at 800-438-6278 (hearing impaired: 800-952-9245) or the Computershare website at computershare.com/walmart.

If you request replacement statements from Computershare, there is a $5 charge per statement for previous years' statements. Or, you can obtain copies free of charge through the website at computershare.com/walmart.

Ending your participation and closing your account

To cancel your payroll deductions to the Associate Stock Purchase Plan, complete an online benefit enrollment session on the WIRE, WalmartOne.com/ASPP or Workday.

After you cancel your payroll deductions, you can close your account by asking Computershare to issue you a stock certificate or by directing them to sell your stock and send you a check. To avoid paying a sales transaction fee twice, cancel your payroll deductions before closing your account. You also have the option to stop payroll deductions and to continue to hold your shares through the Plan at Computershare.

If you leave the company

If you leave the company, you will have several options concerning the status of your account:

- You can keep your account open without the weekly or biweekly payroll deduction and the company match. You can make voluntary cash purchases and benefit from having no broker's fee. There is an annual maintenance fee of $35 per year, which will be automatically deducted from your account through the sale of an appropriate number of shares or portion of a share of stock to cover the fee during the first quarter of the year.
- You can close your account and receive all full shares in certificate form and a check for any fraction of a share you own.
- You can close your account and sell some or all of the shares in your account.

In order to prevent any residual balances and to avoid paying a sales transaction fee twice, wait until you receive your final paycheck before closing your account.

It is very important that you update Computershare if you have an address change after you have left the company.

Prospectus

The information below constitutes a prospectus under Section 10(a) covering securities that have been registered under the Securities Act of 1933. The information constituting a prospectus ends on page 220.

20,000,000 Shares

WAL-MART STORES, INC.

Common Stock
($.10 par value per share)

WAL-MART STORES, INC.
2016 Associate Stock Purchase Plan
(formerly, the Wal-Mart Stores, Inc. 2004 Associate Stock Purchase Plan and the Walmart Stores, Inc. Associate Stock Purchase Plan of 1996)

This prospectus relates to the purchase of the number of shares of the common stock, $0.10 par value per share, of Wal-Mart Stores, Inc. ("Walmart," the "Company" or "we") shown above under the Wal-Mart Stores, Inc. 2016 Associate Stock Purchase Plan (the "Plan") by eligible Walmart associates who elect to participate in the Plan.

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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.

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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 or other jurisdiction 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 "Part I, Item 1A. **Risk Factors**" in Walmart's Annual Report on Form 10-K most recently filed with the Securities and Exchange Commission for a discussion of certain risks that may affect our business, operations, financial condition, results of operations and cash flows. See Stock Ownership; fees and risks later in this chapter.

The date of this Prospectus is October 11, 2016

Introduction and overview

The Plan is an amendment and restatement of the Wal-Mart Stores, Inc. 2004 Associate Stock Purchase Plan which had previously amended and restated the Wal-Mart Stores, Inc. Associate Stock Purchase Plan of 1996. The Plan was most recently approved by the stockholders of Walmart at our Annual Stockholders' Meeting held on June 3, 2016. As of June 3, 2016, up to 10,943,171 shares of the company's common stock, par value $.10 per share (the "Stock"), were available from the company or on the open market under the Plan; 20,000,000 shares of Stock were available for purchase from the company under the Plan; and 100,000,000 shares of Stock were available for purchase on the open market under the Plan. As of the date of this Prospectus, 20,000,000 shares have been registered with the United States Securities and Exchange Commission for offer and sale on Registration Statements on Form S-8. 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 shares of Stock by payroll deduction. In addition, if they make or have made purchases through such payroll deductions under the Plan, they may also purchase shares of Stock by making voluntary contributions to the Plan out of their other funds. Under the Outstanding Performance Award Program, the company may reward associates for exceptional job performance by awarding shares of Stock to them.

We believe that the Plan is not subject to any provisions of the Employee Retirement Income Security Act of 1974, as amended. The Plan is not qualified under Section 401(a) or 423 of the Internal Revenue Code of 1986, as amended.

Plan administration; account management

The Plan provides that the Global Compensation Committee of our Board of Directors (the "Committee") has the overall authority for administering the Plan. The Committee may delegate (and revoke the delegation of) some or all aspects of Plan administration to the officers or managers of the company or of a wholly-owned or majority-owned subsidiary of the company (which subsidiaries are referred to in this Prospectus as "affiliates"), subject to terms as it deems appropriate. The members of the Committee are selected by Walmart'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 Walmart for any reason. At the date of this Prospectus, the members of the Committee were Mr. C. Douglas McMillon, our President and Chief Executive Officer of the company; Mr. Gregory B. Penner, the Chairman of our Board of Directors and Mr. S. Robson Walton. Mr. Walton is the beneficial owner of in excess of 51% of the outstanding shares of the Stock, including the shares of Stock that constitute approximately 45% of the outstanding shares of the Stock that are owned by Walton Enterprises, LLC, of which Mr. Walton is a managing member. Mr. Penner is the son-in-law of Mr. Walton.

The Committee has selected a Third Party Administrator, currently Computershare Trust Company, N.A. ("Computershare"), to establish and maintain accounts under the Plan. Computershare also serves as the company's stock transfer agent and provides other stock-related services to the company and its shareholders.

The Committee, as administrator of the Plan, or its delegate, must follow the terms of the Plan, but otherwise has full power and discretion to administer the Plan, including, but not limited to the power to: (i) determine when, to whom and in what types and amounts contributions should be made; (ii) authorize the company to make contributions to eligible associates in any number and to determine the terms and conditions applicable to each such contribution; (iii) set a minimum and maximum dollar, share or other limitation on the various contributions permitted under the Plan; (iv) determine whether an entity of which we own more than 50% or otherwise control, directly or indirectly ("an affiliate") should become (or cease to be) a Participating Employer (as defined below); (v) determine whether (and which) associates of non-U.S. Participating Employers should be eligible to participate in the Plan; (vi) make all determinations deemed necessary or advisable for the administration of the Plan; (vii) make, amend, waive and rescind rules and regulations for the administration of the Plan; and (viii) 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, any funds contributed to the Plan by any associate or the proceeds of any sale of shares of Stock in trust for the benefit of the participants.

Plan participation and eligibility

If you are eligible to participate in the Plan, you can become a participant in the Plan by enrolling online (where available) on the WIRE, WalmartOne.com/ASPP or Workday, to authorize payroll deductions to be taken from your regular compensation and contributed to the Plan for the purchase of Stock to be held in your Plan account. You can also become a participant in the Plan if the Committee grants you an award of Stock under the Outstanding Performance Award Program.

All associates of the company and approved affiliates of the company ("Participating Employers") are eligible to participate in the Plan, except:

- If you are restricted or prohibited from participating in the Plan under the law of your state or country of residence, you may not participate in the Plan or your participation in the Plan may be limited. It is your responsibility to ensure there are no such restrictions or prohibitions on your participation in the Plan.
- You must have attained the age of majority in your state of residence or employment to participate. It is your responsibility to ensure you are of sufficient age to participate. The company may terminate your participation if it discovers you are not of legally sufficient age to participate in the Plan.

- If you are a member of a collective bargaining unit whose benefits were the subject of good faith collective bargaining, you are excluded from participation in the Plan.
- If your employer is a non-U.S. Participating Employer, you may participate only if you are an approved associate (listed by group, category or by individual).
- If you are an officer of Walmart subject to subsection 16(a) of the Securities Exchange Act of 1934, or otherwise subject to our 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 from the company or a Participating Employer, 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.

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Plan contributions — Stock Purchase Program

To make payroll deduction contributions, you need to complete an online benefits enrollment session on the WIRE, WalmartOne.com/ASPP or Workday. Once you have properly enrolled in the Plan, your payroll deduction contributions will continue in accordance with your most recent payroll deduction authorization (subject to any restrictions imposed by the Plan) as long as you are employed by the company or a Participating Employer, unless you change or terminate your payroll deduction authorization or the Plan itself is terminated.

Please note that no deduction will be drawn from any paycheck in which your payroll deduction contribution exceeds your net pay after taxes are withheld. You can change or terminate your payroll deduction authorization by completing an online benefits enrollment session on the WIRE, WalmartOne.com/ASPP or Workday. Your request will be processed as soon as practicable. Your enrollment or request may be delayed or rejected if your enrollment or requested change is prohibited at the time of the attempted enrollment or the request by any company policy, including the company's Insider Trading Policy.

Note that payroll deduction contributions are generally taken from your last paycheck as an associate. If you do not want to have payroll deduction contributions taken from your last paycheck, it is important that you timely terminate your payroll deduction authorization. If you work in a state that requires your last paycheck to be paid outside of the normal payroll cycle, payroll deduction contributions will not be taken out of your last paycheck.

Payroll deductions can be as little as $2 or as much as $1,000 per biweekly payroll period. Payroll deductions for associates paid on a weekly basis can be as little as $1 or as much as $500 per weekly payroll period. The amount of any biweekly or weekly deduction in excess of the minimum must be in multiples of $0.50. The Company or your Participating Employer will make a matching cash contribution on your behalf to your Plan account when you make contributions to the Plan by payroll deduction. The matching contribution is currently 15 percent of the first $1,800 you contribute to the Plan by payroll deduction, or up to $270 per Plan year. The company's matching contribution will be used to buy Stock for your Plan account.

If you participate or have participated in payroll deductions under the Plan and your Plan account has not been closed as described below, you can also voluntarily contribute cash (in U.S. dollars) from your other resources to fund the purchase of Stock under the Plan to be held in your Plan account, including after your employment with the Company or any Participating Employer has been terminated. Any voluntary contributions must be made directly to Computershare. Instructions for making such voluntary contributions are available from Computershare. Neither the Company nor your Participating Employer will make matching contributions on amounts you contribute directly to Computershare. In addition, you may also deposit shares of Stock that you hold outside of the Plan (whether you originally acquired those shares through the Plan or otherwise) to your Plan account by making arrangements directly with Computershare.

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The total of your payroll deductions and voluntary cash contributions to the Plan cannot exceed $125,000 per Plan year (April 1 through March 31). Dividends credited to your Plan account will not count against the maximum.

The Committee establishes and may change the maximum and minimum contributions, may change the conditions for voluntary cash or Stock contributions, and may change the amount of the matching contributions of an employer at any time.

OUTSTANDING PERFORMANCE AWARD PROGRAM

Under the Outstanding Performance Award component, you can be granted an award of Stock for demonstrating consistently outstanding performance in your job over the period of a month, a quarter or a year. The Committee approves all Outstanding Performance Awards and sets maximum dollar limitations on these awards from time to time.

Your Stock under the Outstanding Performance Award component will be given to you through an account maintained for your benefit by Computershare.

STOCK PURCHASES

Your employer will send all of your payroll deductions along with any matching contributions to Computershare as soon as practicable following each pay period. Computershare will purchase Stock for your Plan account no later than five business days after it receives the funds. If you make a voluntary cash contribution outside of payroll deductions, Computershare will purchase your Stock with that voluntary cash contribution no later than five business days after it receives the funds.

Computershare may purchase Stock for the Plan accounts on a national stock exchange, from the company, or from a combination of these places. However, the Committee reserves the right to direct Computershare to purchase from a particular source, consistent with applicable securities rules and the applicable rules of any national stock exchange.

Typically, when Computershare purchases Stock for the Plan on a national stock exchange, the shares are purchased as part of a bundled group rather than individually for each participant. In some instances, the shares of Stock for a bundled group must be purchased for the Plan over more than one day. When shares of Stock are purchased for you as part of a bundled group, your purchase price for each share of Stock will be equal to the average price of all shares of Stock purchased for that group as determined by Computershare. A participant is not permitted to direct an order for Computershare to purchase shares of Stock solely for himself or herself that are part of the bundled group.

If Computershare buys shares of Stock from the company, whether authorized but unissued shares or treasury shares, the per-share price paid to the company for those shares of Stock will be equal to the Volume Weighted Average Price (VWAP) as reported on the New York Stock Exchange – Composite Transactions on the date of purchase. The VWAP is the weighted average of the prices at which all trades of the company's Stock are made on the NYSE on the date the Stock is purchased from the company. While the Plan permits the Committee to designate another methodology for valuing Stock purchased from the company, as of the date of this Prospectus no other methodology has been designated.

The number of shares allocated to your Plan account in connection with any purchase of Stock will equal the total amount of the contributions and dividends available for your Plan account and used to fund such purchases, divided by the purchase price for each share of Stock attributable to those purchases as discussed above.

Non-U.S. Participants Please Note: All amounts contributed to the Plan by payroll deduction, all matching contributions, and any contributions made pursuant to the Outstanding Performance Award component will be converted from your local currency to U.S. dollars prior to the time the shares of Stock are purchased. The exchange rate will be the exchange rate published in *The Wall Street Journal* (or other similar source) on a date as soon as practicable prior to the date the cash is sent to Computershare. Generally, the exchange rate used is the one for the business day immediately prior to the day the funds are sent to Computershare, but that may not be practicable in all circumstances. All voluntary cash contributions must be converted to U.S. dollars before being sent to Computershare to purchase shares of Stock.

Stock ownership, fees and risks

STOCK OWNERSHIP

From the time that shares of Stock are credited to your Plan account, you will have full ownership of those shares (including any fractional shares) of Stock. The shares of 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. You may not transfer or assign your Plan account to another person who is not an eligible participant in the Plan. There is no automatic lien or security interest on the shares of Stock held in your Plan account, and the terms of the Plan do not provide for anyone to have or to have the ability to create a lien on any funds or shares of Stock credited to your Plan account. However, you may pledge, hypothecate or deal with the shares of Stock credited to your Plan accounts in the same manner as you may do with other shares of Stock you may own, subject to compliance with our Insider Trading Policy. If you pledge shares of Stock credited to your Plan account to secure a loan, the lender will have a security interest in the shares of Stock held in your Plan account. Neither Walmart nor any Participating Employer is a sponsor of or will be responsible for any amounts owed by a participant. If you fail to repay the amounts you owe to the lender for your loan, including the accrued interest and any fees thereon, the lender may foreclose its lien on, and sell, the number of shares pledged to secure the loan that will yield net sales proceeds in an amount necessary to pay the amounts you owe the lender. If the net proceeds from such a sale of shares are less than the amount you owe the lender, you, and not Walmart or a Participating Employer, will be responsible for paying the deficiency from your other resources.

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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, notices of internet availability of proxy materials and other materials distributed by the company to its stockholders. To vote the shares of Stock held in your Plan account, you must deliver signed voting instructions, also known as proxy instructions, in a timely manner described in the company's proxy materials. If you do not provide properly completed and executed voting instructions as described in the company's proxy materials, your shares will not be voted with respect to any election of directors, any advisory vote on executive compensation, or many other matters that may be subject to a shareholder vote. However, in those circumstances, your shares of Stock may be voted in the manner recommended by the company in its proxy statement or as directed by the Committee on matters defined by the New York Stock Exchange as "routine," such as the ratification of the appointment of the company's independent auditors, provided that doing so would comply with applicable law and any applicable listing standard of a national stock exchange.

FEES AND ACCOUNT STATEMENTS

The company pays all fees associated with the purchase of Stock. Generally, no maintenance fees or other charges will be assessed to your Plan account as long as you are employed by the company or one of its affiliates (even if that affiliate is not a Participating Employer). However, you must pay any commissions or charges resulting from other Computershare services you request, for example, brokerage commissions and other fees applicable to the sale of Stock. Computershare can tell you if a particular request would cause you to incur a charge. The fees charged by Computershare described in this Prospectus are subject to change from time to time.

At least annually, you will receive a statement of your account under the Plan, reflecting all activity with respect to your Plan account for the period of time covered by the statement. You may elect to receive your statements online. If you elect to do so, you will receive an email informing you that your statement is ready and can be found on computershare.com/walmart. Your annual statement will also contain important tax information. It is very important that you keep your statement so that you will know the difference between your purchase price and sales price of any shares of Stock you sell. You will need this information for your income taxes.

You may also access information regarding your account at any time by logging on to computershare.com/walmart. You can access your account information by phone at 800-438-6278 (hearing impaired 800-952-9245).

If you request replacement statements from Computershare, there is currently a $5 charge per statement for statements for years preceding the most recently completed plan year. Or, you can obtain copies free of charge through the website at computershare.com/walmart.

RISKS

Many of your risks of Plan participation are the same as those of any other stockholder of the company, in that you assume the risk that the value of the Stock may increase or decrease. There are no guarantees as to the value of a share of Stock. This means that you assume the risk of fluctuations in the value or market price of the Stock. Our latest Annual Report on Form 10-K filed with the SEC and, as noted below, incorporated by reference in this Prospectus, discusses, and other of our reports filed with the SEC may discuss, certain risks relating to the company,

its operations and financial performance that can affect the value, market price and liquidity of the Stock. The company urges you to review those discussions in connection with any determination to participate in the Plan, to change the terms of your participation in the Plan, to terminate your participation in the Plan or to make any voluntary contributions under the Plan.

If you are a non-U.S. participant, you also assume the risk of fluctuation in currency exchange rates. Also, until your payroll deductions (as well as the corresponding matching contributions) are applied by Computershare to purchase shares of Stock, such funds 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 representing any or all full shares of Stock credited to your Plan account at no cost to you. Your shares that are represented by a stock certificate will no longer be credited or otherwise related to any Plan account that you continue to have in effect and the dividends paid on those shares will not be reinvested under the Plan.

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You may also have Computershare transfer any or all of the shares of Stock credited to your Plan account into your name in the Direct Registration System. Such a transfer means that you would hold your shares as "book-entry" securities and your ownership would be shown on our stock transfer records and represented by a statement which shows your holdings of shares of Stock.

You may request that Computershare sell all or a portion of the shares of Stock (including any fractional interests) credited to your Plan account at any time, whether or not you want to close your Plan account.

You will be charged a brokerage commission, as well as any other applicable fees, if for any reason you have Computershare sell shares of Stock held in your Plan account. Any brokerage commission or fees will be at the rates posted by Computershare from time to time. These rates are available upon request from Computershare. A current schedule of Computershare's fees applicable to the Plan can be found at computershare.com/walmart. The company negotiated the amount of such fees with Computershare.

If you choose to sell your Stock, your Stock will be sold pursuant to a market order. Although the Plan permits sales of shares of Stock held in Plan accounts to be made through batch orders and such sales have been made through batch orders in the past, sales of shares of Stock under the Plan are now made solely pursuant to market orders. As a result, if you direct Computershare to sell any shares of Stock credited to your Plan account, Computershare will sell those shares in the open market at the then current best available price. However, the price at which your order will be executed is not guaranteed, and the last-traded price for the Stock prior to the execution of your order to sell your shares of Stock is not necessarily the price at which your order will be executed. From time to time, we repurchase shares of Stock in the open market under a stock repurchase program adopted by our Board of Directors. As a result, if Computershare sells shares credited to your Plan account in the open market, we could be the purchaser of such shares. However, we will typically not know if any of the shares of Stock we purchase in the open market are purchased from you. Your shares of Stock will be sold as soon as your request can reasonably be processed. Generally, market orders are executed immediately after they are placed. We expect that any sales of your shares of Stock will be executed over the New York Stock Exchange (the "NYSE"), but orders for those sales need not be executed over the NYSE. If the NYSE is closed when your order is ready to be processed, your sale transaction will be processed as early as practicable on the next NYSE trading day. Orders for the sale of shares of Stock under the Plan may be executed by or through an affiliate of Computershare that is registered with the SEC as a broker-dealer under the Securities Exchange Act of 1934.

Sales of the Stock will be made in U.S. dollars. If you are employed outside the U.S. by a Participating Employer and if provided by Computershare for your country, the proceeds from the sale may be converted for a fee to another currency if you request it when you request your Stock to be sold. If the proceeds are converted to another currency, the exchange rate that will be used is the exchange rate published in *The Wall Street Journal* (or other similar source) 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.

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If you terminate your payroll deduction authorization, or your employment with the company and all its affiliates has terminated, you may choose to continue your Plan account; or you may close your Plan account if you specify this to Computershare. Specifically:

- You may keep your Plan account open (without the weekly or biweekly payroll deduction and your employer's matching contributions). If you keep your account open, you may continue to make voluntary cash contributions and no brokerage commissions will be charged on the purchase of Stock. If you cease to be employed by the company or one of its affiliates, an annual maintenance fee will be charged to your account. Computershare has the option to collect such maintenance fee either in the form of quarterly installments, or in an annual lump sum payment, which is due in the first quarter of each calendar year and will be paid by means of the sale of an appropriate number of shares or portion of a share of Stock by Computershare. (If you are transferred to a company affiliate that is not a Participating Employer, the company may continue to pay the maintenance fee for you.)
- If you own at least one full share of Stock, you may close your Plan account by moving your Stock into a "General Shareholder" account maintained on your behalf by Computershare. You may accomplish this move either by receiving all full shares in certificate form with a check for any fractional share ownership or by re-depositing the shares in the General Shareholder account, or Computershare can move the shares electronically at your request. You should contact Computershare for more information about the fees associated with a General Shareholder account.
- You may close your Plan account by having all shares of Stock in your account sold and the proceeds paid to you, or you can have certificates for full shares (and cash proceeds of any fractional shares paid to you) delivered to you instead. The proceeds of any sale of full or fractional shares will be net of brokerage commissions, sales fees and other applicable charges. Your account will be closed automatically if you terminate employment and there are no shares or fractional shares in your account.

If you die before your Plan account has been closed, your Plan account will be distributed per the legal documentation submitted to Computershare or to your estate, unless you had previously arranged with Computershare to have your Stock held in a joint account. In the event you have a joint account, the joint account holder may either make arrangements with Computershare to move your shares into a General Shareholder account maintained by Computershare at his or her own expense or to have the Stock (or proceeds from the sale thereof) distributed, less any applicable fees or commissions.

To add or remove a joint tenant to or from your account, call Computershare at 800-438-6278.

Plan amendment and termination

The Plan has no set expiration date. The Board of Directors of the company, the Committee or any other duly appointed committee of the Board of Directors 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 or matching funds the company has contributed that have not yet been used to purchase shares of Stock; (2) any shares (or fractional shares) of Stock credited to your Plan account; or (3) any dividends or distributions declared with respect to the Stock after you have made a contribution to the Plan but before the effective date of the amendment or termination.

Tax information

The following summary of the U. S. income tax consequences of the Plan is based on the Internal Revenue Code and any regulations thereunder as in effect as of the date of this Prospectus. The summary does not cover any state or local income taxes or taxes in jurisdictions other than the United States. You should consult your tax advisor regarding individual tax consequences before purchasing Stock under the Plan.

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STOCK PURCHASES UNDER THE STOCK PURCHASE PLAN

You have no federal income tax consequences when you enroll in the Plan or when shares of Stock are purchased for you under the Stock Purchase Plan either by payroll deduction or voluntary contribution. The amount of your payroll deductions and any voluntary contributions under the Plan are not deductible for purposes of determining your federal taxable income. The amount of your wages that you have deducted under the Plan and the full value of company matching contributions are ordinary income to you in the calendar year of deduction or the contribution, as the case may be, and will be reported on your pay stub and your W-2. The company deducts all applicable wage withholding and other required taxes from your other compensation (by increasing your payroll withholding and other tax deductions for such purposes) with respect to the amount of your wages deducted under the Plan and the matching contributions to your Plan account, if any. The company is entitled to a tax deduction for the amount of the matching contribution in the same year as you realize the income.

OUTSTANDING PERFORMANCE AWARDS UNDER THE OUTSTANDING PERFORMANCE AWARD PROGRAM

Stock grants under the Outstanding Performance Award Program are taxable as ordinary income in the calendar year of the award, regardless of whether the Stock certificates are given directly to you or the Stock is awarded to your Plan account. Your ordinary income will be the market value of a share of Stock on the date the award is granted, times the number of shares of Stock granted. The market value of any Stock awarded will be reported to you on your W-2. The company will deduct applicable wage withholding and other required taxes from your other compensation (by increasing your payroll deduction for such purposes). The company is entitled to a tax deduction in the same amount and in the same year as you realize the ordinary income.

STOCK SALES OR CERTIFICATE DISTRIBUTIONS

You will not recognize any taxable income when you request to have certificates delivered to you for some or all of the shares of Stock held in your Plan account. However, when you sell or otherwise dispose of your shares of Stock — whether through Computershare or later after you have received your Stock certificates — the difference between the fair market value of the Stock at the time of sale and the fair market value of the Stock on the date you acquired it will be taxed as a capital gain or loss. The holding period to determine whether the capital gain or loss is long-term or short-term will begin on the date you acquire the Stock (i.e., the date the Stock is credited to your Plan account). The company will have no deduction as a result of your disposition of shares of Stock and will not be liable for the payment of any income or other taxes payable by you on any gain you may realize on the sale of the shares of Stock or imposed on or in connection with the sale transaction.

Available information

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

Walmart People Services
Wal-Mart Stores, Inc.
508 SW 8th Street
Bentonville, Arkansas 72716-0295

Computershare may be contacted by calling 800-438-6278 (800 GET-MART), online at computershare.com/walmart, or by writing to the following address for all correspondence, including transactions, Stock certificate requests, Stock powers, voluntary purchases and any customer service inquiries:

Computershare
Attn: Wal-Mart ASPP
P.O. Box 43080
Providence, Rhode Island 02940-3080

Electronic delivery of prospectuses and other documents

To help reduce costs of operating the Plan and to help with our sustainability efforts, we ask you to allow us to deliver prospectuses and other documents related to the Plan electronically and that you access the prospectuses and documents we provide to participants in the Plan over WalmartOne.com. Your enrollment in the Plan will constitute your consent to receive or access communications from us about the Plan and prospectuses relating to the purchase of shares of Stock under the Plan electronically through access on WalmartOne.com, unless you affirmatively elect to receive paper copies of such communications. At any time after enrollment you may revoke that consent by sending a written revocation of the consent to receive Plan documents electronically to the Benefits Department at the address appearing below. In addition, you may request a paper copy of the then current prospectus relating to purchases of shares of Stock under the Plan and of our most recent Annual Report on Form 10-K by writing the Benefits Department and those documents will be provided to you free of charge.

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, 2016;
- The company's Quarterly Reports on Form 10-Q for the fiscal quarters ended April 30, 2016, and July 31, 2016;
- The company's Current Reports on Form 8-K filed with the Commission on June 7, 2016 and June 20, 2016
- The company's definitive Proxy Statement for the 2016 Annual Shareholders' Meeting, filed with the Commission on April 20, 2016, and
- Exhibit 99.1 to the Company's Registration Statement on Form S-8 (File No. 333-214060).

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 the Section 10(a) prospectus of the company relating to purchases under the Plan of the shares of Stock described on the cover page of this Prospectus. This document and the documents incorporated by reference herein constitute such Section 10(a) prospectus.

These documents and the company's latest Annual Report to Stockholders and any other documents required to be delivered to you under Rule 428(b) under the Securities Act of 1933, as amended, 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, Arkansas 72716-0295

Or you may call People Services at 800-421-1362.

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The Walmart 401(k) Plan

WHERE CAN I FIND?

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The legal name of the Plan is the Walmart 401(k) Plan. This document is being provided solely by your employer. No affiliate of Bank of America Corporation has reviewed or participated in the creation of the information contained herein.

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 the WIRE, WalmartOne.com, Workday or the Plan's website at benefits.ml.com	Call the Customer Service Center at 888-968-4015
• 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 • Request a withdrawal of your rollover contributions • Request a loan from your Plan account	Go to benefits.ml.com	Call the Customer Service Center at 888-968-4015
• Designate a beneficiary	Go to the WIRE, or WalmartOne.com or Workday	

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What you need to know about the Walmart 401(k) Plan

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- You are eligible to make your own contributions to the Plan as soon as administratively feasible after your date of hire is entered into the payroll system. You can contribute from 1% to 50% of your eligible pay each pay period.
- You will begin receiving matching contributions on the first day of the calendar month following your first anniversary of employment with Walmart if you are credited with at least 1,000 hours of service during your first year and you are contributing to your 401(k) Account. (Matching contributions will not be made with respect to contributions you make before you become eligible for matching contributions.)
- The matching contribution will be a dollar-for-dollar match on each dollar you contribute to the Plan after you become eligible for matching contributions, up to 6% of your eligible annual pay.
- You will always be 100% vested in the money you contribute to your 401(k) Account and the money Walmart contributes to your Company Match Account.
- You choose how to invest all contributions to your Plan account.
- If you do not choose how your current contributions to the Plan will be invested, they will be automatically invested in the Plan's default investment option, currently the myRetirement Funds.
- You pay no federal income tax on contributions or any investment earnings until you receive a payout from the Plan.
- You can access and monitor your account any time at benefits.ml.com.
- You can withdraw your rollover contributions at any time.
- You may also request a loan from your Plan account. Loans are subject to certain requirements outlined later in this summary.

This is a summary of benefits offered under the Plan as of October 1, 2017. Should any questions ever arise about the nature and extent of your benefits, the formal language of the Plan document, not the informal wording of this summary, will govern.

Walmart 401(k) Plan eligibility

ASSOCIATES WHO ARE ELIGIBLE TO PARTICIPATE IN THE PLAN

All associates of Wal-Mart Stores, Inc. or a participating subsidiary are eligible to participate in the Plan, except:

- Leased employees; nonresident aliens with no income from U.S. sources; independent contractors or consultants
- Anyone not treated as an employee of Walmart or its participating subsidiaries
- Associates covered by a collective bargaining agreement, to the extent that the agreement does not provide for participation in this Plan
- Associates represented by a collective bargaining representative after Walmart has negotiated in good faith to impasse with the representative on the question of benefits, and
- Certain other associates who may be jointly employed by Walmart and a subsidiary that is not a participating subsidiary in the Plan.

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

WHEN PARTICIPATION FOR PURPOSES OF YOUR CONTRIBUTIONS BEGINS

Eligible associates may begin making their own contributions to the Plan as soon as administratively feasible after their date of hire is entered into the payroll system.

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

WHEN PARTICIPATION FOR PURPOSES OF MATCHING CONTRIBUTION BEGINS

If you are an eligible associate, you will begin receiving matching contributions on the first day of the calendar month following your first anniversary of employment with Walmart if you are credited with at least 1,000 hours of service during the first year and are contributing to your 401(k) Account. (Matching contributions will not be made with respect to contributions you make before you become eligible for matching contributions.) For example, if your date of hire was December 15, 2017 and you are credited with 1,095 hours by December 15, 2018 (your first anniversary), then you will begin receiving matching contributions on January 1, 2019 with respect to any contributions you make to the Plan on or after that date. As an additional example, if your date of hire was December 1, 2017 and you are credited with 1,095 hours by December 1, 2018 (your first anniversary), then you will begin receiving matching contributions on January 1, 2019 with respect to any contributions you make to the Plan on or after that date.

If you are not credited with 1,000 hours of service during that first year, your eligibility for the matching contributions will be determined on hours worked during the Plan year, which runs from February 1 to January 31. You will be eligible to receive matching contributions on any contributions you make to the Plan on or after the February 1 that follows the Plan year in which you are credited with at least 1,000 hours of service. For example, if your date of hire is December 15, 2017 and you are credited with only 595 hours by December 15, 2018 (your first anniversary), but you work 1,095 hours during the February 1, 2018–January 31, 2019 Plan year, you will begin receiving matching contributions on February 1, 2019 with respect to any contributions you make to the Plan on or after that date.

HOW HOURS OF SERVICE ARE CREDITED UNDER THE PLAN

For hourly associates, the hours counted toward the 1,000-hour requirement are credited as follows:

- Hours, including overtime hours, worked by hourly associates for Walmart or any subsidiary are counted.
- Hours for which an associate receives paid leave or personal time off are also counted.
- When a payroll period overlaps two Plan years, hours are credited toward the Plan year in which they are actually worked. However, before February 1, 2015, hours for a payroll period that overlapped Plan years were prorated between the two years.

For salaried associates and truck drivers, the hours counted toward the 1,000-hour requirement are credited as follows:

- Salaried associates and truck drivers are credited with 190 hours per month for each month in which they work at least one hour for Walmart or a subsidiary.
- In general, you must work at least six months of the Plan year to have 1,000 hours credited for the year. (Vacation pay after you leave Walmart will not give you an additional 190 hours of credit.)

If you become an associate of Walmart or any subsidiary as the result of the acquisition of your prior employer, special service crediting rules may apply to you.

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), veterans who return to Walmart or a subsidiary 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 People Services at 800-421-1362 for more details.

Enrolling in the Plan

Shortly after you become eligible to contribute to the Plan, (i.e., shortly after your date of hire), you will receive an enrollment packet at your home address on file. This packet tells you how you can make contributions from your pay on a pretax basis into your 401(k) Account and explains how you can direct the investment of your Plan funds by choosing 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.

Once you satisfy the matching contribution eligibility requirements, Walmart will match all of your subsequent contributions dollar-for-dollar up to 6% of eligible annual pay, as explained in the Walmart's contributions to your Company Match Account section.

To begin making contributions to the Plan, you can enroll online at WalmartOne.com, the WIRE, Workday, or benefits.ml.com. You can also call the Customer Service Center at 888-968-4015. You can enroll at any time after you become eligible.

When you enroll, you can choose:

- The percentage of your pay that 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 accounts among the Plan's investment options. The Plan's investment options and procedures are described in the enrollment packet.

After you enroll, a confirmation notice will be mailed to your home address, or, if you have chosen electronic delivery of Plan materials, you will receive an email notification when the confirmation is available. The confirmation will show the percentage of your pay that you have chosen to contribute from each check and the investment option(s) you have elected. You should review the confirmation to make sure your enrollment information is correct.

Your contributions to the Plan will be effective as soon as administratively feasible, normally within two pay periods. No contributions will be taken from your pay before you become an eligible participant in the Plan. Only participants who elect to contribute their own funds to the Plan will have those contributions matched by the Company (after they meet the eligibility requirements for matching contributions, as explained in the Walmart's contributions to your Company Match Account section).

It is your responsibility to review your paychecks to confirm that your election was implemented. If you believe your election was not implemented, you must promptly notify the Customer Service Center at 888-968-4015, but in no event later than six months after your election, for corrective steps to be taken.

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:

- **401(k) Account:** This account holds your contributions to the Plan (including your catch-up contributions, if any), as adjusted for earnings or losses on those contributions.
- **Company Match Account:** This account holds Walmart's matching contributions, as adjusted for earnings or losses on those contributions.
- **401(k) Rollover Account:** This account holds any contributions that you rolled over to this Plan from another eligible retirement plan, as adjusted for earnings or losses on those contributions.
- **Company Funded 401(k) Account:** This account holds the discretionary Company contributions to the 401(k) portion of the Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.
- **Company Funded Profit Sharing Account:** This account holds the discretionary Company contributions to the profit-sharing portion of the Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.

The chart on the following page provides a summary of some of the differences between these accounts. These differences are discussed in more detail throughout this summary.

Making a rollover from a previous employer's plan or IRA

When you come to work for Walmart, you may have pretax funds owed to you from a previous employer's retirement plan (including a 401(k) plan, a profit-sharing plan, a 403(b) plan of a tax-exempt employer or a 457(b) plan of a governmental employer). If so, you may be able to roll over that money to this Plan. You may also roll over pretax funds you have in an Individual Retirement Account (IRA). If you roll over funds to this Plan, you should keep these points in mind:

- Once you roll funds into the Walmart 401(k) Plan, those funds will be subject to the rules of this Plan, including payout rules, and not the rules of your former employer's plan or your IRA
- Your rollover contribution will be placed in your 401(k) Rollover Account and will be 100% vested, and
- You may withdraw all or any portion of your rollover contributions at any time.

If you're interested in making a rollover contribution to the Plan, you should contact the Customer Service Center at 888-968-4015 or go online to benefits.ml.com to obtain a rollover packet.

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Making contributions to your 401(k) Account

After you become a participant in the Plan, you may generally choose to contribute from 1% up to 50% 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 2017, the limit is $18,000. This amount will be increased from time to time by the IRS. You are always 100% vested in all amounts contributed into your 401(k) Account.

The IRS limits the amount of annual compensation that can be taken into account under the Plan for any participant. For 2017, this limit is $270,000.

Contributions to your 401(k) Account are deducted from your pay before federal income taxes are withheld. This means that you don't pay federal income taxes on amounts you contribute to the Plan. Earnings on these contributions continue to accumulate tax-free and are not taxed until your 401(k) Account is 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. Distributions from the Plan, however, are not subject to Social Security taxes.

In addition, if you contribute your own pay to your 401(k) Account, you may be eligible for a "Saver's Credit." If you are a married taxpayer who files a joint tax return with a modified adjusted gross income (MAGI) of $62,000 or less (for 2017) or a single taxpayer with $31,000 or less (for 2017) in MAGI 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 percentage	Are hardship withdrawals available?	Are in-service withdrawals available after age 59½?
401(k) Account	You	Yes	100%	Yes	Yes
Company Match Account	Walmart	Yes	100%	No	Yes
All Rollover Accounts	You	Yes	100%	Yes	Yes
Company Funded 401(k) Account	Walmart	Yes	100%	No	Yes
Company Funded Profit Sharing Account	Walmart (except for rollovers you made to the Profit Sharing Plan)	Yes	2 years – 20% 3 years – 40% 4 years – 60% 5 years – 80% 6 years – 100% (Rollovers are immediately 100% vested)	No	Yes (to the extent vested)

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HOW YOUR 401(k) CONTRIBUTION IS DETERMINED

The percentage of pay you elect to contribute to the Plan will be applied to the following types of pay:

- Regular salary or wages, including bonuses and any pretax dollars you use for your 401(k) contributions or to purchase benefits available under Wal-Mart Stores, Inc. Associates' Health and Welfare Plan
- Overtime, paid time off (used and paid out), bereavement, jury duty and premium pay
- Most incentive plan payments
- Holiday bonuses
- Special recognition awards, such as the Outstanding Performance Award
- 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, and
- Effective February 1, 2018, transition pay designated as relating to a WARN Act event.

The percentage of pay you elect to contribute to the Plan will not be applied to the following types of pay:

- The 15% Walmart match on the Associate Stock Purchase Plan
- Reimbursement for expenses like relocation
- Approved disability pay
- 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).

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CHANGING YOUR 401(k) CONTRIBUTION AMOUNT

You can increase, decrease, stop, or begin your contributions at any time by logging on to WalmartOne.com, the WiRE, Workday or benefits.mi.com. You may also call the Customer Service Center at 888-968-4015. Your change will be effective as soon as administratively feasible, normally within two pay periods. If you change your contribution amount, a confirmation notice will be sent to your home address or, if you have chosen electronic delivery of Plan documents, you will receive an email notification when the confirmation is available. It is your responsibility to review your paychecks to confirm that your election was implemented. If you believe your election was not implemented, you must notify the Customer Service Center at 888-968-4015 in a timely manner, so that corrective steps can be taken. Your notification will not be considered timely if it is more than six months after the date your election is made. If you do not notify the Customer Service Center in a timely manner, the amount that is being withheld from your paycheck will be treated as your deferral election.

IF YOU ARE AGE 50 OR OLDER (CATCH-UP CONTRIBUTIONS)

If you are age 50 or older (or will be age 50 by the end of the applicable calendar year) and you are contributing up to the Plan or legal limits, you are allowed to make additional contributions. These are called catch-up contributions and are made by payroll deduction just like your normal contributions. For 2017, your catch-up contributions may be any amount up to the lesser of $6,000 or 75% of your eligible annual pay. This amount may be adjusted from time to time by the IRS. Your catch-up contributions will be credited to your 401(k) Account.

For example, if you elect to contribute the maximum amount of $18,000 in the 2017 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 $6,000 during the 2017 calendar year. If you are interested in making catch-up contributions, you can enroll online at WalmartOne.com, the WiRE, Workday or benefits.mi.com, or by calling the Customer Service Center at 888-968-4015.

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CONTRIBUTING TO MORE THAN ONE PLAN DURING THE YEAR

The total amount you can contribute to this Plan and to any other employer plan (including 403(b) annuity plans, simplified employee pensions or other 401(k) plans) is $18,000 for the 2017 calendar year, or $24,000 if you are eligible for catch-up contributions. 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, you should request that the excess amount be refunded to you. The excess amount must be included in your income for that year and will be taxed. In addition, if the excess amount is not refunded to you by April 15 following the year the amount was deferred, you will be taxed a second time when the excess amount is distributed to you. If you wish to request that the excess be returned to you from this Plan, you must contact People Services at 800-421-1362 no later than March 1 following the calendar year in which the excess contributions were made. Any matching contributions related to refunded contributions will be forfeited.

IF YOU HAVE QUALIFIED MILITARY SERVICE

If you missed work because of qualified military service, you may be entitled under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) to make up contributions you missed during your military service (that is, to make contributions equal to the amount you would have been eligible to make if you were working for Walmart).

Because you will only have a certain period of time after you return to work to make these contributions (generally three times the period of military service, up to five years), you should contact People Services at 800-421-1362 if you think you may be affected by these rules.

Walmart's contributions to your Company Match Account

As explained above, you are eligible to receive matching contributions on the first day of the calendar month following your first anniversary of employment with Walmart if you are credited with at least 1,000 hours of service during the that year. Once you have satisfied these requirements, Walmart will make matching contributions to your Company Match Account equal to 100% of your subsequent contributions to your 401(k) Account, including catch-up contributions, up to 6% of your eligible annual pay. Matching contributions will not be made with respect to contributions you make before you become eligible for matching contributions. After you become eligible for matching contributions, the company matching contribution will be made into your Company Match Account each pay period until you reach the full amount of the company matching contribution for which you are eligible for that Plan year. Your eligible annual pay for this purpose is the same as outlined above for determining your 401(k) contributions to the Plan, but does not include amounts paid to you before you become eligible to receive matching contributions.

As previously noted, if you miss work because of qualified military service, you may be entitled under USERRA to make up 401(k) contributions that you missed during your military service. If you do make up any 401(k) contributions, Walmart is required to make up matching contributions you would have received with respect to those contributions. If you think this rule may apply to you, you should contact People Services at 800-421-1362.

VESTING IN YOUR COMPANY MATCH ACCOUNT

You are always 100% vested in Walmart's matching contributions to your Company Match Account.

VESTING IN YOUR COMPANY FUNDED PROFIT SHARING ACCOUNT

If you have a Company Funded Profit Sharing Account (see Your Walmart 401(k) Plan accounts earlier in this summary), the vested percentage of your Company Funded Profit Sharing Account is the portion that you are entitled to receive if you leave Walmart. Your account statements show your vested percentage.

You become vested in your Company Funded Profit Sharing Account (other than rollovers in that account, which are always 100% vested) depending on your years of service with Walmart as follows:

PROFIT SHARING VESTING SCHEDULE*

Years of Service	Vested percentage
Less than two	0%
Two	20%
Three	40%
Four	60%
Five	80%
Six or more	100%

* Applies to participants actively employed on or after January 31, 2008.

NOTE: If you terminated employment before February 1, 2007, 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) or death, your Company Funded Profit Sharing Account will be 100% vested, regardless of your years of service. Your Company Funded Profit Sharing Account will also be 100% vested if the Plan is ever terminated.

VESTING IN YOUR COMPANY FUNDED 401(k) ACCOUNT

You are always 100% vested in Walmart's contributions to your Company Funded 401(k) Account.

Investing your account

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 Benefits Investment 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, as a participant gets closer to retirement. "myRetirement Funds" is a term developed by Walmart for describing these specific Plan investment options.
- **From among a menu of investment options made available under the Plan.** Note that Walmart stock is an investment option only for your Company Funded Profit Sharing Account. Walmart stock is not available for investment through any of your other Plan accounts (although to the extent these other accounts hold Walmart stock, you may always sell such shares, but no future purchases of Walmart stock are allowed).

You may choose one of the investment options or you may spread your money among the various investment options. The investment gains or losses on your accounts will depend upon the performance of the investments you choose.

If you do not make an investment choice for current contributions to your account, they will be invested in one of the myRetirement Funds based on your age. For more information, refer to the Qualified Default Investment Alternative (QDIA) notice and your enrollment packet. These documents can both be obtained by going to benefits.mi.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, for Plan years ending prior to January 31, 2006, all or a significant portion of Walmart's profit-sharing contribution was invested in Walmart stock. If you were a participant in the Plan prior to that date, you may have Walmart stock in your Company Funded Profit Sharing Account. For Plan years ending January 31, 2007 or later, Walmart's profit-sharing contribution was not invested in Walmart stock.

A description of all investment options, including the myRetirement Funds, is included in the enrollment packet you receive when you are eligible to enroll. You also may obtain additional information for each investment option by reviewing the Annual Participant Fee Disclosure Notice. You may obtain a copy free of charge by accessing your account online at benefits.mi.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 Stores, Inc., the Benefits Investment Committee and the trustee are not responsible for losses to your accounts which are the direct and necessary result of investment decisions you make or, if you fail to make an affirmative investment decision, as a result of your accounts being invested in a default fund.

If you have a Company Funded Profit Sharing Account (see Your Walmart 401(k) Plan accounts earlier in this summary) and you choose to invest some or all of your Company Funded Profit Sharing Account in Walmart stock or retain Walmart stock in your other accounts, be aware that since this option is a single stock investment, it generally carries more risk than the options offered through the Plan.

HOW TO OBTAIN MORE INVESTMENT INFORMATION

It is also important to periodically review your investment portfolio, your investment objectives and the investment options under the Plan to help ensure that your investments are in line with your objectives and your risk tolerance. If you would like more sources of information on individual investing and diversification, you may go to the website of the Department of Labor, http://www.dol.gov/ebsa/investing.html.

You may obtain more specific information regarding your investment rights and investment options under the Plan at benefits.mi.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.mi.com or by calling the Customer Service Center at 888-968-4015. If you make an investment change, a confirmation notice will be sent to your home address or you will receive an email notification when the confirmation is available if you have chosen electronic delivery of your Plan materials. It is your responsibility to make sure your change is made. If you do not receive a confirmation notice or you do not see that your change has been applied, contact the Customer Service Center at 888-968-4015.

If you call the Customer Service Center at 888-968-4015 prior to 3:00 p.m. Eastern time, your investment change generally will be processed on the day you call. Depending on the investment change, there may be up to a three-day settlement period before your funds are invested in your new election.

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DIVERSIFICATION

To help you diversify your retirement savings, the Plan offers a variety of investment options with different levels of risk and potential for increase in value. To "diversify" means that you "put your eggs in more than one basket." To help achieve long-term retirement security, you should give careful consideration to the benefits of a well-balanced and diversified investment portfolio. This strategy can help reduce risk and may provide consistent returns because a decline in the value of one investment may potentially be offset by an increase in the value of another. If you invest more than 20% of your retirement savings in any one stock, such as Walmart stock, or any one industry, your savings may not be properly diversified. Although diversification cannot ensure a profit or protect against loss, it can be an effective strategy to help you manage investment risk.

When deciding how to invest your retirement savings, you should take into account all of your assets, including any retirement savings outside of the Plan. For example, you may own Walmart stock through other means. No single approach is right for everyone because, among other factors, individuals have different financial goals, different time horizons for meeting their goals, and different tolerances for risk. Therefore, you should keep in mind your rights to diversify your Plan account and carefully consider how you choose to invest your Plan account. You can obtain information about your right to diversify your account and all of the investment options available under the Plan by accessing your account online at benefits.ml.com or by calling the Customer Service Center at 888-968-4015. It is also important to periodically review your investment portfolio, your investment objectives and the investment options under the Plan to help ensure that your investments remain appropriate for your retirement goals and your tolerance for investment risk. If you would like more sources on individual investing and diversification, you may go to the website of the Department of Labor, http://www.dol.gov/ebsa/investing.html.

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More about owning Walmart stock

VOTING

If any of your account is invested in Walmart stock through the Plan, each year you will receive all of the materials generally distributed to the shareholders of Walmart, including an instruction card telling the trustee how you would like the shares in your Plan account to be voted. The materials will be mailed to your home address or sent electronically, based on your online elections.

You can instruct the trustee, through the company's transfer agent, to vote Walmart stock held in your Plan accounts. This usually occurs in May of each year. Your instructions to the transfer agent and the trustee are kept confidential at all times. You will send your voting instructions directly to the transfer agent, who will compile the votes and notify the Benefits Investment Committee of the total votes cast. The Benefits Investment Committee will then notify the Plan trustee of the total votes that are to be cast.

If you do not provide instruction to the trustee on how you would like your shares voted, the Benefits Investment Committee will vote those shares at its discretion. If neither you nor the Benefits Investment Committee exercise voting rights, the trustee or an independent fiduciary appointed by the trustee may vote the unvoted shares.

CONFIDENTIALITY

Procedures have been designed to protect the confidentiality of your rights with respect to shares of Walmart stock held under the Plan, including the right to purchase, sell, hold or vote on proxy matters. For example, procedures with the Company's transfer agent for Walmart stock have been implemented that prevent Wal-Mart Stores, Inc. and the Benefits Investment Committee from finding out how any individual participant or beneficiary voted (except as necessary to comply with securities laws) and from having access to your individual proxy cards or proxy card shareholder comments.

In addition, access to information about your decisions to buy, sell or hold Walmart stock generally is limited to those assisting in the administration of the Plan. The Benefits Investment Committee is responsible for ensuring that these procedures are sufficient to protect the confidentiality of this information and that the procedures are being followed. If the Benefits Investment Committee determines that a situation has potential for undue influence by the Walmart with respect to your rights as shareholder (through your Plan Account), the Benefits Investment Committee will appoint an independent party to perform activities that are necessary to prevent undue influence.

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DIVIDENDS ON YOUR WALMART STOCK

If you have Walmart stock in your accounts, your accounts will be credited with any dividends paid by Wal-Mart Stores, Inc. 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 (and Profit Sharing Rollover Account) will also be reinvested in Walmart stock, except as noted below.

If you are an active participant (excludes beneficiaries and alternate payees, as defined in the If you get divorced section) 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 or

Profit Sharing Rollover 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 accounts 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 or Profit Sharing Rollover Account. If you do not opt for the cash payout, your dividends will be reinvested in Walmart stock.

You may make an election any time by calling the Customer Service Center at 888-968-4015. Your most recently filed election will apply to all subsequent dividends until you change your election. (You may change your election only once each business day.) Keep in mind that your election must be made no later than the close of business on the day prior to the record date for the dividend in order to be effective for that dividend. You will not be able to make any elections or election changes during the period from the record date of the dividend through the dividend pay date (which is usually three to four weeks after the record date).

Each year, Wal-Mart Stores, Inc. releases the quarterly record dates for dividend payouts. You can find this information on walmart.com. You may also contact the Customer Service Center at 888-968-4015 if you need information about upcoming record dates for dividends. You should keep in mind that a dividend payout will be taxable to you.

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 options, the values of your accounts and fees assessed to your account during the quarter. You can easily get information about your accounts, including a quarterly statement, at any time online at benefits.mi.com or by calling the Customer Service Center at 888-968-4015. You can also request a paper copy of any quarterly statement at any time free of charge by calling the Customer Service Center at 888-968-4015.

FEES CHARGED TO YOUR ACCOUNT

Administrative and investment fees may be assessed to your accounts. You can find information on fees in the Annual Participant Fee Disclosure Notice and online at benefits.mi.com.

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

- You may request a loan from your Plan account.
- Rollovers can be withdrawn at any time.
- In the case of a financial hardship or after you attain age 59½.

It's important to understand how any type of payout or loan from the Walmart 401(k) Plan affects your tax situation. For more information, see The income tax consequences of a payout later in this summary.

FINANCIAL HARDSHIP WITHDRAWALS

You may withdraw some or all of your 401(k) Account (other than earnings on those contributions) and your 401(k) Rollover Account as necessary to meet a "financial hardship."

Under IRS guidelines, a financial hardship may exist if the request is for:

- Payment of medical care expenses not covered by insurance for you, your spouse, your dependents or your affirmatively-designated primary beneficiary
- Costs directly related to the purchase of your primary residence (home)
- Payment of tuition, fees and room and board expenses for up to the next 12 months of post-high school education for you, your spouse, your dependents or your affirmatively-designated primary beneficiary
- Payments necessary to prevent eviction from, or foreclosure on, your primary residence
- Payment for burial or funeral expenses for your deceased parent, spouse, children, dependent or your affirmatively-designated primary beneficiary, or
- Expenses for the repair of damage to your principal residence that would qualify for a casualty deduction under federal income tax rules.

Federal tax law requires that you must have already obtained all in-service payouts available (including in-service withdrawals of rollover contributions or at age 59½ and any nontaxable participant loans available to you under this Plan) 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% penalty tax if you are under age 59½ or if the payout is not for certain medical purposes. For more information, see The income tax consequences of a payout later in this chapter.

You can make a request for a financial hardship payout online at benefits.ml.com or by calling the Customer Service Center at 888-968-4015.

WITHDRAWALS AFTER YOU REACH AGE 59½

Any time after you reach age 59½, you may elect to withdraw all or any portion of your Plan accounts, to the extent vested, even though you are still working for Walmart. You can make a request for a withdrawal online at benefits.ml.com or by calling the Customer Service Center at 888-968-4015.

WITHDRAWALS OF ROLLOVER CONTRIBUTIONS

You may withdraw all or any portion of your 401(k) Rollover Account and your Profit Sharing Rollover Account at any time even if you are still working for Walmart or its subsidiaries.

PLAN LOANS

You may apply for a loan from the vested portion of your Plan account while you are still working for Walmart. The Administrator has established a written loan program which explains these requirements in more detail. You can request a copy of the loan program or make a request for a loan online at benefits.ml.com or by calling the Customer Service Center at 888-968-4015.

Generally, the rules for loans include the following:

- The maximum loan amount is limited by IRS rules, which generally limit your total loan balances to the lesser of (1) 50% of the total of your vested Plan account or (2) $50,000 (reduced by the excess, if any, of your highest outstanding loan balance during the one-year period prior to the date of the loan over your current outstanding balance of loans). The minimum loan amount is $1,000.
- All loans must be secured by a pledge of up to one-half of your vested Plan account.
- A fee will be charged to process your loan application. Additional fees may be accessed for residential loans. (This amount may change from time to time.)
- All loans will bear a commercially reasonable rate of interest set by the Administrator from time to time.
- Loans must be repaid in regular installments over a one- to five-year period, unless you are using the loan proceeds to buy a house for yourself, in which case the repayment period may be longer as set forth in the written loan program from time to time.
- You may have only one general purpose loan and one residential loan outstanding at any time.
- All loans will be considered a directed investment from your account under the Plan. Your payments of principal and interest on the loan will be credited to your Plan accounts.
- If you fail to make payments when due under the loan, you will be considered to be in default. Under certain circumstances, a loan that is in default may be considered a distribution from the Plan. The significance of the loan balance being treated as a distribution is that the amount of this distribution will be taxable to you as ordinary income and could be subject to excise taxes. A Form 1099-R will be issued to you and the total amount of the distribution will be reported to the IRS.

When you are on an authorized unpaid leave of absence, you may be excused from making scheduled loan repayments for a period up to one year. If you have an outstanding loan when you are called to qualified military service, special rules under USERRA may apply. If you think you may be affected by these rules, call the Customer Service Center at 888-968-4015 for more details.

If you die: your designated beneficiary

In the event of your death, your entire Plan balance will be paid out to your beneficiary. It is very important for you to keep your beneficiary information up to date. Beneficiary choices should be made at WalmartOne.com, the WIRE or Workday. Since your spouse or partner has certain rights in the death benefit, you should immediately update your beneficiary election if there is a change in your relationship status.

If you have a spouse and wish to name someone other than your spouse as your designated beneficiary, your spouse must consent to that designation. You must complete the Alternate Beneficiary Form for Married Participants Form B and your spouse must complete the Spousal Consent portion of that form. The Spousal Consent form must be notarized and must accompany the Form B in order to be valid. Form B and the Spousal Consent form can be found on the WIRE, or you may talk to the personnel representative at your facility. Any beneficiary designation you make will be effective for all of your Plan 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:

- Spouse or partner (as defined below); if none, then
- Living children (stepchildren are not included); if none, then
- Living parents; if none, then
- Living siblings; if none, then
- The estate.

Please note that if you designate your spouse as your beneficiary and you later divorce, your designation will not be effective after the divorce unless you complete a new designation form. Similarly, if you do not have a spouse and you later marry, your prior beneficiary designation will not be effective after the marriage unless you complete a new designation form with your spouse's consent.

Also, note that if you designate a beneficiary and your beneficiary dies before the benefit check is issued the benefit will be paid to your contingent beneficiary or, if none, under the default rules above. If your beneficiary dies after the benefit check has been issued, the benefit will be paid to your beneficiary's estate. Note, however, that if your spouse or partner is your beneficiary, the benefit will always be paid to the spouse's or partner's estate if he or she dies after you but before the benefit is paid. Again, it is very important for you to keep your beneficiary information up to date. Beneficiary choices should be made at WalmartOne.com, the WIRE or Workday.

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NOTE: Effective June 26, 2013, your same-sex spouse will be treated in the same manner as an opposite-sex spouse for Plan purposes. Keep in mind that if you had a same-sex spouse on that date, any beneficiary designation you had in effect which designated someone other than your spouse as your beneficiary immediately became invalid on that date. Your spouse will automatically be your beneficiary unless you make a new beneficiary designation with your spouse's consent.

Effective January 1, 2014, if you have a "partner" and you have not made an affirmative beneficiary designation, your partner will be your beneficiary unless you affirmatively designate a different beneficiary (regardless of whether the designation occurred before or after your partnership began). Your "partner" for Plan purposes means:

- Your domestic partner, as long as you and your domestic partner:
  - Are in an ongoing, exclusive and committed relationship similar to marriage and have been for at least 12 months and intend to continue indefinitely;
  - Are not married to each other or to anyone else;
  - Meet the age for marriage in your home state and are mentally competent to consent to contract in that state;
  - Are not related in a manner that would bar a legal marriage in the state in which you live, and
  - Are not in the relationship solely for the purpose of obtaining benefits coverage, or
- Any other person to whom you are joined in a legal relationship recognized as creating some or all of the rights of marriage in the state or country in which the relationship was created.

You should take action to ensure that your beneficiary under the Plan reflects your current intent. Beneficiary choices should be made at WalmartOne.com, the WIRE or Workday.

BENEFICIARY DESIGNATIONS MADE BEFORE OCTOBER 31, 2003

If you made a beneficiary designation under the 401(k) Plan on or before October 31, 2003, that designation will continue to apply to your 401(k) Account, your Company Funded 401(k) Account, your Company Match Account, and your 401(k) Rollover Account. Similarly, if you made a beneficiary designation under the Profit Sharing Plan on or before October 31, 2003, that designation will continue to apply to your Company Funded Profit Sharing Account and Profit Sharing Rollover Account. If you change your beneficiary designation after October 31, 2003, it will apply to all Plan accounts and any prior designations will be ineffective.

Note that changes in your relationship status may affect your beneficiary designation, as explained above.

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

If you get divorced

If you go through a divorce, all or part of your Plan balance may be awarded to an "alternate payee" in the court order, called a "Qualified Domestic Relations Order" (QDRO). An alternate payee may be your spouse or former spouse, child or other dependent. (Federal law at this time does not permit the recognition of a QDRO for a partner unless the partner is also a dependent of the participant.) Because there are very strict requirements for these cases, you should contact the QDRO Administrator at 877-MER-QDRO (877-637-7376) for a free copy of the procedures your attorney should use in drafting the court order. After the court order is received by the QDRO Administrator, it must be reviewed to determine if it meets legal requirements for this type of order and will take a period of time to be processed. The administrative fee for processing your QDRO will be charged to your account or as directed in the Order.

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If you leave Walmart

When you stop working for Walmart, you are entitled to receive a payout of all of your vested accounts in the Plan.

It is important to understand how any type of payout from the Walmart 401(k) Plan affects your tax situation. For more information, see The income tax consequences of a payout later in this summary.

You may elect to receive your payout 30 calendar days after your termination is entered into the payroll system. For example, if your termination is entered into and processed by the payroll system on July 19, 2017, you may elect your payout on or after August 18, 2017.

A notice will normally be mailed to your home address or sent electronically, based on your delivery elections, after you leave Walmart and its subsidiaries to inform you that you are entitled to payment. Please make sure that your address is correct on your payroll check when you leave Walmart and its subsidiaries 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 request 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 (excluding your 401(k) Rollover Account) is $1,000 or less at any time.** This automatic payout will be made as soon as possible after the last business day of the third calendar month following the calendar month in which your termination date is entered into the payroll system, unless you consent to an earlier payout. as described above. In the example above, if your account is eligible for automatic payout and you do not consent to payout on or after August 19, 2017, your payout will automatically be made to you as soon as possible after October 31, 2017, or
- **If you are over age 70, regardless of the amount of your total vested Plan balance.** This automatic payout will be made as soon as possible after the last business day of the second calendar month following the calendar month in which you turn age 70, unless you consent to an earlier payout. as described above. For instance, if you turn age 70 in July 2017 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 date after September 30, 2017, according to Plan provisions.

If your total vested Plan balance is more than $1,000 and you are under age 70, you must consent to your payout. Payout will be made as soon as possible after your consent is received by the Customer Service Center at 888-968-4015, but no earlier than 30 calendar days after your termination is entered into the payroll system.

If your total vested Plan balance is more than $1,000, you can choose to delay your payout until any date up to age 70, but your Plan balance will be subject to an annual maintenance fee and possibly other expenses. For more information regarding these charges, refer to the Annual Participant Fee Disclosure Notice. If you choose to delay your payout, you will be able to continue to make changes in your investment choices just as you did while you were an active participant in the Plan.

If you return to work with Walmart before your payout is completed, the payout will be canceled and no payout will be made from your account.

THE AMOUNT OF YOUR PAYOUT

The entire value of your 401(k) Account, your Company Funded 401(k) Account, your 401(k) Rollover Account and the Company Match Account will be paid out to you. In addition, if you have a Company Funded Profit Sharing Account (see Your Walmart 401(k) Plan accounts earlier in this summary), you will also be paid the value of the vested portion of your Company Funded Profit Sharing Account. You will forfeit (give up) the nonvested portion of your Company Funded Profit Sharing Account, as explained in the Vesting in your Company Funded Profit Sharing Account earlier in this summary.

The amount you will receive will be based on the value of your accounts as of the date the payout is processed. If a cash payout is made directly to you rather than rolled over to an 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 (and Profit Sharing Rollover 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 payout 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 70 (regardless of the amount of your vested accounts), your payout will be made directly to you in a single cash payout. If you wish to take any of your payout in the form of Walmart stock or if you wish to roll over your payout to an IRA or other employer plan, you must contact the Customer Service Center at 888-968-4015 with your payout instructions within the time period shown in your payout notice. If you fail to contact the Customer Service Center at 888-968-4015 in a timely manner, your payout will be made in a single cash payment to you.

If the total of your vested accounts in the Plan is more than $1,000, your payout will not be made until you make an election regarding the form of payout and consent to the distribution, or until you reach age 70. To obtain your payout, you should contact the Customer Service Center at 888-968-4015.

If you leave and are rehired by Walmart

If you leave Walmart and its subsidiaries and are later rehired as an eligible associate, you will be immediately eligible to make your own contributions to the Plan on your date of rehire.

If you leave Walmart and its subsidiaries after you became eligible to receive matching contributions and are later rehired by Walmart, you will automatically be eligible to receive matching contributions on your rehire date. Similarly, if you leave Walmart and its subsidiaries after you met the 1,000-hour requirement for matching contribution eligibility but before your actual participation date, you will be eligible to receive matching contributions beginning on the later of the date you would have initially become a participant or your rehire date (with respect to contributions you make after that date). If you were not a participant when you left, or had not satisfied the 1,000-hour requirement, you will be treated as a new associate when you are rehired and will be required to complete the eligibility requirements (see When participation begins earlier in this summary) in order to be eligible to receive matching contributions under 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 500 hours of service or less. If you are absent from work due to an FMLA leave and have worked 500 hours or less in the Plan year, you will be credited with enough hours to bring you up to 500.01 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 subsidiary before you have five consecutive breaks in service and you pay back to the Plan the total amount of your payout within five years after you are rehired. If you return to work with Walmart or a subsidiary after five or more consecutive breaks in service, or if you chose not to repay your payout as discussed above, the nonvested portion of your Company Funded Profit Sharing Account that was forfeited will not be reinstated.

If you were zero percent vested in your Company Funded Profit Sharing Account when you terminated employment, your nonvested Company Funded Profit Sharing Account will automatically be reinstated if you are rehired prior to five consecutive breaks in service.

Forfeitures of nonvested Company Funded Profit Sharing Accounts of terminated participants generally are used to pay Plan expenses and for certain other purposes, such as to restore account balances as discussed above.

When you are rehired, your years of service with Walmart before you left will be counted for purposes of determining your vesting in Walmart's contributions to your Company Funded Profit Sharing Account.

The income tax consequences of a payout

The tax consequences of your participation in the Plan are your responsibility. This explanation is only a brief description of the U.S. federal tax consequences related to your participation in the Plan. This description is based on current law and current interpretations of the law by the Internal Revenue Service. Because the law is subject to change and because the application of the law may vary depending on your particular circumstances, this description is general in nature and you should not rely on it in determining your tax consequences. You are strongly urged to consult a tax advisor.

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Walmart is entitled to a deduction on the amount of its contributions, as well as your contributions, to the Plan. Your contributions and Walmart's contributions to the Plan, as well as earnings on those contributions, generally are not subject to federal income taxes until they are paid to you.

Special taxation rules apply to Roth contributions transferred from another Plan as part of a Plan merger. Contact the Plan Administrator or your tax advisor for more information.

POSTPONE PAYING TAXES ON PAYOUTS THROUGH A ROLLOVER

Although payouts from the Plan are subject to federal income taxes, the Internal Revenue Code provides favorable tax treatment to payouts in certain circumstances. For example, you can postpone paying taxes on your payout if you direct the Plan to issue your payout directly to an IRA or to another employer's qualified retirement plan, a 403(b) plan or a governmental 457 plan. This is called a direct rollover. (The check will be made payable to the IRA or other plan trustee and will be delivered to you or your IRA or rollover institution. If the check is mailed to you, you will be responsible for delivering it to the IRA or other plan trustee within 60 days.)

If you elect this method for your payout, no taxes will be withheld from the amount you are rolling over. It will not be taxed until you later receive a payout from the IRA or other plan.

If you do not elect to have your payout directly rolled over, federal law requires that Walmart withhold 20% of the payout for federal taxes, in addition to any required state withholding. In some cases, 20% withholding may not be enough, which could mean that you will owe additional taxes when you file your income tax return.

If you do not elect a direct rollover (and instead receive an actual payout from the Plan), you may still roll over those funds to an IRA or an employer's qualified retirement plan, 403(b) plan or governmental 457 plan, as long as you do so within 60 calendar days after you received the distribution. The amount rolled over will not be subject to federal income tax until you take it out of the IRA or other plan. If you want to roll over 100% of your payout to an IRA or other plan, however, you will have to use other money to replace the 20% that was withheld from your payout. If you roll over only the 80% that you received, you will be taxed on the 20% that was withheld.

NOTE: You may roll over all or any portion of your account that is eligible for rollover to a Roth IRA. Any amount rolled over that would have been taxable if not rolled over will be taxable at the time of the rollover to the Roth IRA. (Note that you may voluntarily choose to have taxes withheld from amounts at the time you roll over to a Roth IRA.)

For more information regarding these rollover rules, you should review the Special tax notice addendum that follows. You should retain this addendum for review when you are eligible to take a distribution.

EARLY WITHDRAWAL PENALTY

In addition to the income tax withholding, if you take a payout prior to age 59½ rather than rolling it over, in most cases you will be subject to a 10% early withdrawal penalty by the IRS. There are some exceptions to the penalty, such as death, disability, retirement after age 55 and payouts for certain medical expenses. Special rules also apply to distributions made to reservists who are called to active military duty.

TAXATION OF PAYOUTS OF WALMART STOCK

There are also special rules for distributions of Walmart common stock. If you receive cash (in excess of $200) in addition to Walmart stock and the cash is not directly rolled over, some withholding may apply, but the withheld amount will 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.

You should also keep in mind that if you elect cash payouts of dividends paid on Walmart stock held in your Company Funded Profit Sharing Account, the dividend is taxable to you and is not eligible for rollover. The dividend is also taxable if you request a financial hardship payout from your 401(k) Account within five business days of the record date for a dividend and the dividend is automatically paid out to you in cash. The dividend payout is not subject to the 10% early withdrawal penalty discussed above. In some cases, Wal-Mart Stores, Inc. will be entitled to deduct dividends paid on shares subject to this election.

TAXATION OF PAYOUTS TO BENEFICIARIES AND ALTERNATE PAYEES

The tax treatment discussed above applies only to payouts to participants. Different rules may apply to payouts to beneficiaries of deceased participants. In general, if your spouse is your beneficiary, he or she will have the same federal income tax treatment and rollover options that you would have had. Other beneficiaries, including partners, will only be entitled to a direct rollover to an inherited IRA or Roth IRA. The 10% early withdrawal penalty does not apply to payouts to your beneficiary.

The spouses or former spouse of a participant who receives a payout from the Plan under a qualified domestic relations order (QDRO) generally have the same federal income tax treatment and options as the participant would have had. In some cases, however, a payout on behalf of a non-spouse

dependent, including a partner, pursuant to a QDRO (e.g., state-ordered child support) may result in federal income taxation to the participant even though the payout is made to or on behalf of the dependent alternate payee.

TAXATION OF LOANS

Under current tax law, loans made from the Plan, regardless of their purpose, are not considered taxable income to the participant unless a default occurs. If you default on a loan from the Plan (as discussed above), your tax statement will show the amount of income to report for the year of the default. You may also be subject to 10% early withdrawal penalty.

Filing a Walmart 401(k) Plan claim

If you think you are entitled to a benefit beyond that processed by the Plan's recordkeeper (Merrill Lynch), you may file a claim with the Administrator or its delegate at:

Wal-Mart Stores, Inc.
Attn: Financial Benefits
508 SW 8th Street
Bentonville, Arkansas 72716-0295

For questions about filing a claim, contact People Services 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 the Administrator receives your claim. The Administrator or its delegate can extend this period for up to an additional 90 days if it determines that special circumstances require an extension. You will receive notice of any extension before the expiration of the original 90-day period. The written notice you receive will state the specific reasons for the denial of your claim, a specific reference to the provisions of the Plan upon which the denial is based, and a description of the review procedures and the time limits applicable to such procedures, including your right to bring a court action following a denial on appeal.

If you do not agree with the decision of the Administrator or its delegate, you can request a review of the decision by the Administrator. The Administrator 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 Administrator at:

Wal-Mart Stores, Inc.
Attn: Financial Benefits
508 SW 8th Street
Bentonville, Arkansas 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 Administrator 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 Administrator will promptly conduct the review. Written notice of the Administrator'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 Administrator's decision will include specific reasons for the decision and will refer to the specific provisions of the Plan on which the decision is based.

You must exhaust these procedures before you can file a lawsuit with respect to your Plan benefits. If you file a lawsuit, it must be filed within one year from the date of your payout or, if no payout is made, the date your request for benefits is denied, in whole or in part, by the Administrator on appeal (or, if earlier, the date the Administrator fails to respond to your claim or appeal within the time periods provided above).

Administrative information

PLAN NAME

The legal name of the Plan is the Walmart 401(k) Plan.

PLAN SPONSOR AND ERISA 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: Financial Benefits
508 SW 8th Street
Bentonville, Arkansas 72716-0295 800-421-1362

As the ERISA 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 Administrator, the Benefits Investment Committee or the trustee of the Trust. ERISA is the federal law that imposes certain responsibilities on Wal-Mart Stores, Inc., the Administrator, the Benefits Investment Committee and the trustee with respect to your retirement benefits.

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Subsidiaries of Wal-Mart Stores, Inc. are permitted to participate in the Plan. You may obtain a list of subsidiaries currently participating in the Plan by contacting People Services.

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER

71-0415188

NAMED ADMINISTRATIVE FIDUCIARY

The individual from time to time holding the position of Senior Vice President, Global Benefits Division, of Walmart is the Administrator. The Administrator is the named administrative fiduciary of the Plan. As the named administrative fiduciary of the Plan, the Administrator is generally responsible for the management, interpretation and administration of the Plan, including but not limited to eligibility determinations, benefit payments and other functions required, necessary or advisable to carry out the purpose of the Plan.

You may contact the Administrator at the following address:

Senior Vice President, Global Benefits Division/Administrator
c/o Wal-Mart Stores, Inc.
508 SW 8th Street
Bentonville, Arkansas 72716-0295

NAMED INVESTMENT FIDUCIARY

The Benefits Investment Committee is the named investment fiduciary of the Plan. As the named investment fiduciary, the Committee is responsible for the Plan's investment policies, including selection of investment options to be made available under the Plan and the selection of the default investment option.

You may contact the Benefits Investment Committee at the following address:

Benefits Investment Committee
c/o Wal-Mart Stores, Inc.
508 SW 8th Street
Bentonville, Arkansas 72716-0295

PLAN TRUSTEE

Northern Trust Company
50 S. LaSalle Street
Chicago, Illinois 60603

One or more trusts hold all Plan assets, such as contributions by participants and Walmart's contributions. As trustee of the Trust, Northern Trust Company receives and holds contributions made to the Plan in trust and invests those contributions according to the policies established under the Plan.

AGENT FOR SERVICE OF LEGAL PROCESS

Corporation Trust Company
1209 Orange Street
Corporation Trust Center
Wilmington, Delaware 19801

Service of legal process may also be made on the ERISA Plan Administrator or the trustee.

PLAN NUMBER

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PLAN YEAR

February 1 through January 31

TYPE OF PLAN

The Walmart 401(k) Plan is a defined contribution plan (401(k), profit sharing and employee stock ownership plan).

ASSIGNMENT

Because this is a retirement plan governed by ERISA and other federal laws, your accounts cannot be assigned or used as collateral for a loan, nor can your accounts be garnished or be subject to bankruptcy proceedings. They can; however, be part of a divorce settlement, as explained in the If you get divorced section earlier in this summary.

NO PBGC COVERAGE

ERISA created a governmental agency called the Pension Benefit Guaranty Corporation (PBGC). One of the purposes of the PBGC is to provide plan benefit insurance. However, this insurance is available only to defined benefit pension plans, and our Plan is a defined contribution plan. Therefore, benefits under the Plan are not insured by the PBGC.

PLAN AMENDMENT OR TERMINATION

Walmart reserves the right to amend or terminate the Plan at any time. Amendments are made by Walmart's Board of Directors or by its Executive Vice President, Global People Division. Neither the Plan nor the benefits described in

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this summary may be orally amended. All oral statements and representations have no force or effect even if the statements and representations are made by a management associate of Walmart or a participating subsidiary, by the Administrator, by any member of the Benefits Investment Committee or by Merrill Lynch.

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

Wal-Mart Stores, Inc.
Attn: People Services
508 SW 8th Street
Bentonville, Arkansas 72716-0295

You can also contact the Customer Service Center at 888-968-4015.

MISTAKEN PAYOUTS

If any payout is made under the Plan to the wrong party, or if a payout is made to the right party but in the wrong amount, the Administrator can recover the mistaken payout from the recipient by either reducing his or her Plan account or future payouts due to the recipient, or may demand that the recipient promptly repay the Plan.

STATEMENT OF ERISA RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the ERISA 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 ERISA 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 ERISA 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: People Services
  508 SW 8th Street
  Bentonville, Arkansas 72716-0295

- Receive a summary of the Plan's annual financial report. The ERISA 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 ERISA Plan Administrator or the 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 ERISA Plan Administrator or the Administrator. 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 ERISA Plan Administrator or the Administrator. 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.

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Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Special tax notice addendum

YOUR ROLLOVER OPTIONS

The law requires that participants receive this notice before receiving a distribution from the Plan that is eligible to be rolled over to an IRA or an employer plan. You may or may not currently be eligible to receive a distribution from the Plan. If you are eligible for a distribution, however, you should review this notice carefully before you elect a distribution from the Plan. This notice is intended to help you decide whether to elect a rollover. If you are not currently eligible for a distribution, you should retain this notice and review it when you are eligible for a distribution.

Rules that apply to most payments from the Plan are described in the General information about rollovers section. Special rules that only apply in certain circumstances are described in the Special rules and options section.

GENERAL INFORMATION ABOUT ROLLOVERS

How can a rollover affect my taxes? You will be taxed on a payment from the Plan if you do not roll it over. If you are under age 59½ and do not do a rollover, you will also have to pay a 10% additional income tax on early distributions (unless an exception applies, as explained below). If you do a rollover, however, you will not have to pay tax until you receive payment later and the 10% additional income tax will not apply if the payment is made after you are age 59½ (or if an exception applies).

Where may I roll over the payment? You may roll over the payment to either an IRA (an individual retirement account or individual retirement annuity, including a Roth IRA) or an employer plan (a tax-qualified plan, section 403(b) plan or governmental section 457(b) plan) that will accept the rollover. The rules of the IRA or employer plan that holds the rollover will determine your investment options, fees and rights to payment from the IRA or employer plan (for example, no spousal consent rules apply to IRAs and IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the IRA or employer plan.

How do I do a rollover? There are two ways to do a rollover. You can do either a "direct rollover" or a "60-day rollover."

If you do a "direct rollover," the Plan will make the payment directly to your IRA or an employer plan. You should contact the IRA sponsor or the administrator of the employer plan for information on how to do a direct rollover.

If you do not do a direct rollover, you may still do a "60-day rollover" by making a deposit into an IRA or eligible employer plan that will accept it. You will have 60 days after you receive the payment to make the deposit. If you do not do a direct rollover, the Plan is required to withhold 20% of the payment for federal income taxes (up to the amount of cash received). This means that, in order to roll over the entire payment in a 60-day rollover, you must use other funds to make up for the 20% withheld. If you do not roll over the entire amount of the payment, the portion not rolled over will be taxed and will be subject to the 10% additional income tax on early distributions if you are under age 59½ (unless an exception applies).

How much may I roll over? If you wish to do a rollover, you may roll over all or part of the amount eligible for rollover. Generally, any payment from the Plan is eligible for rollover, except:

- Required minimum distributions after age 70½ (or after death)
- Hardship distributions
- ESOP dividends
- Corrective distributions of contributions that exceed tax law limitations
- Loans treated as deemed distributions (for example, loans in default due to missed payments before your employment ends)

The Plan Administrator or the payer can tell you what portion of a payment is eligible for rollover.

If I don't do a rollover, will I have to pay the 10% additional income tax on early distributions? If you are under age 59½, you will have to pay the 10% additional income tax on early distributions for any payment from the Plan (including amounts withheld for income tax) that you do not roll over, unless one of the exceptions listed below applies. This tax is in addition to the regular income tax on the payment not rolled over.

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The 10% additional income tax does not apply to the following payments from the Plan:

- Payments made after you separate from service if you will be at least age 55 in the year of the separation
- Payments made due to disability
- Payments after your death
- Payments of ESOP dividends
- Corrective distributions of contributions that exceed tax law limitations
- Payments made directly to the government to satisfy a federal tax levy
- Payments made under a qualified domestic relations order (QDRO)
- Certain payments made while you are on active duty if you were a member of a reserve component called to duty after September 11, 2001 for more than 179 days

If I do a rollover to an IRA, will the 10% additional income tax apply to early distributions from the IRA? If you receive a payment from an IRA when you are under age 59½, you will have to pay the 10% additional income tax on early distributions from the IRA, unless an exception applies. In general, the exceptions to the 10% additional income tax for early distributions from an IRA are the same as the exceptions listed above for early distributions from a plan. However, there are a few differences for payments from an IRA, including:

- There is no exception for payments after separation from service that are made after age 55.
- The exception for qualified domestic relations orders (QDROs) does not apply (although a special rule applies under which, as part of a divorce or separation agreement, a tax-free transfer may be made directly to an IRA of a spouse or former spouse).
- An exception for payments made at least annually in equal or close to equal amounts over a specified period applies (without regard to whether you have had a separation from service).
- There are additional exceptions for (1) payments for qualified higher education expenses, (2) payments up to $10,000 used in a qualified first-time home purchase, and (3) payments after you have received unemployment compensation for 12 consecutive weeks (or would have been eligible to receive unemployment compensation but for self-employed status).

Will I owe state income taxes? This notice does not describe any state or local income tax rules (including withholding rules).

SPECIAL RULES AND OPTIONS

If you miss the 60-day rollover deadline: Generally, the 60-day rollover deadline cannot be extended. However, the IRS has the limited authority to waive the deadline under certain extraordinary circumstances, such as when external events prevented you from completing the rollover by the 60-day rollover deadline. To apply for a waiver, you must file a private letter ruling request with the IRS. Private letter ruling requests require the payment of a nonrefundable user fee. For more information, see IRS Publication 590, *Individual Retirement Arrangements (IRAs).*

If your payment includes employer stock that you do not roll over: If you do not do a rollover, you can apply a special rule to payments of employer stock that are paid in a lump sum after separation from service (or after age 59½, disability, or the participant's death). Under the special rule, the net unrealized appreciation on the stock will not be taxed when distributed from the Plan and will be taxed at capital gain rates when you sell the stock. Net unrealized appreciation is generally the increase in the value of employer stock after it was acquired by the Plan. If you do a rollover for a payment that includes employer stock (for example, by selling the stock and rolling over the proceeds within 60 days of the payment), the special rule relating to the distributed employer stock will not apply to any subsequent payments from the IRA or employer plan. The Plan Administrator can tell you the amount of any net unrealized appreciation.

If you have an outstanding loan that is being offset: If you have an outstanding loan from the Plan, your Plan benefit may be offset by the amount of the loan, typically when your employment ends. The loan offset amount is treated as a distribution to you at the time of the offset and will be taxed (including the 10% additional income tax on early distributions, unless an exception applies) unless you do a 60-day rollover in the amount of the loan offset to an IRA or employer plan.

If you were born on or before January 1, 1936: If you were born on or before January 1, 1936 and receive a lump sum distribution that you do not roll over, special rules for calculating the amount of the tax on the payment might apply to you. For more information, see IRS Publication 575, *Pension and Annuity Income.*

If you roll over your payment to a Roth IRA: If you roll over a payment to a Roth IRA, a special rule applies under which the amount of the payment rolled over will be taxed. However, the 10% additional income tax on early distributions will not apply (unless you take the amount rolled over out of the Roth IRA within five years, counting from January 1 of the year of the rollover). For payments

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from the Plan during 2010 that are rolled over to a Roth IRA, the taxable amount can be spread over a two-year period starting in 2011. If you roll over the payment to a Roth IRA, later payments from the Roth IRA that are qualified distributions will not be taxed (including earnings after the rollover). A qualified distribution from a Roth IRA is a payment made after you are age 59½ (or after your death or disability, or as a qualified first-time homebuyer distribution of up to $10,000) and after you have had a Roth IRA for at least five years. In applying this five-year rule, you count from January 1 of the year for which your first contribution was made to a Roth IRA. Payments from the Roth IRA that are not qualified distributions will be taxed to the extent of earnings after the rollover, including the 10% additional income tax on early distributions (unless an exception applies). You do not have to take required minimum distributions from a Roth IRA during your lifetime. For more information, see IRS Publication 590, Individual Retirement Arrangements (IRAs).

You cannot roll over a payment from the Plan to a designated Roth account in an employer plan.

If you are not a plan participant

Payments after death of the participant. If you receive a distribution after the participant's death that you do not roll over, the distribution will generally be taxed in the same manner described elsewhere in this notice. However, the 10% additional income tax on early distributions does not apply, and the special rule described under the section If you were born on or before January 1, 1936 applies only if the participant was born on or before January 1, 1936.

If you are a surviving spouse: If you receive a payment from the Plan as the surviving spouse of a deceased participant, you have the same rollover options that the participant would have had, as described elsewhere in this notice. In addition, if you choose to do a rollover to an IRA, you may treat the IRA as your own or as an inherited IRA.

An IRA you treat as your own is treated like any other IRA of yours, so that payments made to you before you are age 59½ will be subject to the 10% additional income tax on early distributions (unless an exception applies) and required minimum distributions from your IRA do not have to start until after you are age 70½.

If you treat the IRA as an inherited IRA, payments from the IRA will not be subject to the 10% additional income tax on early distributions. However, if the participant had started taking required minimum distributions, you will have to receive required minimum distributions from the inherited IRA. If the participant had not started taking required minimum distributions from the Plan, you will not have to start receiving required minimum distributions from the inherited IRA until the year the participant would have been age 70½.

If you are a surviving beneficiary other than a spouse: If you receive a payment from the Plan because of the participant's death and you are a designated beneficiary other than a surviving spouse, the only rollover option you have is to do a direct rollover to an inherited IRA or Roth IRA. Payments from the inherited IRA or Roth IRA will not be subject to the 10% additional income tax on early distributions. You will have to receive required minimum distributions from the inherited IRA or Roth IRA.

Payments under a qualified domestic relations order. If you are the spouse or former spouse of the participant who receives a payment from the Plan under a qualified domestic relations order (QDRO), you generally have the same options the participant would have (for example, you may roll over the payment to your own IRA or an eligible employer plan that will accept it). Payments under the QDRO will not be subject to the 10% additional income tax on early distributions.

If you are a nonresident alien: If you are a nonresident alien and you do not do a direct rollover to a U.S. IRA or U.S. employer plan, instead of withholding 20%, the Plan is generally required to withhold 30% of the payment for federal income taxes. If the amount withheld exceeds the amount of tax you owe (as may happen if you do a 60-day rollover), you may request an income tax refund by filing Form 1040NR and attaching your Form 1042-S. See Form W-8BEN for claiming that you are entitled to a reduced rate of withholding under an income tax treaty. For more information, see also IRS Publication 519, *U.S. Tax Guide for Aliens*, and IRS Publication 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*.

If you have Roth contributions that were merged into the Walmart 401(k) Plan, those contributions are subject to special tax rules when they are distributed from the Walmart 401(k) Plan. In general, your Roth contributions are not taxed upon distribution, even if you do not elect a rollover.

Earnings on those contributions are also not taxed if the distribution is a "qualified distribution." A "qualified distribution" is a payment made after age 59½ (or after your death or disability) and after you have had a Roth account for at least five years (counting from January 1 of the year you made your first Roth contribution). If the distribution is not a qualified distribution, the earnings will be taxed and, if you are under 59½ (and no other exception applies), the additional 10% income tax would also apply, unless you elect a rollover.

You may roll over your Roth contributions only to a Roth IRA or to a designated Roth account in another employer plan that will accept the rollover. The rules of the Roth IRA or employer plan that holds the rollover will determine your investment options, fees, and rights to payment from the Roth IRA or employer plan (for example, no spousal consent

rules apply to Roth IRAs and Roth IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the Roth IRA or the designated account in the employer plan. In general, these tax rules are similar to those described above, but differences include:

- If you do a rollover to a Roth IRA, all of your Roth IRAs will be considered for purposes of determining whether you have satisfied the 5-year rule (counting from January 1 of the year for which your first contribution was made to any of your Roth IRAs).
- If you do a rollover to a Roth IRA, you will not be required to take a distribution from the Roth IRA during your lifetime and you must keep track of the aggregate amount of the after-tax contributions in all your Roth IRAs (in order to determine your taxable income for later Roth IRA payments that are not qualified distributions).
- Eligible rollover distributions from a Roth IRA can only be rolled over to another Roth IRA.

The tax rules governing Roth contributions are complex. You should consult with your tax advisor before electing distribution.

OTHER SPECIAL RULES

If your payments for the year are less than $200, the Plan is not required to allow you to do a direct rollover and is not required to withhold for federal income taxes. However, you may do a 60-day rollover.

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FOR MORE INFORMATION

You may wish to consult with the Plan Administrator or payer, or a professional tax advisor, before taking a payment from the Plan. Also, you can find more detailed information on the federal tax treatment of payments from employer plans in: IRS Publication 575, *Pension and Annuity Income*; IRS Publication 590, *Individual Retirement Arrangements (IRAs)*; and IRS Publication 571, *Tax-Sheltered Annuity Plans (403(b) Plans*. These publications are available from a local IRS office, on the web at www.irs.gov, or by calling 800-TAX-FORM.

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Claims and appeals

WHERE CAN I FIND?

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Claims and appeals

As a participant in the Associates' Health and Welfare Plan (the Plan), you have the right to appeal a decision regarding Plan eligibility and benefits. This chapter describes the process and the deadlines for appealing a claim that has been partially or fully denied in the areas of eligibility, medical, pharmacy, dental, vision, HMO plans, life insurance, AD&D, disability or critical illness and accident insurance. To protect your right to appeal, it's important to follow these procedures and meet the deadlines.

CLAIMS AND APPEALS RESOURCES	
Find What You Need	
Submit a claim for benefits	For medical, pharmacy, dental and vision claims, see your plan ID card for the claims address or call your health care advisor at the number on your plan ID card. Submit Centers of Excellence claims to the administrator as shown in the chart later in the chapter. Submit all other claims to the Plan's Third Party Administrators as shown later in this chapter.
Appeal the denial of a claim	Submit appeals to the addresses provided in this chapter for the Plan's Third Party Administrators and/or People Services, depending on the nature of your appeal. Your initial denial letter will also specify where to file an appeal.
Appeal a decision on eligibility for coverage under the benefit plans	Write to: Walmart People Services Attn: Internal Appeals Or for COBRA appeals, write to: WageWorks Addresses are listed later in this chapter.
Designate an authorized representative to submit appeals on your behalf	Call the number on your plan ID card or call People Services at 800-421-1362

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What you need to know about claims and appeals

- You have the right to appeal an adverse eligibility decision affecting your or a family member's coverage.
- You have the right to appeal an adverse preauthorization decision regarding your requested benefits.
- You must submit claims for benefits directly to the Third Party Administrator or provider of the Plan.
- You have the right to appeal a benefit claim that has been partially or fully denied.
- You can appoint another party to appeal on your behalf. The Plan will provide the appropriate form for you to complete and sign. This is the only authorization form that will be accepted for another party to appeal on your behalf.
- After a final decision of an appeal of a medical, pharmacy or Centers of Excellence claim is made by the Third Party Administrator or the Plan, you may have the right to request an independent external review of the decision if your claim involves medical judgment.
- Decisions regarding enrollment, eligibility status and questions related to eligibility waiting periods are not eligible for external review, but will be eligible for voluntary review under the Plan. In addition, for the medical, dental, and vision plans, appeals denied for nonmedical administrative reasons (e.g., because you exceeded the Plan's visit limits) are eligible for voluntary review under the Plan.

Deadlines to file a claim or bring legal action

Unless otherwise specified in the chapter describing the applicable benefit, you or your dependent(s) must file an initial claim for benefits under the Plan within 18 months from the date of service. Since the procedures for filing a claim or an appeal of a decision are different for different benefit plans and Third Party Administrators, be sure to review the relevant section of this chapter for more information. You or your dependent(s) must complete the required claims and appeals process described in this Claims and appeals chapter before you may bring legal action or, for certain medical, pharmacy, Centers of Excellence, transplant, dental or weight loss surgery claims, or pursue an external review. You may not file a lawsuit for benefits if the initial claim or appeal is not made within the time periods set forth in the claims procedures of the Plan.

You must file any lawsuit for benefits within 180 days after the final decision on appeal (whether by the Plan or after external review). You may not file suit after that 180-day period expires. You or your dependent(s) are not required to request a voluntary review by the Plan or an external review of the decision on appeal before filing a lawsuit. If you or your dependent(s) request a voluntary review or an external review of the decision on appeal, where applicable, the time taken by the voluntary review or external review will not be counted against the 180 days you have to file a lawsuit.

Benefits may not be assigned

You may not assign your legal rights or rights to any payments under this Plan. However, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by you or your dependents, but only as a convenience to you. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) you or your dependents under any circumstances.

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 People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Eligibility decisions regarding the transplant and weight loss surgery benefit waiting period will be determined under the claims and appeals time frames for medical claims, as described below.

COBRA participants should send the appeal, in writing, to the following address:

WageWorks (COBRA Appeals)
P.O. Box 226591
Dallas, Texas 75222-6591

Your appeal will be handled within 60 days from the date it is received (30 days for COBRA appeals), unless an extension is required.

The 60-day period may be extended if it is determined that an extension is necessary due to matters beyond the Plan's control. You will be notified prior to the end of the 60-day period if an extension or additional information is required. Appeals of enrollment or eligibility decisions are not eligible for external review but will be eligible for voluntary review.

Medical, pharmacy, Centers of Excellence, dental and vision benefits claims process

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

- Medical, pharmacy and Centers of Excellence benefits except for HMO Plans and the eComm PPO Plan; see **HMO plan claims and appeals procedures** and **eComm PPO Plan claims and appeals procedures** later in this chapter
- Dental benefits (through Delta Dental)
- Vision benefits (through VSP), and
- A rescission of coverage, which is a cancellation of coverage that has a retroactive effective date, except where cancellation of coverage is due to failure to pay required contributions or premiums in a timely manner.

If you choose to prenotify the Third Party Administrator of a scheduled medical service before you receive treatment or file a claim for benefits, where it is not otherwise required under the Plan, the Third Party Administrator's response is nonbinding on the Plan and not subject to appeal. However, if the Third Party Administrator requires you or your provider to preauthorize services (including under the Centers of Excellence program and the Accountable Care Plans), and your request for prior authorization is denied, that decision is subject to appeal.

Refer to the respective chapters in this Summary Plan Description for information on filing your initial claim. Initial claims will be determined by Plan Administrators as listed in the chart on the following page:

CLAIMS AND APPEALS ADMINISTRATION: ROUTINE MEDICAL, PHARMACY, DENTAL AND VISION	
Medical (For Centers of Excellence claims, see below)	**Your Third Party Administrator** (see your plan ID card) Including services performed at a Centers of Excellence facility but not covered under the Centers of Excellence program and transplant claims not required to be performed at Mayo Clinic. If you are a participant in one of the Mercy Accountable Care Plans, Mercy will handle prior authorizations and HealthSCOPE Benefits will process claims.
Pharmacy	**Express Scripts**
Dental	**Delta Dental**
Vision	**VSP**

CENTERS OF EXCELLENCE	
NOTE: If you are enrolled in an Accountable Care Plan, please call your health care advisor to be directed to the appropriate administrator.	
Heart surgery	**Health Design Plus**
Breast, lung, and colorectal cancer travel review	**HealthSCOPE Benefits**
Spine surgery	**Health Design Plus**
Hip and knee replacement	**Health Design Plus**
Transplant	**HealthSCOPE Benefits**
Weight loss surgery	**Health Design Plus**

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The time period in which your claim will be determined depends on the type of claim. The Plan requires prior authorization for all Centers of Excellence services and certain other services, as described in the Preauthorization section of The medical plan chapter. For these benefits, you or your provider must file a claim for approval before you receive treatment, or your claim may not be paid. These are called "pre-service claims." If your pre-service claim is urgent, your claim will be decided under the urgent care time frames. A claim is urgent where making a determination under the normal time frames could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

If you are filing a claim after you have already received services, your claim is a post-service claim. If your claim arises when there is a reduction in ongoing care, your claim is a concurrent care claim.

The chart on the following page shows deadlines for making claims determinations for these types of claims.

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CLAIMS PROCESS AND TIMING	
Urgent claims Any claim for medical care or treatment where making a determination under the normal time frames could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.	Notice will be sent as soon as possible, taking into account the medical exigencies, and in no case later than 72 hours after receipt of the claim. You may receive notice orally, in which case a written notice will be provided within three days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information. If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request.
Pre-service claims A claim for services that have not yet been rendered and for which the Plan requires prior authorization.	If your pre-service claim is improperly filed, you will be sent notification within five days of receipt of the claim. If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the claim. If the Plan determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Plan expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Plan then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Post-service claims A claim for services that already have been rendered, or where the Plan does not require prior authorization.	A notice will be sent within a reasonable time period, but not longer than 30 days from receipt of the claim. If the Plan determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Plan expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Plan then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Concurrent care claims A claim related to a reduction of ongoing services.	You will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction so that you will be able to appeal the decision before the coverage is reduced or terminated, unless such a reduction or termination is due to a Plan amendment or termination of the Plan.

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If your claim is denied, the denial will include the following information:

- The specific reason(s) for the denial
- Reference to provisions of the Plan on which the denial was based
- Information regarding time limits for appeal
- A description of any additional information necessary to consider your claim and why such information is necessary
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitation, an explanation of this rule (or a statement that it is available upon request), and
- Notice regarding your right to bring legal action following a denial on appeal.

For medical, pharmacy, Centers of Excellence and vision benefits, the denial also will include:

- Information sufficient to identify the claim involved, including, as applicable, the date of service, health care provider and claim amount
  - 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, CENTERS OF EXCELLENCE, PHARMACY, DENTAL OR VISION CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

You may request an appeal of the decision. In order for your appeal to be considered, it must:

- Be in writing
- Be sent to the correct address
- Be submitted within 365 days of the date of the initial denial (for medical, Centers of Excellence and dental claims) or 180 days (for pharmacy and vision claims), and
- Contain any additional information/documentation you would like considered.

If your appeal involves an urgent claim, please contact your Third Party Administrator for information about how to file your claim orally.

Aetna and Express Scripts allow two levels of review. The second appeal must be submitted within 60 days of the date of the first appeal denial. All other Third Party Administrators have one level of appeal.

Send your written request for review of the initial claim to the Third Party Administrator that administers your claims:

Appeals for medical and transplant benefits not required to be performed at Mayo Clinic, services performed at a Centers of Excellence facility but not covered under the Centers of Excellence program, and for weight loss services not performed under the weight loss surgery benefit

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

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

HealthSCOPE Benefits
Attn: Appeals
P.O. Box 2359
Little Rock, Arkansas 72203
800-804-1272

UnitedHealthcare National Appeals Service Center
P.O. Box 30575
Salt Lake City, Utah 84130-0575
888-285-9255

Centers of Excellence for heart, spine, and hip and knee replacement surgeries and weight loss surgery: Health Design Plus

Centers of Excellence: Walmart
Attn: Appeals Coordinator
1755 Georgetown
Hudson, Ohio 44236

Centers of Excellence for heart and weight loss surgery at Emory Accountable Care Plan

HealthSCOPE Benefits, Inc.
Attn: Appeals Coordinator
27 Corporate Hill Drive
Little Rock, Arkansas 72205

Centers of Excellence for heart and weight loss surgery at Emory Accountable Care Plan

HealthSCOPE Benefits, Inc.
Attn: Appeals Coordinator
27 Corporate Hill Drive
Little Rock, Arkansas 72205

Centers of Excellence for weight loss surgery at Mercy Accountable Care Plan

HealthSCOPE Benefits, Inc.
Attn: Appeals Coordinator
27 Corporate Hill Drive
Little Rock, Arkansas 72205

Centers of Excellence for weight loss surgery at Banner Accountable Care Plan

Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, Kentucky 40512

Centers of Excellence for cancer care and Mayo Clinic transplant appeals: HealthSCOPE Benefits

HealthSCOPE Benefits, Inc.
Attn: Appeals Coordinator
27 Corporate Hill Drive
Little Rock, Arkansas 72205

Pharmacy appeals

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, Missouri 63166-6588

Dental appeals

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

Vision appeals

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, California 95670

NOTE: There is a special claims and appeals process for certain Centers of Excellence benefits (see details later in this chapter).

Your appeal will be conducted without regard to your initial determination by someone other than the party who decided your initial claim. No deference will be afforded to the initial determination. You will have the opportunity to submit written comments, documents or other information in support of your appeal. You have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. The Third Party Administrator, on behalf of the Plan, will provide you with any new or additional evidence or rationale considered in connection with your claim sufficiently in advance of the appeals determination date to give you a reasonable opportunity to respond.

If your claim involves a medical judgment question, the Plan will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the Plan will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

A final decision on appeal will be made within the time periods specified in the chart that follows, depending on the type of claim:

APPEAL PROCESS AND TIMING	
Urgent claims	You will be notified of the determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim (36 hours for Aetna appeals).
Pre-service claims	You will be notified of the determination within a reasonable period of time, taking into account the medical circumstances, but no later than 30 days from the date your request is received (15 days for Aetna appeals).
Post-service claims	You will be notified of the determination within a reasonable period of time, but no later than 60 days from the date your request is received (30 days for Aetna appeals).

If your claim is denied on appeal, you will receive a denial notice that includes:

- The specific reason(s) for the denial
- Reference to provisions of the Plan on which the denial was based
- A statement describing your right to request copies, free of charge, of all documents, records or other information relevant to your claim
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on a medical necessity or similar limitation, an explanation of this rule (or a statement that it is available upon request)
- A description of any voluntary review procedures available, and
- Notice regarding your right to bring legal action following a denial on appeal.

For medical, pharmacy and Centers of Excellence benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount (if applicable)
  - 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.

SPECIAL PROCEDURES FOR APPROVAL OF A TRANSPLANT LOCATION OTHER THAN MAYO CLINIC

As described in The medical plan chapter, all transplant recipients (except kidney, cornea and intestinal recipients) must undergo a pre-transplant evaluation at Mayo Clinic. For these transplants, Mayo Clinic will make a recommendation regarding transplant services at Mayo Clinic. You may file a prior authorization request to receive a transplant at a facility other than Mayo Clinic if there is significant risk that travel to Mayo Clinic could result in death. In addition, if Mayo Clinic does not recommend a transplant because it is not deemed the appropriate medical course of treatment or the patient is not an appropriate candidate, you may file a prior authorization request with the Plan.

These requests will be considered by an Independent Review Organization appointed by the Plan Administrator, which may approve the transplant for a different acceptable facility.

The Independent Review Organization will not include any employee of Walmart, Mayo Clinic or a Third Party Administrator of the Plan. The Independent Review Organization will review any pertinent medical files that were reviewed or generated by Mayo Clinic, as well as any additional materials you submit, and will consider your condition, alternative courses of treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit the transplant would have.

Send your written request for review of preauthorization transplant claims to:

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500
800-421-1362

If you are filing a claim for services at a facility other than Mayo Clinic because there is significant risk that travel to Mayo Clinic could result in death, you should file as soon as possible. If you are filing a claim because Mayo Clinic has determined that the transplant is not an appropriate medical course of treatment, your claim must be received by the Plan within 120 calendar days of the initial denial of transplant treatment by Mayo Clinic (where Mayo has determined that treatment is inappropriate). If the claim is urgent, the Independent Review Organization will make its determination within 72 hours after receipt of the claim (otherwise, the Independent Review Organization will make its determination within 15 days of receipt of the claim). An urgent claim is any claim for medical care or treatment where making a determination under the normal time frame could seriously jeopardize the life, health or ability to regain maximum function, or, in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

If the urgent claim is determined to be incomplete, you will receive a notice within 24 hours of receipt of the claim, and you will have 48 hours to provide additional information.

For non-urgent claims, the deadline to decide the claim may be extended 15 days, and the Independent Review Organization will send a notice explaining the extension. 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 Organization. The Independent Review Organization 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 if your claim involves medical judgment.

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 for post-service claims outlined earlier in this chapter.

SPECIAL PROCEDURES FOR APPROVAL OF EXCEPTIONS TO PLAN COVERAGE TERMS FOR SPINE SURGERY AND HIP AND KNEE REPLACEMENT

As described in The medical plan chapter, spine surgery and hip and knee replacement that are eligible to be performed at a Centers of Excellence facility must be pre-approved by the administrator of the program and performed at a Centers of Excellence facility in order for Centers of Excellence benefits to be payable. You may file a prior authorization request to receive services at a non-Centers of Excellence facility and receive in-network benefits if there is significant risk that travel could result in paralysis or death (a "pre-service" claim) or where a Center of Excellence facility does not recommend spine surgery or hip or knee replacement because it is not deemed the appropriate medical course of treatment or the patient is not an appropriate candidate for surgery (also a "pre-service" claim).

In addition, if you have already received surgical treatment because your circumstances called for immediate surgery, without which you would likely have suffered paralysis or loss of life, or if spine surgery or hip or knee replacement has been provided by a network provider in a course of treatment that began prior to the effective date of this provision, you may request that the services you received at a non-Centers of Excellence facility be covered as in-network services (a "post-service" claim).

These claims will be considered by an Independent Review Organization appointed by the Plan Administrator, which may approve coverage at the in-network level for the spine surgery or hip or knee replacement at a non-Centers of Excellence facility.

The Independent Review Organization will not include any employee of Walmart, the Centers of Excellence facility for spine surgery or hip or knee replacement, or a Third Party Administrator of the Plan. The Independent Review Organization will review any pertinent medical files that were reviewed or generated by the Centers of Excellence facility, as well as any additional materials you submit, and will consider your condition, alternative courses of

treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit the surgical procedure would have.

Send your written request for an exception to the Plan's coverage terms for spine surgery or hip or knee replacement to:

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500
800-421-1362

If you are filing a pre-service claim for services at a non-Centers of Excellence facility because there is significant risk that travel could result in paralysis or death, you should file as soon as possible. If you are filing a pre-service claim because a Center of Excellence facility determined that the surgery is not an appropriate medical course of treatment, your claim must be received by the Plan within 120 calendar days of the initial denial by the Centers of Excellence facility. If you are filing a post-service claim because you already received surgery elsewhere, as described above, you must file your claim within 120 calendar days of the date of service.

If a pre-service claim is urgent, the Independent Review Organization will make its determination within 72 hours after receipt of the claim (otherwise, the Independent Review Organization will make its determination within 15 days of receipt of a pre-service claim or within 30 days of receipt of a post-service claim). An urgent claim is any claim for medical care or treatment where making a determination under the normal time frame could seriously jeopardize the life, health or ability to regain maximum function, or, in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim. If the urgent claim is determined to be incomplete, you will receive a notice within 24 hours of receipt of the claim, and you will have 48 hours to provide additional information. For non-urgent claims, the deadline to decide the claim may be extended 15 days, and the IRO will send a notice explaining the extension. 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 Organization. The Independent Review Organization will decide a request for urgent review of a pre-service claim within 72 hours after receipt, non-urgent review of a pre-service claim within 30 days after receipt, and review of a post-service claim within 60 days of receipt. You then may appeal a denial of an internal review appeal under the external appeal process described in this section if your claim involves medical judgment.

REQUESTING TO WAIVE THE ONE-YEAR WAITING PERIOD FOR TRANSPLANT BENEFITS

If the treating physician certifies that, absent the transplant, the individual's death is imminent within 48 hours, the otherwise applicable 12-month waiting period for transplant benefits may be waived. To request this waiver, the claimant must file a prior-authorization request.

These requests will be considered by the Plan Administrator, which may approve the waiver of the one-year waiting period. Send your written request to:

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500
800-421-1362

Your request will be treated as an urgent or pre-service claim. See the Appeal process and timing chart earlier in this chapter for details on the time frames under which the Plan Administrator will notify you of its determination in response to your request.

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

If you have additional information that was not in your appeal, you may ask for a voluntary review of the decision on your appeal within 180 days of the date on the appeal denial letter. The same criteria and response times that applied to your appeal are generally applied to this voluntary level of review.

The claimant must send a written request for a voluntary appeal for enrollment or eligibility status to:

Walmart People Services
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

See Deadlines to file a claim or bring legal action earlier in this chapter regarding the deadline to bring legal action.

REQUESTING A VOLUNTARY REVIEW OF YOUR DENIED MEDICAL, DENTAL OR VISION BENEFIT APPEAL FOR ADMINISTRATIVE REASONS

You may request a voluntary review of the decision on your appeal of a denied medical, dental or vision benefit claim if your appeal was denied for an administrative reason, such as exceeding the number of allowed visits, and not for a

medical judgment reason. You must file your request within 180 days of the date on the appeal denial letter. The same criteria and response times that applied to your appeal are generally applied to this voluntary level of review.

The claimant must send a written request for a voluntary appeal for administrative denial to:

Walmart People Services
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

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

If your internal appeal for medical, pharmacy or Centers of Excellence benefits under the Plan is denied based on medical judgment, you may have the right to further appeal your claim pursuant to an independent external review process.

Your external appeal will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan's decision, and the independent review organization's decision will be binding on the Plan. Your internal appeal denial notice will include more information about your right to file a request for an external review as well as contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

The claimant must send a written request for an external medical appeal to:

Walmart People Services
Attn: External Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500
800-421-1362

External pharmacy appeals should be sent to:

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, Missouri 63166-6587

Information regarding rights related to medical, pharmacy, Centers of Excellence, dental, vision and short-term disability benefits

RIGHT TO REQUEST MEDICAL RECORDS

The Plan has the right to request medical records for any associate or covered individual.

THE PLAN'S RIGHT TO RECOVER OVERPAYMENT

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan (or the Third Party Administrator) 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 any participant, beneficiary or dependent. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan's collection effort is not successful. The Plan may also bring a lawsuit to enforce its rights to recover overpayments.

If the overpayment is made to a provider, the Plan (or any Third Party Administrator) may reduce or deny benefits, in the amount of the overpayment, for otherwise covered services for current and/or future claims with the provider on behalf of any participant, beneficiary, or dependent in the Plan. If a provider to whom an overpayment was made has patients who are participants in other health and welfare plans administered by the Third Party Administrator, the Third Party Administrator may reduce payments otherwise owed to the provider from such other health plans by the amount of the overpayment.

YOUR RIGHT TO RECOVER OVERPAYMENT

If you overpay your contributions or premiums for any coverage under the Plan (except COBRA), the Plan will refund excess contributions or premiums to you upon request. In this circumstance, any refunds you receive may be offset by any benefits paid during this period by the Plan if you or a dependent was not eligible for such coverage.

RIGHT TO AUDIT

The Plan has the right to audit your and your dependents' claims, including claims of medical providers. The Plan (or the Third Party Administrator) may reduce or deny benefits for otherwise covered services for all current and/or future claims with the provider made on behalf of you or your dependent, or a participant in any other health and welfare plan administered by the Third Party Administrator based

on the results of an audit. The Plan may also reduce or deny benefits for otherwise covered services for all current and/or future claims filed by you or a dependent based on the results of an audit.

RIGHT TO SALARY/WAGE DEDUCTION

To the extent that the Plan may recover from you or your dependents all or part of benefits previously paid, you shall be deemed, by virtue of your enrollment in this medical coverage, to have agreed that the company may deduct such amounts from your wages or salary and pay the same to the Plan until recovery is complete. If you enroll for coverage under the Plan, you will be treated by the Plan as if you had consented to the applicable payroll deductions for such coverage. In addition, if you fail to affirmatively enroll or re-enroll during annual enrollment, you will be treated by the Plan as if you had consented to the automatic re-enrollment described in the Eligibility and enrollment chapter, including the applicable payroll deductions.

RIGHT TO REDUCTION, REIMBURSEMENT AND SUBROGATION

The Plan has the right to:

- Reduce or deny benefits otherwise payable by the Plan, and
- Recover or subrogate 100% of the benefits paid or to be paid by the Plan for covered persons, to the extent of any and all of the following payments:
  - Any judgment, settlement or payment made or to be made because of an accident or malpractice (except for malpractice that results in paraplegia/quadriplegia, severe burns, total and permanent physical or mental disability, or death), including but not limited to other insurance
  - Any auto or recreational vehicle insurance coverage or benefits, including but not limited to uninsured/underinsured motorist coverage
  - Business medical and/or liability insurance coverage or payments, and
  - Attorney's fees.

The Plan's lien exists at the time the Plan pays medical benefits. If a covered person files a petition for bankruptcy, the covered person agrees that the Plan's lien existed in time prior to the creation of the bankruptcy estate.

Also note that:

- "Covered person" means any participant (as defined by ERISA) or dependent of a participant who is entitled to medical coverage under the Plan
- The Plan has first priority with respect to its right to reduction, reimbursement and subrogation
- The Plan has the right to recover interest on the amount paid by the Plan because of the accident
- The Plan has the right to 100% reimbursement in a lump sum
- The Plan is not subject to any state laws or equitable doctrine, including but not limited to the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of a covered person's attorney's fees and costs
- The Plan is not responsible for the covered person's attorney's fees, expenses or costs
- The right of reduction, reimbursement and subrogation is based on the Plan language in effect at the time of judgment, payment or settlement
- The Plan's right to reduction, reimbursement and subrogation applies to any funds recovered from another party, by or on behalf of the estate of any covered person, and
- The Plan's right to first priority shall not be reduced due to the participant's own negligence.

The Plan will not pursue reduction, reimbursement or subrogation where the injury or illness that is the basis of the covered person's recovery from any party results in:

- Paraplegia or quadriplegia
- Severe burns
- Total and permanent physical or mental disability, or
- Death.

In addition to the exceptions listed above, the Plan Administrator has the authority, in its sole discretion, to determine not to pursue the Plan's rights to reduction, reimbursement or subrogation. For more information, contact the Plan Administrator.

Whether a covered person has a "total and permanent physical or mental disability" will be determined based on criteria developed and applied by the Plan Administrator 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 Plan Administrator 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 Plan Administrator.

Even in circumstances where the Plan is not prohibited from seeking reduction, reimbursement or subrogation based on the exceptions described previously in this chapter, the Plan's right to reduction, reimbursement or subrogation will be limited to no more than 50% of the total amount recovered by or on behalf of the covered person from any party (which shall not be reduced for the covered person's attorney's fees or costs). The Plan requires all covered persons and their representatives to cooperate in order to guarantee reimbursement to the Plan from third-party benefits. Failure to comply with this request

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will entitle the Plan to withhold benefits due to you or your dependents under the Plan. You, your dependents and/or your representatives cannot do anything to hinder reimbursement of overpayment to the Plan after benefits have been accepted by you, your dependents and/or your representatives.

The Plan's rights to reduction, reimbursement and subrogation apply regardless of whether such payments are designated as payment for, but not limited to:

- Pain and suffering, or
- Medical benefits.

The Plan's rights apply regardless of whether a covered person has been made whole or fully compensated for his or her injuries.

Additionally, the Plan has the right to file suit on your behalf for the condition related to the medical expenses in order to recover benefits paid or to be paid by the Plan.

Claims for benefits and right to appeal reduction, reimbursement and subrogation decisions

The Plan's decision to seek reduction, reimbursement or subrogation is a determination of benefits under the Plan and may be appealed in accordance with the procedures below.

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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 People Services
Attn: Subrogation Review
508 SW 8th Street
Bentonville, Arkansas 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).

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IF A CLAIM RELATED TO A REDUCTION, REIMBURSEMENT OR SUBROGATION DECISION 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 People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

The appeal will be conducted without regard to the initial determination by someone other than the party who decided the initial claim for benefits. The claimant has the right to request copies, free of charge, of all documents, records or other information relevant to the claimant's claim for benefits. The claimant also has the right to submit written comments, documents, records and other information, which the Plan will take into account in making its decision on appeal. In deciding any claim for benefits that is based in whole or in part on a medical judgment, the Plan's claims fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be an individual who is neither an individual who was consulted in connection with the Plan's decision on the initial claim for benefits, nor the subordinate of the health care professional. If the advice of a health care professional is obtained in deciding an appeal, the name of the health care professional will be provided to the claimant upon request, regardless of whether the Plan relied on the advice. The Plan must provide the claimant written notice of the Plan's decision on review within 60 days following the Plan's receipt of the claimant's appeal.

If the claim for benefits is denied on appeal, the Plan will provide a denial notice to the claimant that includes:

- The specific reason(s) for the denial
- Specific reference to provisions of the Plan on which the denial was based
- A statement describing the claimant's right to request copies, free of charge, of all documents, records or other information relevant to the claimant's claim for benefits
- A statement that the claimant has the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- A description of available voluntary review procedures, if any, and
- Notice regarding the claimant's right to bring a court action following a denial on appeal.

The only method by which the claimant can request the Plan not to reduce benefits is to file a claim for benefits. An initial claim for benefits must be filed within 12 months from the date of the notice. The claimant must complete the required claims and appeals process described in these claims procedures before bringing legal action. A claimant may not file a lawsuit for benefits if the claimant's initial claim for benefits or appeal is not made within the time periods set forth in these claims procedures. A claimant must file any lawsuit for benefits within 180 days after the decision on appeal. A claimant may not file suit after that 180-day period expires.

Covered person's responsibility regarding right of reduction and/or recovery

To aid the Plan in its enforcement of its right of reduction, recovery, reimbursement and subrogation, you and/or your designated representative must, at the Plan's request and at its discretion:

- Take any action
- Give information, or
- Sign documents so required by the Plan.

Failure to aid the Plan and to comply with such requests may result in the Plan's withholding or recovering benefits, services, payments or credits due or paid under the Plan.

The Plan can seek reimbursement of 100% of medical benefits paid from any judgment, payment or settlement that is made on behalf of the covered person for whom the medical benefits were paid. Reimbursement to the Plan of 100% of these charges shall be made at the time the payment is received by you, your dependent(s) or your representative.

HMO plan claims and appeals procedures

In some facilities, Walmart offers health insurance coverage through a Health Maintenance Organization (HMO) as part of the Associates' Health and Welfare Plan. If you participate in an HMO, the HMO will provide a benefit booklet that, together with this document, will serve as the Summary Plan Description for the HMO coverage and will describe its claims and appeals procedures. Contact your HMO for additional information.

eComm PPO Plan claims and appeals procedures

In some facilities, Walmart offers the eComm PPO Plan as part of the Associates' Health and Welfare Plan. If you participate in the eComm PPO Plan, Aetna, the Plan's Third Party Administrator, will provide a booklet that, together with this document, will serve as the Summary Plan Description for the eComm PPO Plan coverage and describe its claims and appeals procedures. Contact Aetna for additional information.

Accident and critical illness insurance claims process

Accident and critical illness insurance claims should be submitted within 60 days of the occurrence or commencement of any covered accident or critical illness to:

Allstate Benefits Workplace Division
Walmart Claims Unit
P.O. Box 414848
Jacksonville, Florida 32203-1488

You may also provide notice of claim as follows:

Online: **allstatebenefits.com/mybenefits**
By phone: **800-514-9525**
By fax: **877-423-8804**

Be sure to provide the following information for the covered person:

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

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

CRITICAL ILLNESS

When you submit a claim to Allstate Benefits and your claim is denied, a notice will be sent within a reasonable time period, but no later than 30 days after Allstate Benefits receives the claim (filed in accordance with the Critical Illness Certificate of Insurance). In special circumstances, an extension of time may be needed to make a decision. In that case, Allstate Benefits may take a 15-day extension. You will receive written notice of the extension before the end of the 30-day period.

If your claim is denied, your denial will consist of a written explanation, which will include:

- The specific reason(s) for the denial
- Reference to provisions of the Plan on which the denial was based
- Information regarding time limits for appeal
- A description of additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that 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 Benefits. In connection with an appeal, you may request, free of charge, all documents that are relevant (as defined by ERISA) to your claim. You may also submit with your appeal any comments, documents, records and issues that you believe support your claim, even if you have not previously submitted such documentation. You may have representation throughout the review procedure.

An appeal must be filed with Allstate Benefits in accordance with the claim filing procedures described in your denial letter within 180 days of receipt of the written notice of denial of a claim. Allstate Benefits will render a decision no later than 60 days after receipt of your written appeal. The decision after your review will be in writing and will include:

- The specific reason(s) for the denial
- Reference to provisions of the Plan on which the denial was based
- A statement that you have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that is available upon request)
- A description of any voluntary review procedures offered by the Plan and your right to obtain information about such procedures, and
- A statement regarding your right to bring court action following a denial on appeal.

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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 Section 502(a). You cannot take any legal action until you have exhausted the Plan's claims review procedure described above.

ACCIDENT INSURANCE

When you submit a claim to Allstate Benefits and your claim is denied, a notice will be sent within a reasonable time period, but no later than 30 days after Allstate Benefits receives the claim (filed in accordance with the Accident Certificate of Insurance). In special circumstances, an extension of time may be needed to make a decision. In that case, Allstate Benefits may take a 15-day extension. You will receive written notice of the extension before the end of the 30-day period.

If your claim is denied, your denial will consist of a written explanation, which will include:

- The specific reason(s) for the denial
- Reference to provisions of the Plan on which the denial was based
- Information regarding time limits for appeal
- A description of additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that it is available upon request), and
- Notice regarding your right to bring a court action following a denial on appeal.

You also will receive a notice if the claim on appeal is approved.

APPEALING AN ACCIDENT CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

You may appeal any denial of a claim for benefits by filing a written request with Allstate Benefits. In connection with an appeal, you may request, free of charge, all documents that are relevant (as defined by ERISA) to your claim. You may also submit with your appeal any comments, documents, records and issues that you believe support your claim, even if you have not previously submitted such documentation. You may have representation throughout the review procedure.

An appeal must be filed with Allstate Benefits in accordance with the claim filing procedures described in your denial letter within 180 days of receipt of the written notice of denial of a claim. Allstate Benefits will render a decision no later than 60 days after receipt of your written appeal. The decision after your review will be in writing and will include:

- The specific reason(s) for the denial
- Reference to provisions of the Plan on which the denial was based
- A statement that you have the right to receive, upon request and free of charge, 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 Section 502(a). You cannot take any legal action until you have exhausted the Plan's claims review procedure described above.

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadlines to bring legal action.

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

Company-paid, optional associate and dependent life insurance, business travel accident insurance and AD&D claims should be submitted to:

Prudential Insurance Companies of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, Pennsylvania 19176

Life insurance and business travel accident claims must be filed within 12 months of date of death or loss. AD&D claims must be filed within 90 days of loss. See the applicable insurance chapter for details on the information required to file each type of claim. 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
- Reference to the specific plan provisions on which the determination was based
- A statement describing your right to request copies, free of charge, of all documents, records or other information relevant to your claim
- A description of Prudential's review procedures and applicable time limits
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- A statement describing any appeals procedures offered by the Plan and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

VOLUNTARY SECOND APPEAL OF LIFE INSURANCE, AD&D, OR BUSINESS TRAVEL ACCIDENT CLAIMS

If your appeal is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a voluntary second appeal of your denial in writing to Prudential. You must submit your second appeal within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit any written comments, documents, records and any other information relating to your claim. The same criteria and response times that applied to your first appeal are generally applied to this voluntary second appeal.

See Deadlines to file a claim or bring legal action earlier in this chapter regarding the deadline to bring legal action.

Claims process for disability coverage claims

NOTE: This section describes the claims and appeals process for the short-term disability plan for hourly associates (basic and enhanced), the long-term disability plan and the truck driver long-term disability plan. For claims and appeals information for the short-term disability plans for salaried associates and truck drivers, refer to the respective chapters.

Claims under the short-term disability plan for hourly associates for all states except California, Hawaii, New Jersey, New York and Rhode Island should be submitted to:

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

Claims under the short-term disability plan for hourly associates who work in Hawaii, New Jersey and New York only, and all claims under the long-term disability and truck driver long-term disability plans should be submitted to:

Liberty
Group – Charlotte WM
P.O. Box 7216
London, Kentucky 40742-7216

Short-term disability claims for hourly associates who work in Rhode Island and California should be submitted directly to the applicable state. For information, call the phone number listed in Short-term disability resources at the beginning of the Short-term disability chapter.

Claims for short-term disability benefits in Hawaii, New Jersey and New York must be submitted to Sedgwick within 30 days of the date your disability begins. Sedgwick will notify Liberty of your disability claim.

For all other states, you must submit your short-term disability claim to Sedgwick within 90 days of the date your disability begins in order to assure consideration for benefits. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

If you are on approved short-term disability and are eligible for long-term disability, you claim automatically will be transitioned to Liberty for consideration.

Once a claim has been filed, a decision will be made in no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for up to two additional 30-day periods, provided that, prior to any extension period, you are notified in writing that an extension is necessary due to matters beyond control, those matters are identified and you are given the date by which a decision will be rendered. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date your response is received. If your claim is approved, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and will include:

- Specific reasons for the decision
- Specific reference to the policy provisions on which the decision is based
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- A description of the review procedures and time limits applicable to such procedures
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA after you appeal the decision if you receive a written denial on appeal, and
- If an internal rule, guideline, protocol or other similar criteria was relied upon in making the denial, either
  - The specific rule, guideline, protocol or other similar criteria, or
  - A statement that such a rule, guideline, protocol or other similar criteria was relied upon in making the denial and that a copy will be provided free of charge to you upon request.

APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for benefits is denied and you would like to appeal, you must submit a written or oral appeal to Sedgwick or Liberty (as applicable) within 180 days of the denial. Your appeal should include any comments, documents, records or any other information you would like considered

You will have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. Your appeal will be reviewed, without regard to your initial determination, by someone other than the party who decided your initial claim.

Sedgwick or Liberty (as applicable) will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if it is determined that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification of the denial that will include:

- The specific reason(s) for the adverse determination
- Reference to the specific plan provisions on which the determination was based
- A statement describing your right to request copies, free of charge, of all documents, records or other information relevant to your claim
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- A statement describing any appeal procedures offered by the Plan and your right to bring a civil suit under ERISA.

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See Deadlines to file a claim or bring legal action earlier in this chapter regarding the deadline to bring legal action.

For hourly associates, short-term disability appeals should be sent to:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14028
Lexington, Kentucky 40512

Statutory disability appeals for associates who work in Hawaii, New Jersey and New York need to be submitted directly to the applicable state. Associates can get information on this process by reviewing the claim denial information provided by Liberty or by calling Liberty at 877-353-6404.

Short-term disability appeals for associates who work in Rhode Island and California should be submitted directly to the applicable state. For information, call the phone number listed in Short-term disability resources at the beginning of the Short-term disability for hourly associates chapter.

For salaried associates and truck drivers, see the Salaried short-term disability plan chapter or the Truck driver short-term disability plan chapter, as appropriate, for detailed information on the appeals process for those plans.

Long-term disability and truck driver long-term disability appeals should be sent to:

Group Benefits Claim Appeal Unit Liberty
Group — Charlotte WM
P.O. Box 7216
London, Kentucky 40742-7216

VOLUNTARY SECOND APPEAL OF A CLAIM FOR BENEFITS UNDER THE HOURLY SHORT-TERM DISABILITY PLAN

If you are an hourly associate whose short-term disability coverage is administered through Sedgwick and your appeal is denied, you may make a voluntary second appeal of your denial orally or in writing to Sedgwick. You must submit your second appeal within 180 days of the receipt of the written notice of denial. 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, as described above, are generally applied to this voluntary second appeal.

All short-term disability appeals should be sent to:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14028
Lexington, Kentucky 40512

See Deadlines to file a claim or bring legal action earlier in this chapter regarding the deadlines to bring legal action.

Resources for Living benefits

You do not have to file a claim or appeal for Resources for Living benefits. You may access the Resources for Living website or contact Resources for Living at any time.

However, if you have a question about your benefits, or disagree with the benefits provided, you may contact People Services or file a claim or appeal by writing to the following address:

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Any claims or appeals will be determined under the time frames and requirements applicable to medical benefits.

International business travel medical insurance

Claim forms are generally not required for GeoBlue services. However, if you have a question about your benefits or disagree with the benefits provided, you may contact GeoBlue or file a claim by writing the following address:

GeoBlue
One Radnor Corporate Center, Suite 100
Radnor, Pennsylvania 19087

Any claims and appeals will be determined under the time frames and requirements set out in the GeoBlue policy. Contact GeoBlue at any time by calling 888-412-6403. Outside the U.S. call collect: 610-254-5830.

Legal information

WHERE CAN I FIND?

Legal information

This chapter describes your legal rights as a participant in the Associates' Health and Welfare Plan, including information about the confidentiality of your personal medical information as spelled out in the Notice of Privacy Practices — HIPAA Information. You will also find information on your rights to enrollment or premium assistance under Medicaid or the Children's Health Insurance Program (CHIP), the prescription drug coverage available through Medicare Part D and the decisions you need to make about your prescription drug coverage, if you're eligible for Medicare.

LEGAL INFORMATION RESOURCES

Find What You Need	Online	Other Resources
Contact the Plan Administrator		Write to: Walmart Plan Administrator Associates' Health and Welfare Plan 508 SW 8th Street Bentonville, Arkansas 72716-3500 Call 479-621-2058
Answers to questions about the HIPAA Privacy Notice	Email your question to privacy@wal-mart.com	Call People Services at 800-421-1362
Answers to questions about Medicare Part D	Visit medicare.gov for personalized help	800-MEDICARE (800-633-4227) TTY users should call 877-486-2048
Answers to your questions about Medicaid/CHIP	Visit insurekidsnow.gov	877-KIDSNOW (877-543-7669)

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What you need to know about the legal information for the Associates' Health and Welfare Plan

- As a participant in the Associates' Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.
- The HIPAA privacy notice in this chapter describes how medical information about you may be used and disclosed and how you can get access to this information.
- The **Medicare and your prescription drug coverage** section in this chapter explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.
- The Medicaid/Children's Health Insurance Program (CHIP) notice explains special enrollment and premium assistance rights for individuals eligible for these programs.

Associates' Health and Welfare Plan

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, in the Associates' Health and Welfare Plan Wrap Document (Wrap Document), and in 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 (SPD) for the Associates' Health and Welfare Plan.

Plan Year: January 1 through December 31

Plan Number: 501

Type of Plan: Welfare, including medical, dental, vision, short-term disability, long-term disability, truck driver long-term disability, business travel accident insurance, accidental death and dismemberment (AD&D), company-paid life, optional associate and dependent life, accident insurance, critical illness insurance and Resources for Living.

Type of Administration: The Plan Administrator (or its delegates, including Third Party Administrators deciding appeals) shall have complete discretion to interpret and construe the provisions of the Plan, make findings of fact, correct errors and supply omissions. All decisions and interpretations of any of the Plan (or its 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 Plan Administrator (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, Arkansas 72716-0295

Plan Administrator/Named Fiduciary:
Senior Vice President, Global Benefits Division,
Wal-Mart Stores, Inc.
Associates' Health and Welfare Plan
508 SW 8th Street
Bentonville, Arkansas 72716-3500
479-621-2058

Agent for Service of Legal Process:
Corporation Trust Company
1209 Orange Street Corporation Trust Center
Wilmington, Delaware 19801

Legal process may also be served on the Plan Administrator or Trustee.

Plan Sponsor's EIN: 71-0415188

FUNDING FOR THE PLAN

Wal-Mart Stores, Inc. may fund Plan benefits out of its general assets or through contributions made to the Wal-Mart Stores, Inc. Associates' Health and Welfare Trust. Contributions also may be required by employees, in an amount determined by Wal-Mart Stores, Inc. in its discretion. All assets of the Plan, including associate contributions and any dividends or earnings of the Plan, shall be available to pay any benefits provided under the Plan or expenses of the Plan, including insurance premiums.

Plan Trustee:
J. P. Morgan
4 New York Plaza, 15th Floor
New York, New York 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 or by a management associate of the company. Only written statements by the Plan Administrator 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 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.

Note that the Associates' Medical Plan does not have a pre-existing condition exclusion.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, can fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request materials from the Plan and do not receive them within 30 days, you can file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you can file suit in a state or federal court. Generally, you must complete the appeals process before filing a lawsuit against the Plan. However, you should consult with your own legal counsel in determining when it is proper to file a lawsuit against the Plan.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you can file suit in a federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you can seek assistance from the U.S. Department of Labor, or you can file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

You can also obtain certain publications about your rights under ERISA by calling the Employee Benefits Security Administration publications hotline at 866-444-3272 or by going to dol.gov/ebsa.

Notice of privacy practices — HIPAA information

Effective date of this notice: September 23, 2013

ASSOCIATES' MEDICAL PLAN (AMP), DENTAL PLAN, VISION PLAN AND RESOURCES FOR LIVING (RFL) NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. You have certain rights under the Health Information Portability and Accountability Act (HIPAA). HIPAA governs when and how your medical health information held by the AMP, dental plan, vision plan and RFL may be used and disclosed and how you can get access to this information. Please share a copy of this notice with your family members who are covered under the AMP, dental plan, vision plan and RFL.

WALMART'S COMMITMENT TO YOUR PRIVACY

This HIPAA Notice of Privacy Practices applies only to the self-insured AMP, dental and vision plans and to RFL (Plans) maintained by Wal-Mart Stores, Inc. (Walmart). References to "we" and "us" throughout this notice mean the Plans. Walmart also provides benefits for some associates through a Health Maintenance Organization (HMO), a fully insured PPO Plan and a fully insured international business travel medical plan. For these benefit options, the insurer of the HMO or PPO Plan or international business travel medical plan is responsible to protect your health information under the HIPAA rules, including providing you with its own notice of privacy practices.

The Plans are dedicated to maintaining the privacy of your health information for as long as the Plans hold your health information or for fifty years after your death. In operating the Plans, we create records regarding you and the benefits we provide to you. This notice will tell you about the ways in which we may use and disclose health information about you. We will also describe your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to:

- Maintain the privacy of your health information, also known as Protected Health Information (PHI)
- Provide you with this notice
- Comply with this notice, and
- Notify you if there is a breach of your unsecured PHI.

The Plans reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If there is a material revision to this notice, the new notice will be distributed to you. You may obtain a paper copy of the current notice by contacting the Plans using the contact information listed at the end of this notice. The most current notice is also available on the benefits website on the WIRE.

HOW THE AMP, DENTAL PLAN, VISION PLAN AND RFL MAY USE AND DISCLOSE YOUR PHI

The law permits us to use and disclose your protected health information (PHI) for certain purposes without your permission or authorization. The following gives examples of each of these circumstances:

1. **For Treatment.** We may use or disclose your PHI for purposes of treatment. For example, we may disclose your PHI to physicians, nurses and other professionals who are involved in your care.
2. **For Payment.** We may use or disclose your PHI to provide payment for the treatment you receive under the Plans. For example, we may contact your health care provider to certify that you have received treatment (and for what range of benefits), and we may request details regarding your treatment to determine if your benefits will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members or other insurance companies.
3. **For Health Care Operations.** We may use or disclose your PHI for our health care operations. For example, our claims administrators in some states or the Plans may use your PHI to conduct cost-management and planning activities. Any information which we use or disclose for underwriting purposes will not include any of your PHI which is genetic information.
4. **To the Plans' Sponsor.** The Plans may use or disclose your PHI to Walmart, the Plan Sponsor. The Plans' Sponsor will only use your PHI as necessary to administer the Plans. The law only permits the Plans to disclose your PHI to Walmart, in its role as the Plans' 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 third party involved in your health care including a family member, close friend or a person you identified to the Plan as involved in your health care, provided that you agree to this disclosure. If you are not present or available to agree or disagree to disclose your PHI to a third person requesting

the PHI, then the Plans may use professional judgment to determine if the disclosure of PHI is in your best interests. If it is determined that a disclosure of PHI is then in your best interest, the Plans may disclose the minimum amount of PHI necessary to meet the need. Additionally, you have the right to request that the Plans limit any disclosure of PHI to specific individuals involved in your health care.

OTHER USES OR DISCLOSURES OF YOUR PHI WITHOUT AN AUTHORIZATION

The law allows us to disclose your PHI in the following circumstances without your permission or authorization:

1. **When Required by Law.** The Plans will use and disclose your PHI when we are required to do so by federal, state or local law.
2. **For Public Health Risks.** The Plans may disclose your PHI for public health activities, such as those aimed at preventing or controlling disease, preventing injury, reporting reactions to medications or problems with products, and reporting the abuse or neglect of children, elders and dependent adults.
3. **For Health Oversight Activities.** The Plans may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include investigations, inspections, audits and licensure.
4. **For Lawsuits and Disputes.** The Plans may use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we receive satisfactory assurances from the party seeking the information that reasonable efforts have been made to inform you of the request and given you the opportunity to raise an objection to the court or obtain an order protecting the information the party has requested.
5. **To Law Enforcement.** The Plans may release your PHI if asked to do so by a law enforcement official in certain circumstances, including but not limited to the following:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe might have resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime or the description, identity or location of the person who committed the crime), and
   - In cases where a law enforcement agency has requested PHI for purposes of identifying or locating an individual, HIPAA permits that if certain specific situations are met, the Plans must disclose to the law enforcement agency limited information such as name, address, Social Security number, ABO blood type, type of injury, date and time of treatment or death and distinguishing physical characteristics.
6. **To Avert a Serious Threat to Health or Safety.** The Plans may use or disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
7. **For Military Functions.** The Plans may use or disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans), and if required to assure the proper execution of a military mission if the appropriate military authority has published the required information in the Federal Register.
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: for the institution to provide health care services to you; for the safety and security of the institution; and/or 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.** The Plans may disclose your PHI upon your death to a coroner, funeral director or to tissue or organ donation services, as necessary to permit them to perform their functions.
12. **Research.** HIPAA permits the Plans to disclose PHI for government-approved research purposes. It is the policy of the Plans not to disclose PHI for research purposes and will not disclose your PHI for such purposes unless the PHI is required to be disclosed under law.
13. **Psychotherapy Notes.** An authorization is always required to use or disclose psychotherapy notes to a third person unless the use or disclosure is permitted under HIPAA regulations. Permissible uses or disclosures include: use for treatment, payment or health care operations; use by the originator of the notes for treatment; use by the Plans to defend themselves in a lawsuit that you initiate; when required by the Secretary of the Department of Health

and Human Services; when such disclosure is required by law; for health oversight activities as permitted under the regulations; disclosure to a person who can reasonably prevent serious harm to an individual or the public; and disclosure to a medical examiner or coroner for the purpose of identifying a deceased person, determining cause of death or such other purposes permitted by law. While the regulations permit covered entities to use and disclose psychotherapy notes for purposes of training health professionals or students, the Plans do not engage in such training exercises and cannot disclose the information for these purposes.

14. **Victims of Abuse, Neglect or Domestic Violence.** The Plans may disclose your PHI if there is reasonable belief that you are a victim of abuse, neglect or domestic violence. Such disclosure is permitted under HIPAA only if required by law or with your permission or to the extent the disclosure is expressly authorized by statute and only if, in the Plan's best judgment, the disclosure is necessary to prevent serious harm to you or other potential victims.
15. **Health Oversight Activities and Joint Investigations.** The Plans must disclose PHI requested of health oversight agencies for purposes of legally authorized audits, investigations including joint investigations, inspections, licensure, disciplinary actions or other oversight activities of authorized entities.
16. **Disaster Relief Efforts.** The Plans may use or disclose your PHI to notify a family member or other individual involved in your care of your location, general condition or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notification.

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USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

The Plans will obtain your written authorization for any other uses or disclosures of your PHI, including for most uses and disclosures of psychotherapy notes, except in situations noted above, uses and disclosures of PHI for marketing purposes, and uses or disclosures that are a sale of PHI. The Plan will not condition your eligibility to participate in the Plan or payment of benefits under the Plan upon your authorization, except where allowed by law. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization at any time in writing. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization, except for where we have taken action in reliance on your authorization before we received your written revocation.

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.

YOUR RIGHTS RELATED TO YOUR PHI

You have the following rights regarding your PHI that we maintain:

1. **Right to Request Confidential Communications.** You have the right to request that the Plans communicate with you about your health and related issues in a particular manner or at a certain location if you feel that your life may be endangered if communications are sent to your home. For example, you may ask that we contact you at work rather than home. In order to request a type of confidential communication, you must make a written request to the address at the end of this section specifying the requested method of contact or the location where you wish to be contacted. For us to consider granting your request for a confidential communication, your written request must clearly state that your life could be endangered by the disclosure of all or part of this information.
2. **Right to Request Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. We generally are not required to agree to your request except in limited circumstances; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. To request a restriction in our use or disclosure of your PHI, you must make your request in writing to the address at the end of this section. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit the Associates' Medical Plan's, dental plan's, vision plan's or RFL's use, disclosure or both; and (c) to whom you want the limits to apply.
3. **Right to Inspect and Copy.** Except for limited circumstances, you have the right to inspect and copy the PHI that may be used to make decisions about you. Usually, this includes medical and billing records. To inspect or copy your PHI, you must submit your request in writing to the address listed at the end of this section. The Plans must directly provide to you, and/or the individual you designate, access to the electronic PHI in the electronic form and format you request, if it is readily producible, or, if not, then in a readable electronic format as agreed to between you and the Plan. The Plans may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances, in which case you may submit a request to the Plan at the address below that the denial be reviewed.
4. **Right to Request Amendment.** You have the right to request that we amend your PHI if you believe it is incorrect or incomplete. To request an amendment, you must submit a written request to the address listed at the end of this section. You must provide a reason that supports your request for amendment. We may deny your request if you ask us to amend PHI that is: (a) accurate

and complete; (b) not part of the PHI kept by or for the Plan; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by the Plan, unless the individual or entity that created the PHI is not available to amend it. Even if we deny your request for amendment, you have the right to submit a statement of disagreement regarding any item in your record you believe is incomplete or incorrect. If you request, it will become part of your medical record and we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

5. **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures. An accounting of disclosures is a list of certain disclosures we have made of your PHI, for most purposes other than treatment, payment, health care operations and other exceptions pursuant to law or pursuant to your authorization. To request an accounting of disclosures, you must submit a written request to the address at the end of this section. You must specify the time period, which may not be longer than the six-year period prior to your request. We will notify you of the cost involved in complying with your request and you may choose to withdraw or modify your request at that time.
6. **Paper Notice.** You have a right to request a paper copy of this notice, even if you have agreed to receive this notice electronically.

If you believe your privacy rights have been violated, you may file a complaint with the Associates' Medical Plan, dental plan, vision plan or RFL, or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, you must submit it in writing to the address listed at the end of this section. Neither Walmart nor the Plans will retaliate against you for filing a complaint.

If you have questions about this notice or would like to exercise one or more of the rights listed in this notice, please contact:

Walmart People Services
Attn: HIPAA Compliance Team
508 SW 8th Street
Mail Stop #3500
Bentonville, Arkansas 72716-3500

Email your questions to: privacy@wal-mart.com
Telephone: 800-421-1362

Medicare and your prescription drug coverage

Please read this notice about Medicare and your prescription drug coverage carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the Associates' Health and Welfare Plan (the Plan) and your prescription drug coverage option under Medicare. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

There are important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Some of the Walmart prescription drug plans (as described later in this notice under the heading Which Walmart plans are considered creditable coverage?) are, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and are therefore considered creditable coverage. If you are a participant in one of these plans, you may keep your current coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
- Other Walmart plan options (as described later in this notice under the heading Which Walmart plans are considered non-creditable coverage?) are, on average for all Plan participants, not expected to pay out as much as the standard Medicare prescription drug coverage will pay. If you are a participant in one of these plans, your coverage is non-creditable coverage. This is important because for most people enrolled in these plan options, enrolling in Medicare prescription drug coverage means you will get more help 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.

If you have non-creditable coverage under the Plan, it may affect how much you pay for Medicare D drug coverage in the future. When you become eligible for Medicare D, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offered by Medicare prescription drug coverage in your area. Read this notice carefully — it explains your options.

CREDITABLE AND NON-CREDITABLE COVERAGE

What is the meaning of the term "creditable coverage"? Creditable coverage means that your current prescription drug coverage is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Prescription drug coverage that does not satisfy this requirement is not creditable coverage.

WHICH WALMART PLANS ARE CONSIDERED CREDITABLE COVERAGE?

Walmart has determined that the following Plans' prescription drug coverages are considered creditable according to Medicare guidelines:

- HRA High Plan
- HRA Plan
- Select Network Plan
- Accountable Care Plan
- HMO Plans
- eComm PPO Plan

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 any of the Plans listed above, 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 any of the Plans listed above. If your dependent is enrolled in Medicare Part D and you are not, you are eligible to enroll in a Walmart medical or HMO plan, but your dependent would not be eligible for coverage.

If you drop your medical coverage with Walmart and enroll in a Medicare prescription drug plan, you and your eligible dependents will have the option of re-enrolling in the Walmart Plan during annual enrollment or with a valid status change event. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

WHICH WALMART PLANS ARE CONSIDERED NON-CREDITABLE COVERAGE?

The following Plan's prescription drug coverage is considered non-creditable according to Medicare guidelines:

- HSA Plan

If your coverage is non-creditable, you might want to consider enrolling in Medicare prescription drug coverage or a Walmart creditable Plan listed above because the coverage you have is, on average for all participants, not expected to pay out as much as the standard Medicare prescription drug coverage will pay.

WHEN CAN I ENROLL FOR MEDICARE PRESCRIPTION DRUG COVERAGE?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

If you have creditable prescription drug coverage and you lose it through no fault of your own, you will be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you have non-creditable prescription drug coverage and you drop coverage under the Plan, 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 continuous 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.

Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may always be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following Medicare annual enrollment period beginning in October to join.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current coverage under the Associates' Medical Plan (AMP) will be affected. Plan guidelines restrict you from enrolling in the AMP 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 the AMP, but your dependent would not be eligible for coverage.

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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, but only during annual enrollment or due to a status change event.

If you enroll in a Medicare Part D plan and decide within 60 days to switch back to a plan under the Walmart AMP, you will automatically be re-enrolled for the same coverage you had prior to the status change event. See the Eligibility and enrollment chapter for further details.

FOR MORE INFORMATION ABOUT MEDICARE AND YOUR PRESCRIPTION DRUG COVERAGE

- You will get this notice each year before your Medicare enrollment period.
- If we make a plan change that affects your creditable coverage, you will receive another notice.
- If you need a copy of this notice, you can request one from People Services 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 every year from Medicare. You can also get more information about Medicare prescription drug plans from these sources:

- Visit medicare.gov.
- Call your state health insurance assistance program for personalized help. (See your copy of the "Medicare & You" handbook for its telephone number.)
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

For people with limited income and resources, extra help paying for the Medicare prescription drug plan is available. For more information about this resource, visit the Social Security Administration online at socialsecurity.gov, or call 800-772-1213 (TTY 800-325-0778).

REMEMBER

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 whether or not you have creditable coverage and therefore whether or not you are required to pay a higher premium (a penalty).

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your Wal-Mart Stores, Inc., your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Wal-Mart Stores, Inc. Plan, the Plan must allow you and your dependents to enroll in the Plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at askebsa.dol.gov or call 866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your state for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800-221-3943 State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 800-359-1991 State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone: 800-403-0864

IOWA – Medicaid
Website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 888-695-2447

MAINE – Medicaid
Website:
http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 800-862-4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 800-657-3739

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: https://dwss.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid phone: 609-631-2392
CHIP website: http://www.njfamilycare.org/index.html
CHIP phone: 800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800-541-2831

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NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid website: https://medicaid.utah.gov/
CHIP website: http://health.utah.gov/chip
Phone: 877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid phone: 800-432-5924
CHIP website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP phone: 855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

Valued Plan Participant

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

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

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

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

To learn about or use our grievance process, contact People Services at 1-800-421-1362.

To file a complaint of discrimination, contact the U.S. Department of Health and Human Services, Office of Civil Rights:

Phone: 1-800-368-1019 or 1-800-537-7697 (TDD)

Website: https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf

Email: OCRCompliant@hhs.gov

Interpreter services are available at no cost: 1-800-421-1362.

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

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

汉语普通话
翻译服务免费提供。1-800-421-1362.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Glossary of terms

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Glossary of terms

Accountable Care Plan: A type of plan in which a group of doctors, clinics, hospitals and other providers work together in an effort to coordinate efficient and high-quality care for participants within the organization's service area. Care is coordinated through care management processes and through a close relationship between participants and their primary care physicians. The Plan's terms for paying providers for their services include financial incentives to manage care.

Active work or **actively at work:** For medical, dental, vision, Resources for Living, critical illness, accidental death and dismemberment, and accident insurance coverage, "active work" means you have reported to work for Walmart.

For company-paid life insurance, optional associate life insurance, optional dependent life insurance, business travel accident insurance and all types of disability coverage, "active work" means you are actively at work with the company on a day that is one of your scheduled work days and you are performing all of the regular duties of your job on a full-time basis or a part-time basis (depending on your classification as a full-time or part-time associate). You will be deemed to be actively at work on a day that is not one of your scheduled work days only if you were actively at work on the preceding scheduled work day.

Annual deductibles: The amount you pay each year for eligible charges before the Plan pays a portion of your covered expenses. Under the Accountable Care Plans and the Select Network Plan, doctor visits are not subject to the deductible but are subject to a copayment that must be paid each time you use the service. If you choose one of the HRA plans, your Walmart-provided HRA funds will be used toward your annual deductibles. See The medical plan chapter for specific details.

Annual enrollment: 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): Refers to the medical plans offered by Walmart (the HRA High Plan, HRA Plan, HSA Plan, Accountable Care Plans and Select Network Plan). See The medical plan chapter for more information.

Authorized company business travel: A trip the company authorizes you to take for the purpose of furthering the company's business. An authorized trip:

- Begins when you leave your residence or regular place of employment, and
- Ends when you return to your residence or regular place of employment.

Behavioral health benefits: The benefits for mental health and substance abuse, including alcohol and drug abuse.

Behavioral health facility: With respect to behavioral health benefits, a medical facility that provides:

- 24-hour inpatient care
- Partial hospitalization or outpatient care that requires six to eight hours of service per day, five to seven days per week
- Intensive outpatient care that requires two to four hours of service per day, three to five days per week, or
- A residential treatment facility.

Brand-name drug: A drug manufactured by a single manufacturer that has been evaluated for safety and effectiveness when compared with similar drugs treating the same condition and identified for inclusion on the covered brand-name drug list.

Catch-up contributions: Additional contributions allowed by the IRS to an associate's Health Savings Account if the account holder is age 55 or older. Catch-up contributions are also allowed by the IRS to an associate's 401(k) plan if the associate is age 50 or older.

COBRA: The Consolidated Omnibus Budget Reconciliation Act, which allows associates and their eligible dependents who experience a loss in coverage due to a qualifying event to continue medical, dental and vision coverage.

Coinsurance: The amount you pay for eligible expenses under the medical and dental plans after you've met your annual deductible. See The medical plan and The dental plan chapters for specific coinsurance details.

Company: Wal-Mart Stores, Inc. and its participating subsidiaries.

Coordination of benefits: When two benefit plans insure the same participant and coordinate coverage, the process of designating one plan as primary and the other as secondary.

Copay or **copayment:** A fixed dollar amount required for certain covered services or supplies, such as prescriptions or for certain services under the vision plan, or for certain provider visits if you are enrolled in an Accountable Care Plan, the Select Network Plan, an HMO or the eComm PPO Plan.

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Copay assistance: When discounts, coupons, pharmacy discount programs or similar arrangements are provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug discount/coupons provided to pharmacies when you fill a prescription). See The medical plan and The pharmacy benefit chapters for details.

Covered expenses: Charges for procedures, supplies, equipment or services covered under the Associates' Medical Plan that are:

- Medically necessary
- Not in excess of the maximum allowable charge
- Not excluded under the Plan, and
- Not otherwise in excess of Plan limits.

Custodial care: Services that are given merely as "care" in a facility or home to maintain a person's present state of health, which cannot reasonably be expected to significantly improve.

Disability or **disabled:** Under all coverage options available under the long-term disability (LTD) and truck driver LTD plans, "disability" means that, due to a covered injury or sickness during the benefit waiting period and for the next 24 months of disability, you are unable to perform the material and substantial duties of your own occupation (or, under the truck driver LTD plan, you lose medical certification in accordance with the Federal Motor Carrier Safety Regulations). After 24 months of benefit payments, "disability" means that you are unable to perform the material and substantial duties of any occupation.

In determining whether you are disabled, Liberty will not consider employment factors, including but not limited to: interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing or loss of professional or occupational license or certification for reasons other than a covered injury or sickness.

To qualify for LTD benefits:

- You must be unable to return to work after the initial benefit waiting period of disability.
- You must continue to be under the appropriate care of a qualified doctor (qualified doctors include legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses).
- Liberty must receive and approve certification with accompanying medical documentation of a disability from your qualified doctor before benefits are considered for payment.

With respect to short-term disability (STD) coverage, see also "total disability."

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

Eligible dependents: Limited to (and where properly enrolled for coverage, as described in the Eligibility and enrollment chapter):

- Your spouse, as long as you are not legally separated
- Your domestic partner (or "partner"), as long as you and your domestic partner:
  - Are in an ongoing, exclusive and committed relationship similar to marriage and have been for at least 12 months and intend to continue indefinitely
  - Are not married to each other or anyone else
  - Meet the age for marriage in your home state and are mentally competent to consent to contract
  - Are not related in a manner that would bar a legal marriage in the state in which you live, and
  - Are not in the relationship solely for the purpose of obtaining benefits coverage.
- Any other person to whom you are joined in a legal relationship recognized as creating some or all of the rights of marriage in the state or country in which the relationship was created (also referred to as "partner")
- Your dependent children through the end of the month in which the child reaches age 26 (or older, if incapable of self-support) who are:
  - Your natural children
  - Your adopted children or children placed with you for adoption
  - Your stepchildren
  - Your foster children
  - The children of your partner, provided your relationship qualifies under the definition of spouse/partner, or
  - Someone for whom you have legal custody or legal guardianship, provided he or she is living as a member of your household and you provide more than half of his or her support.

If a court order requires you to provide medical, dental or vision coverage for children, the children must meet the Plan's eligibility requirements for dependent coverage.

Evidence of Insurability: See *Proof of Good Health.*

Experimental and/or investigational: Medical procedures, supplies, equipment or services that are defined as experimental and/or investigational according to protocols established by the Third Party Administrators.

Explanation of benefits (EOB): A document sent to Plan participants explaining how a claim was paid or applied.

Extended treatment plan: A plan of care that is consistent with the American Psychiatric Association's standard principles of treatment and is in place of confinement in a hospital or institution. The plan must be in writing and signed by a physician.

Health care advisor: For associates who enroll in the Associates' Medical Plan, a resource who serves as a single point of contact for all inquiries and communication with your Third Party Administrator. Your health care advisor can answer questions about your health care benefits and claims, help you find providers and coordinate care.

Health Reimbursement Account (HRA): An "account" to which the company allocates a specific sum of money to help pay your eligible medical expenses before you have to pay toward the costs of covered medical expenses (except prescriptions). If you choose the HRA High Plan, Walmart will contribute $500 if you select associate-only coverage, or $1,000 if you cover your dependents. If you choose the HRA Plan, Walmart will contribute $300 if you select associate-only coverage, or $600 if you cover your dependents. Your HRA balance may not exceed your network annual deductible for the plan that you are enrolled in. The new Plan year allocation may only be used for the cost of medical goods or services incurred within that Plan year.

Health Savings Account: A tax-advantaged custodial account you can open with HealthEquity, if you are enrolled in the HSA Plan, which can be used to pay for qualified medical expenses (as defined by the IRS), tax-free. Walmart will match your contributions dollar-for-dollar up to $350 if you select associate-only coverage, or $700 if you cover your dependents.

HIPAA: Health Insurance Portability and Accountability Act of 1996, which protects the privacy of personal health information.

Hospital: An institution where sick or injured individuals are given medical or surgical care. The hospital must be a licensed and legally operated acute care general facility that provides:

- Room and board and nursing services for all patients on a 24-hour basis, with a staff of one or more doctors available at all times, and
- On-premise facilities for diagnosis, therapy and major surgery.

A hospital is an institution that is not primarily a nursing home, rest home, convalescent home, institution for treating substance abuse or custodial care institution.

Initial enrollment period: The first time you are eligible to enroll for benefits under the Plan. Initial enrollment periods may vary by job classification. See the charts in the Eligibility and enrollment chapter.

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

- Family and Medical Leave Act (FMLA)
- Personal, and
- Military.

The decision to grant a request for leave shall be based on applicable laws, the nature of the request, the effect on work requirements and consistency with the policy guidelines and procedures.

Materials copay: Under the vision plan, the copay charged for covered lenses and/or frames, as distinct from the copay charged for eye examinations. See The vision plan chapter for details.

Maximum allowable charge (MAC): Under the medical plan, applies to both covered in-network and covered out-of-network services. MAC is the maximum amount the Plan will cover or pay for any health care services, drugs, medical devices, equipment, supplies or benefits covered by the Plan. For details, see The medical plan chapter.

Maximum plan allowance (MPA): Under the dental plan, applies to both covered in-network and covered out-of-network dental services. The MPA is the maximum amount the Plan will cover or pay for dental services covered by the Plan. For details, see The dental plan chapter.

Medically necessary or medical necessity: Procedures, supplies, equipment or services that are determined by the Plan to be:

- Appropriate for the symptoms, diagnosis or treatment of a medical condition
- Provided for the diagnosis or direct care and treatment of the medical condition
- Within the standards of good medical practice within the organized medical community
- Not primarily for the convenience of the patient or the patient's doctor or other provider, and
- The most appropriate procedure, supply, equipment or service that can be safely provided, which means:
  - There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications for the patient with the particular medical condition being treated, than other possible alternatives

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- Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable, and
- For hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

Each Third Party Administrator (TPA) follows its own policies and procedures determining whether a procedure, supply, equipment or service is medically necessary; the policies and procedures may vary by TPA. Your Plan benefits are subject to the terms of such policies. For details, see The medical plan chapter.

Network providers: Health care providers that have a written agreement with Third Party Administrators to provide services at discounted rates.

Non-network providers: Health care providers that do not have a written agreement with Third Party Administrators to provide services at discounted rates.

Out-of-network benefits: Payment for covered expenses that are provided by a non-network provider and do not meet the criteria outlined under When network benefits are paid for out-of-network expenses in The medical plan chapter. (Out-of-network benefits are not provided under the Accountable Care Plans or the Select Network Plan, except in cases of emergency, as defined by the Third Party Administrator.)

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

Partially disabled or **partial disability:** Under all coverage options available under the long-term disability (LTD) and truck driver LTD plans, "partially disabled" means that, as a result of sickness or injury, you are able to:

- Perform one or more, but not all, of the material and substantial duties of your own or any occupation on a full-time or part-time basis, or
- Perform all of the material and substantial duties of your own occupation on a part-time basis, and
- Earn between 20% and 80% of your indexed pre-disability earnings.

Preauthorization or **prior authorization:** A notification that may be required as a condition to coverage for certain services by network providers. For more information about services requiring prior authorization, see the Preauthorization and Centers of Excellence sections of The medical plan chapter. Additional details are available by contacting the applicable administrator.

Premium: The amount you pay for the benefits you choose, generally out of each paycheck.

Prenotification: A notification voluntarily made by enrollees/providers to advise Third Party Administrators of any upcoming hospital admissions or outpatient services. As described in the Prenotification section of The medical plan chapter, responses by Third Party Administrators to prenotification inquiries are not binding on the Associates' Medical Plan.

Proof of Good Health or **"Evidence of Insurability"**: Evidence of your health condition, which includes completing a questionnaire regarding your medical history and possibly having a medical exam. The Proof of Good Health questionnaire is made available when you enroll.

Qualified medical expense: An expense that meets the definition of medical expenses under Internal Revenue Code Sec. 213(d). Examples are provided in IRS Publication 502, Medical and Dental Expenses.

Qualified Medical Child Support Order (QMCSO): A final court or administrative order requiring an associate to carry health care coverage for eligible dependents under the Plan, usually following a divorce or child custody proceeding.

Residential treatment facility: A facility offering 24-hour residential programs that are usually short-term in nature and provide intensive supervision and highly structured activities through a written individual treatment plan to persons undergoing an acute demonstrable psychiatric crisis of moderate to severe proportions. The facility must be licensed by the state as a psychiatric residential treatment facility and accredited by the Joint Commission, the nonprofit organization that accredits United States health care programs and organizations.

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 WalmartOne.com.

Spouse/partner: Where properly enrolled for coverage, as described in the Eligibility and enrollment chapter:

- Your spouse, as long as you are not legally separated
- Your domestic partner (or "partner"), as long as you and your domestic partner:
  - Are in an ongoing, exclusive and committed relationship similar to marriage and have been for at least 12 months and intend to continue indefinitely
  - Are not married to each other or anyone else
  - Meet the age for marriage in your home state and are mentally competent to consent to contract

  - Are not related in a manner that would bar a legal marriage in the state in which you live, and
  - Are not in the relationship solely for the purpose of obtaining benefits coverage.
- Any other person to whom you are joined in a legal relationship recognized as creating some or all of the rights of marriage in the state or country in which the relationship was created (also referred to as "partner").

Status change event: An event that allows you to make changes to your coverage outside of the initial enrollment period or annual enrollment period, and in accordance with federal law. These events are listed in the Eligibility and enrollment chapter.

Third Party Administrator (TPA): A third party that makes claims and internal appeals determinations under the Plan, pursuant to a contractual arrangement with the Plan. Third Party Administrators process your claims and internal appeals with respect to the Plan's self-funded medical benefits. Third Party Administrators do not insure any benefits under the Plan.

Total disability or **totally disabled**: Under the short-term disability plans, "total disability" means that you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy. Benefits will be payable during a loss of license only while you are disabled or pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. The determination of whether you are disabled will be made by Sedgwick (or Liberty, as applicable) on the basis of objective medical evidence. Objective medical evidence consists of facts and findings, including but not limited to, X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician; and you must be under the continuous care of a qualified doctor and following the course of treatment prescribed. Loss of license in and of itself is not sufficient for meeting the definition of disability.

Walmart: Wal-Mart Stores, Inc. and its participating subsidiaries.

Your own occupation: Under the long-term disability and truck driver long-term disability plans, the occupation that you were performing at Walmart at the time your disability began. "Any occupation" refers to an occupation that you are or can become reasonably fitted for by training, education, experience, age, and physical and mental capacity.

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For more information

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For more information

IF YOU HAVE QUESTIONS ABOUT...	GET ANSWERS HERE
When you're eligible for benefits or how to enroll	• WalmartOne.com/Benefits • People Services: 800-421-1362
Benefits, medical claims or care management	• WalmartOne.com/Medical • BlueAdvantage Administrators of Arkansas health care advisor: 866-823-3790 • Aetna health care advisor: 855-548-2387 • UnitedHealthcare health care advisor: 888-285-9255 • HealthSCOPE Benefits health care advisor: 800-804-1272
Finding a network provider for medical plans	• WalmartOne.com/ProviderNetworks • Aetna health care advisor: 855-548-2387 • BlueAdvantage Administrators of Arkansas health care advisor: 866-823-3790 • UnitedHealthcare health care advisor: 888-285-9255 • HealthSCOPE Benefits health care advisor: 800-804-1272
Pharmacy benefits	• WalmartOne.com/Prescriptions • Express Scripts: 800-887-6194
Health Savings Account	• WalmartOne.com/HSA • HealthEquity: 866-296-2860
Dental plan	• WalmartOne.com/Dental • Delta Dental: 800-462-5410
Vision plan	• WalmartOne.com/Vision • VSP: 866-240-8390
Accident insurance Critical illness insurance	• WalmartOne.com/Accident • WalmartOne.com/Critical • Allstate Benefits: 800-514-9525
Short-term disability	• WalmartOne.com/ShortTermDisability • Sedgwick or Liberty: 800-492-5678
Long-term disability Truck driver long-term disability	• WalmartOne.com/LongTermDisability • Liberty: 800-492-5678
Life and accidental death and dismemberment (AD&D) insurance	• WalmartOne.com/Life • WalmartOne.com/ADD • Prudential: 877-740-2116
Resources for Living®	• WalmartOne.com/RFL • 800-825-3555, 24/7
Walmart 401(k) Plan	• WalmartOne.com/401k • Benefits.ml.com • Bank of America Merrill Lynch: 888-968-4015
Associate Stock Purchase Plan	• WalmartOne.com/ASPP • Computershare: 800-438-6278 (800-952-9245 for the hearing impaired)

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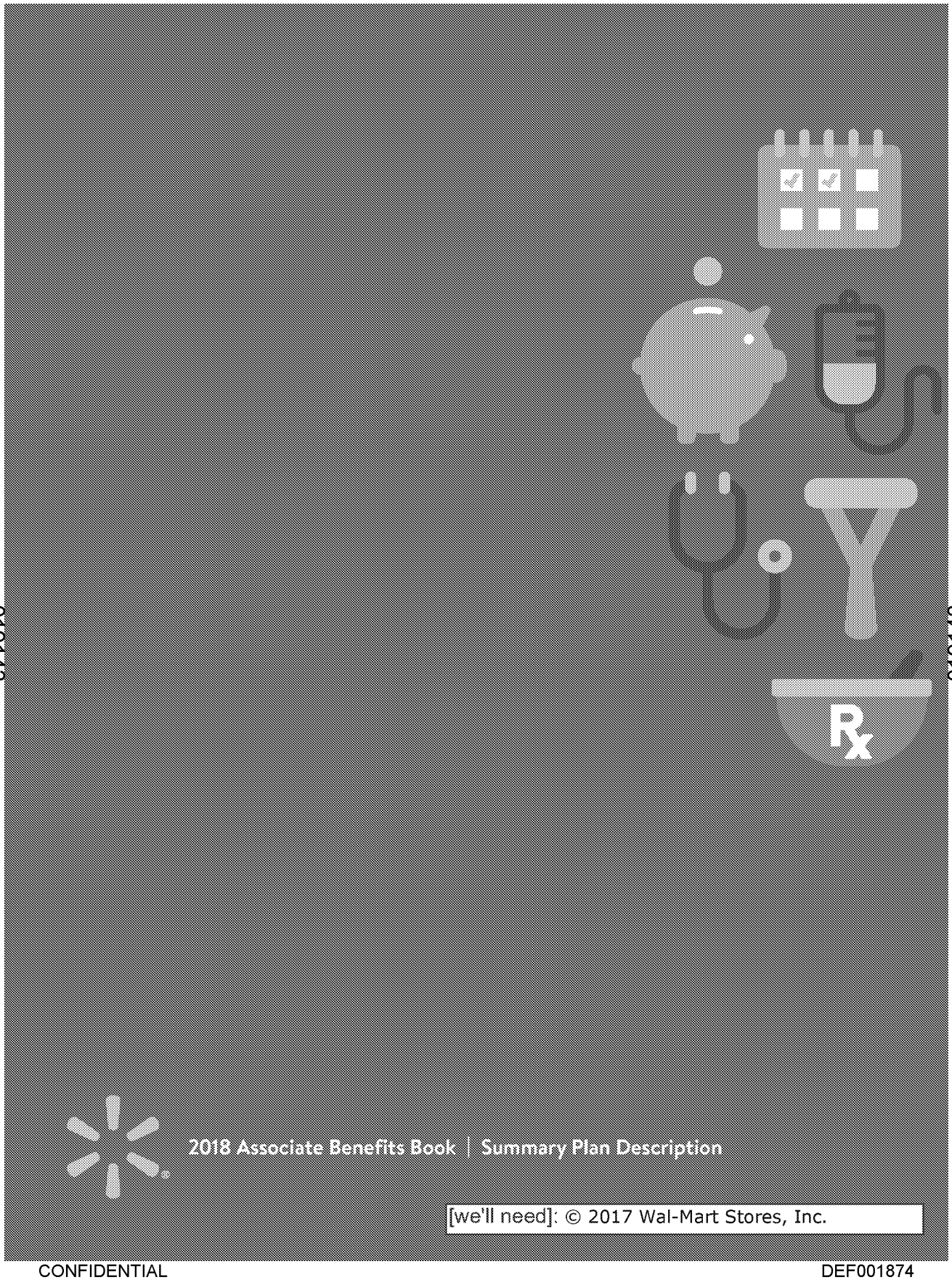

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